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

Health Activity Purchasing Intentions 2014-2015



improving care | managing resources | delivering quality

Delivering a **Healthy WA**

Acknowledgement and Thanks

The ongoing contributions and commitment by many individuals, teams and networks over the past four years has enabled WA Health to make good progress with the transition to ABF/ABM. Your efforts have shaped the development of the 2014-2015 volume of the WA Health Activity Purchasing Intentions. Thank you to everyone.

The following is by no means exhaustive list of some key people who helped to embed health activity purchasing reform and ABF/ABM in our everyday practice. The contributions have built the readiness of WA Health for the 2014-2015 ABF/ABM enhancements. We thank you and acknowledge your leadership, support and commitment:

- All patients and consumers who use WA Health services and work with us to improve care.
- WA clinicians, especially the many dedicated nurses, doctors and allied health professionals who work tirelessly every day to deliver safe and quality care.
- All staff who work in the Performance Activity and Quality Division and the partnering Divisions of the Department of Health.
- Chairs and members of ABF/ABM Working Groups and Committees.
- The WA A/Director General of Health.
- Health Service Chief Executives and their Executive teams.

We would also like to acknowledge and thank the thousands of participants who have attended our training and education programs and clinician and business forums for their input, advice and direction. Your work has ensured ABF/ABM is becoming the “way we do business” and that WA Health will thrive well into the future.

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Foreword

Welcome to the fifth edition of Health Activity Purchasing Intentions (HAPI 5). This is the fifth year of Activity Based Funding and Activity Based Management (ABF/ABM) in WA. It is also the first year of transitioning to the national ABF environment.

In the past four years, we have implemented a number of initiatives to build a solid foundation for ABF/ABM within the WA Health system. The implementation of safety and quality policies and programs has seen greater support for staff to provide the best quality and safe care. Patient safety and quality are fully integrated and continue to be key quality objectives for ABF/ABM.

This year marks a major reform phase. Achievements and lessons learned are shaping the priorities and challenges to be tackled in 2014-2015. The unit cost of providing hospital services in WA continues to exceed the national average. In the next four years, the key purchasing objective is to achieve convergence between the WA public hospital services cost and the national average cost. This requires a reduction in annual cost growth in hospital services from 2.7% in 2014-2015 to 0.9% by 2017-2018.

A particular area requiring improvement for 2014-2015 is tighter adherence to the Admission, Readmission, Discharge and Transfer Policy to ensure reliable activity data is used for reporting, revenue and purchasing functions.

The establishment of WA Health Transition and Reconfiguration Steering Committee, together with the Finance, Purchasing, and Performance Group is strengthening WA Health system's leadership and coordination of the reform and change management, whilst promoting budget stability and sound fiscal management.

HAPI 5 outlines key purchasing priorities, updates and consolidates the previous efforts in embedding ABF/ABM to daily practice across WA Health. We will continue to enhance the ABF/ABM to ensure WA Health continues to deliver safe care of the highest quality in a timely manner to WA communities, at an agreed price.

HAPI 5 will guide you through:

- WA Health's system wide ABF/ABM approach for 2014-2015
- WA Health's planned purchasing of health activity for 2014-2015
- the policy guidelines and pricing methods that shape health activity purchasing decisions for 2014-2015
- updates to health activity funding allocation, including emergency care, acute and subacute care services, non-admitted care, hospital in the home, mental health services, Aboriginal health and other non-hospital products.

To thrive in an ABF/ABM environment requires significant changes, greater efforts and a wide reaching engagement at every level of the organisation.
We are committed to closely working with all our stakeholders.

Beress Brooks
A/EXECUTIVE DIRECTOR
PERFORMANCE ACTIVITY AND QUALITY DIVISION
DEPARTMENT OF HEALTH

Executive Summary

Health Activity Purchasing Intentions 2014-2015 (HAPI 5) indicates WA Health's strategic planning approach for health activity purchasing in an ABF/ABM environment. It focuses on the "purchasing" function and the integrated nature of purchasing within the WA Health system. It aims to ensure that health service delivery can be accurately planned, resourced and managed to deliver high quality patient outcomes at an agreed price.

A range of work streams and programs have been undertaken to enable the implementation of ABF/ABM and its purchasing function. These include development of clinical and business networks and working groups, educational resource development, training and development programs, policy guidelines, activity, costing and pricing methodologies, and a constant evaluation and action cycle.

HAPI 5 maintains focus on the important role of patient safety and quality, the WA Health Clinical Services Framework, the role delineation of "Purchaser" and "Provider", government policy, the alignment with national ABF, and other clinical and economic evidence that provide context for the application of ABF/ABM within WA Health system. More details are in section 1.

Safety and Quality Investment for Reform, Performance-based Premium Payments, Safety and Quality Monitoring Systems, the compliance with Admission, Readmission, Discharge and Transfer Policy and changes to the activities that are subject to ABF are highlighted in section 2.

Over the past four years the WA ABF/ABM operating model has encouraged the delivery of better quality care, and more efficient and transparent use of public resources. The WA operating model, price, weighted activity units and adjustments are discussed in section 3.

Funding allocation to Health Services is dependent on the price, activity levels, delivery capacity and the budget. Updates on budget settings and funding allocation are detailed in section 4.

The Service Agreements (SA) provide the binding agreement between the Department of Health (the Department) and Health Services. SAs outline the purchasing plan and payments, activity reporting, measuring, monitoring and performance management. More details are discussed in section 5.

HAPI 5 should be read in conjunction with the other series of ABF/ABM documents, including

- Performance-Based Premium Payments Guide 2014-2015
- Performance Management Framework (PMF) 2014-2015
- Admissions, Readmissions, Discharge & Transfer Policy
- WA Health Clinical Services Framework 2010-2020
- Guide to Managing in an ABF Environment
- Clinical Casemix Handbook
- ABF/ABM Implementation Self Assessment Tool.

1.0 Introduction and Background

1.1 Purchasing within an ABF/ABM Framework

Health services purchasing cover a wide range of activities, including policy development and planning, provision of grant and contract funding. Strategically, health activities are bought with an aim of achieving social objectives in the most cost-effective way.

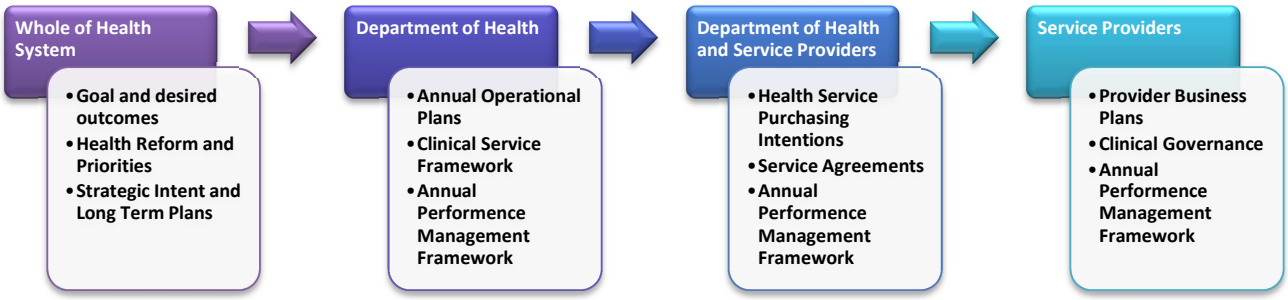
An Activity Based Funding (ABF) framework provides an environment for purchasing from providers based on the level of activity they undertake. Basically, it multiplies a unit price by the volume of activity to determine the quantum of funds for the purchase.

Purchasing priorities and contracts identified by WA Health over the next five years will be informed by a hierarchy of policy and planning processes, including:

- State and Commonwealth Government policy and purchasing priorities
- WA Health Clinical Services Framework 2010-2020 (CSF)
- WA Health Strategic Intent 2010-2015.

The purchasing arrangements are communicated through Service Agreements (SAs) and providers' business plans that specify how the SAs are to be implemented. These links are illustrated in Figure 1.

Figure 1: WA Health Planning Processes and Contracts



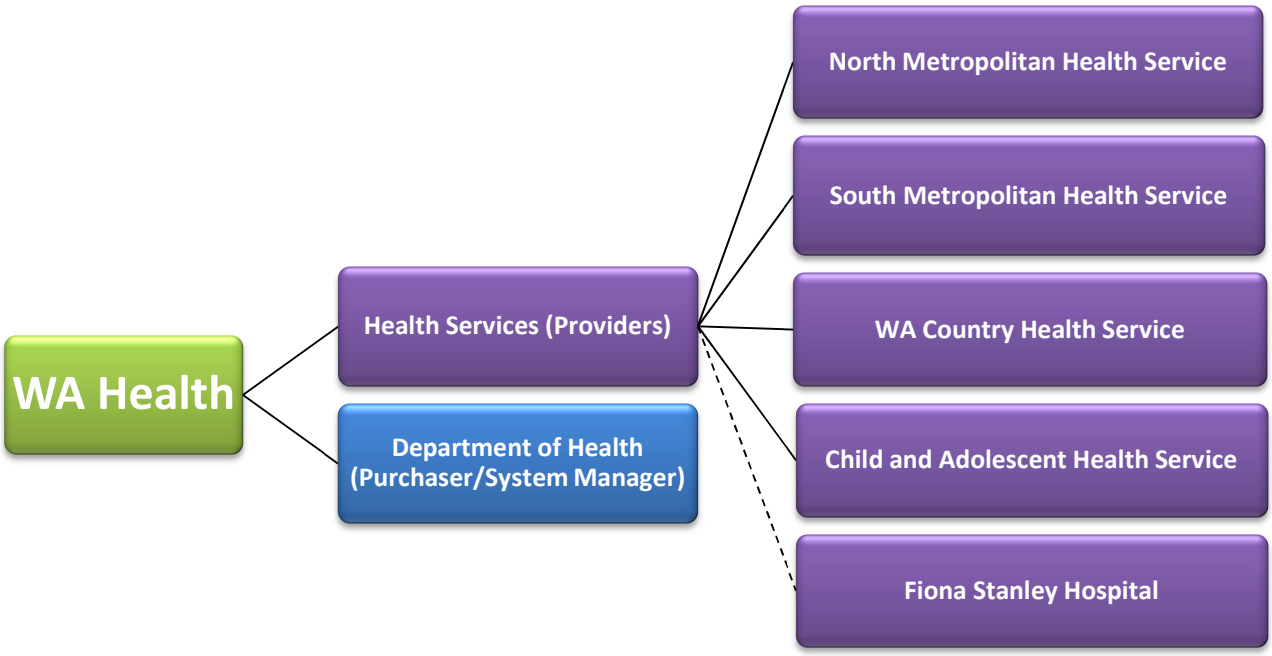
The purchasing priorities and operation of the ABF/ABM in 2014-2015 are informed by:

- epidemiological data
- demographic data
- projections of future service needs and the CSF, which is the high-level policy framework for the planning and delivery of health care services that WA Health is to deliver over the next six years.

Purchaser: Provider Roles and Responsibilities in the WA Health System

The concept of "Purchaser: Provider" role delineation has provided a significant direction in the provision of government services over recent decades, and is integral to the WA approach to ABF/ABM (refer to Figure 2).

Figure 2: WA Health Purchaser: Provider Structure for ABF/ABM Implementation



The intent of ABF/ABM is to achieve health goals within a unified health system by working towards a common vision. The Department has a clear expectation that ABF/ABM is implemented and managed on a daily basis and in partnership with Health Services. Table 1 provides an overview of functions relevant to health activity purchasing and ABF/ABM.

Table 1: Mapping Responsibilities of Purchasing Across the WA Health System

Function/Responsibility	Commonwealth Government	Department of Health Divisions	Mental Health Commission	Health Services	Statewide Services	NGOs
Policy	✓	✓	✓		✓	
Planning	✓	✓	✓	✓	✓	
Funding	✓	✓	✓	✓		
Purchasing	✓	✓	✓	✓	✓	
Providing		✓				✓
Patient and Community	✓	✓	✓	✓		✓
Performance	✓	✓	✓	✓		✓

Western Australia Local Hospital Network

Local Hospital Network (LHN) is a group of hospitals that provides public hospital services in accordance with the National Health Reform Agreement. There are four LHNs (locally termed Health Services)[1], one new major tertiary hospital and a notional LHN in WA:

[1] *YourHealth- Local Hospital Networks, Department of Health and Ageing, Australian Government*

1) Child and Adolescent Health Service (CAHS) is a LHN located in Perth and provides comprehensive care for children
2) North Metropolitan Health Service (NMHS) is the LHN covering the north-eastern metropolitan region of Perth
3) South Metropolitan Health Service (SMHS) is the LHN covering the south-eastern metropolitan region of Perth
    - Fiona Stanley Hospital is a new major tertiary hospital within SMHS due to be opened in 2014-2015
4) WA Country Health Service (WACHS) is the LHN covering all country areas of WA
5) In addition, a 'notional' LHN has been created to recognise health services provided by contracted service providers. This is to ensure that Commonwealth funding is recognised for the provision of these services.

WA Health Transition and Reconfiguration Steering Committee

To better coordinate and harness the efficiency and effectiveness, the Government established the WA Health Transition and Reconfiguration Steering Committee in December 2013. The Committee comprises the Director-General of Health and the Department of Premier and Cabinet, the Under Treasurer and a former Secretary of the Victorian Department of Health in an expert advisory capacity. The Committee's key role is to guide and inform the reform and change management agenda across WA Health, whilst promoting health budget stability and sound fiscal management.

In addition, in January 2014 WA Health established a Finance, Purchasing, and Performance Group under the leadership of the Director General. The Group include all WA Health Services' Chief Executives, the Mental Health Commissioner, and senior Department of Health Executives. The role of the Group is to provide change management leadership at an operational level to ensure that desire system-wide reforms in ABF, revenue, purchasing and performance management can be embedded and sustained within the health system.

1.2 Roles of the WA Health Clinical Services Framework 2010-2020

The WA Health Clinical Services Framework 2010-2020 (CSF 2010) used demand modelling of activity from a 2009-2010 base and outlines the network of services that the WA public health system plans to provide to the WA community between 2010 and 2020. The framework is based on health reform principles recommended by the Reid Report in 2004. They include:

- providing appropriate care closer to where people live
- focusing on primary and community care to reduce demand for hospital services
- ensuring value for money and financial sustainability
- facilitating transparency and accountability.

For purchasing plans to be achievable, they need to align to the health system's capacity to deliver. The CSF is a principal input to the capital planning process, the workforce planning process and the annual budget process. It is the strategic plan to drive the purchasing plans and a mechanism to align activity with capacity. The CSF activity projections are integrated into the ABF process in the following way:

- CSF activity growth rates inform the basis of the Department's budget bid to Government
- CSF activity growth rates for each facility inform the targeted growth rates for ABF.

The CSF focuses much attention on hospital services in recognition of the significant share of health resources that go towards operating public hospitals. In both the metropolitan area and country WA, the current CSF (2010-2020) includes greater detail than the previous CSF on what these hospitals can provide, to the extent of defining roles for rural Integrated Care Centres and Regional Resource Centre facilities. The CSF also covers the non-hospital sector, given the significant contribution of this sector to keeping the community healthy within limited resources.

WA Health is currently preparing the next iteration of the CSF 2014-2024. This involved revised assumptions for population, updated patient flows and service reconfiguration particularly given the impact of new facilities such as the Fiona Stanley Hospital, Perth Children's Hospital and the Midland Health Campus. The updated CSF will provide a blueprint for health service provision. For the first time, it will also provide information on hospital and community-based services delivered by the State's larger private hospitals and by government and the not-for-profit health care sector. A revised CSF is expected to be available for Government consideration by mid-2014.

WA has a number of health reform drivers, similar to other Australian jurisdictions and other developed countries, which include:

- a growing and ageing population
- escalating demand for emergency care and hospital beds
- costly advances in medical technology and pharmaceuticals
- persistent inequity in health status, in particular amongst the Aboriginal population
- current and projected workforce shortages
- increasing community expectations.

To address these issues, purchased services will be aligned with the principles of CSF (within Government approved budget parameters), the health reform agenda and incorporating the following objectives to:

- provide safe, high quality, evidence-based healthcare
- promote a patient centred continuum of care
- keep patients out of tertiary hospitals when clinically appropriate and make better use of more cost-effective general hospitals, including those in country WA
- manage demand for services
- achieve resource and allocative efficiencies.

1.3 Patient Safety and Quality Driving WA Health Purchasing

The underlying principles of the ABF/ABM program are:

- the **patient**, their family and their carers are the central focus of the health system
- **funding** is transparently linked to the efficient delivery of health services and their outcomes
- **evidence** is available to enable performance to be managed
- clinical **leadership** and partnership is essential at all program levels
- **risks** are identified, controlled and managed in a consistent manner
- funding distribution is **equitable**, and recognises the needs of special populations.

These principles will continue to underpin WA Health's design, implementation and review of ABF/ABM in 2014-2015 and beyond.

Figure 3: Components and Outcomes of Safety and Quality within the ABF/ABM Model

The focus of safety and quality within ABF/ABM in 2014-2015 will be on the:

- analysing and learning from the 2014 WA Point Prevalence Survey results
- compliance with the National Safety and Quality Health Service (NSQHS) standards; and
- embedding and reviewing the Performance-based Premium Payment Program, described in section 2.

Health Service Standards and Accreditation

The National Safety and Quality Health Service (NSQHS) standards, and associated accreditation scheme, were developed by The Australian Commission on Safety and Quality in Health Care (ACSQHC) to drive the continuous improvement of the quality and safety of health care in Australia. The NSQHS standards and the associated accreditation scheme became mandatory for all hospitals from 1 January 2013. Accreditation of Mental Health Services is against both the National Standards for Mental Health Services and the NSQHS standards.

Central support for accreditation is provided by three sections of the Performance Activity and Quality Division:

- The **Licensing and Accreditation Regulatory Unit** (LARU) is the WA Regulator of the NSQHS standards. For more information, visit www.health.wa.gov.au/private_licensing
- The **Quality Improvement and Change Management** (QICM) Unit provides policy and practice improvement support to WA Health services for nine of the ten NSQHS standards. Standard seven, Blood and Blood Products, is supported by the Office of the Chief Medical Officer. QICM also provides strategic direction to safety and quality improvements for WA Health services, including via the WA Safety and Quality Strategic Plan 2013-2017: Placing Patients First. The plan is available at http://www.safetyandquality.health.wa.gov.au/docs/WASafetyandQualityStrategicPlan2013-2017.pdf Further information on the ACSQHC framework and goals for health care, and resources to assist with accreditation against the NSQHS standards can be accessed via the Commission's website http://www.safetyandquality.gov.au
- The **Patient Safety Surveillance Unit** (PSSU) develops and manages patient safety data systems, e.g. DATIX clinical incident management system, and disseminates data from these systems, e.g. Report of Death, WA Audit of Surgical Mortality (WAASM) reports.

1.4 Government Policy Guiding WA Health's ABF Purchasing

The main purpose of ABF/ABM is the delivery of safe high quality health care services in a timely fashion and at an agreed price. The ABF/ABM program is part of the broader policy context for WA Health. This includes the Council of Australian Government (COAG) Agreement which has four elements primarily related to the HAPI, including:

- The intergovernmental Agreement (IGA) on Federal Financial Relations (FFR)
- The National Partnership Agreement (NPA) on Improving Public Hospital Services which contains National Emergency Access Targets (NEAT) and National Elective Surgery Targets (NEST)
- The National Healthcare Agreement 2011 (NHA) which contains many of the previous Specific Purpose Payments and NPA indicators
- The National Health Reform Agreement 2011 (NHRA) which has ABF. For more information, visit the COAG website http://www.coag.gov.au/agreements_and_reports

Council of Australian Governments – National Health Reform Agreement 2011

The NHRA sets out the architecture of national health reform, of which ABF is one component. The ABF related aspects of the 2011 reform agenda that are relevant to 2014-2015 include:

- A national approach to funding, on the basis of a National Efficient Price (NEP) Determination for ABF funded public hospital services and a National Efficient Cost (NEC) Determination for block funded public hospital services
- The 2014-2015 NEP and NEC determinations, published by the IHPA in March 2014
- The Department will continue in its role as system manager for public health services and remain responsible for day-to-day hospital system operation and for system-wide public hospital service planning and policy
- Block funding will continue to be used to fund services that are currently difficult to manage on an ABF basis.

1.5 Enabling WA Health's ABF Purchasing

The Department and the Health Services continue to develop and implement activities, resources, programs and systems that support the application of ABF/ABM. The early creation of the WA activity based funding model in 2010 ensured the ABF environment in WA was tailored to focus on the WA Health patient and the patients' individual episodes of care. The WA ABF modelling also made sure that any alignment with national ABF would add to, rather than detract from, the WA public health system.

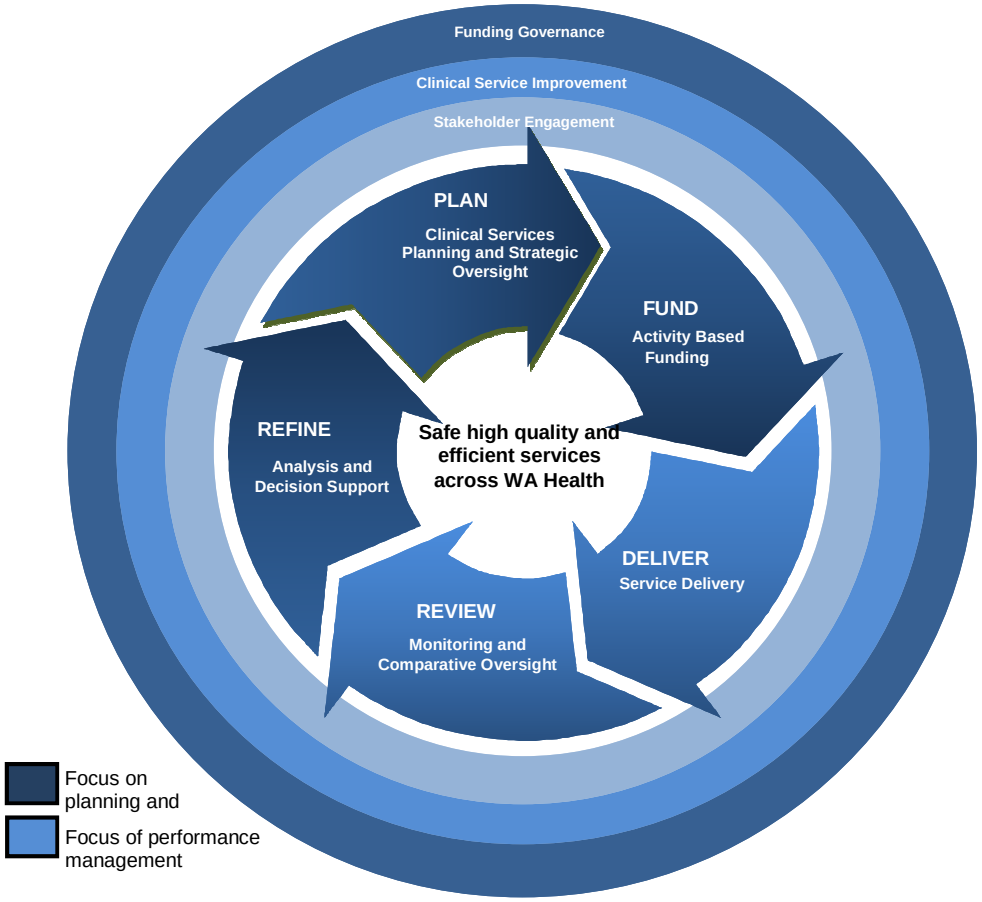
WA Health's initial ABF modelling included the development of the weighted activity units for emergency (eWAU) and in-patient care (iWAU) from 1 July 2010. It then expanded to include outpatients (oWAU) from July 2011. In that time, WA Health has also placed a high degree of importance on ensuring funding flow drivers for safe, high quality care and built incentives for efficient use of public resources.

WA Health has used its experiences of ABF development and implementation to shape the national direction. WA Health has been able to lead, design and provide considered advice and feedback to inform national ABF alignment methodologies. The ABF model now used in WA Health is aligned to the national model, adopting national price weights and associated price loadings.

A significant enabler of the ABF implementation was the design and development of Activity Based Management (ABM). ABM is an approach to plan, budget, allocate and manage health

activity and financial resources to deliver safe, high quality health services, which is a cycle as shown in Figure 4. The ABM approach is applied across the whole of the WA Health system.

Figure 4: Approach to Activity Based Management



A number of resources and education tools have been developed to assist clinicians and business units to manage within an ABF environment on a daily basis. These include:

- ABF/ABM Training and Education Manual
- Managing in an Activity Based Funding Environment a Practical Guide
- Admission, Readmission, Discharge and Transfer (ARDT) Policy for WA Health Services
- Clinical Casemix Handbook
- ABF/ABM Implementation Self-Assessment Tool

These documents can be found on the ABF/ABM intranet site at http://activity/ or http://www.health.wa.gov.au/activity/publications/index.cfm for internet access.

Supporting change management involves leadership, time for peer groups to come together and action learning. Across WA Health change management has been supported through:

- facilitation of Health Services sharing successful implementation strategies
- forming working groups/committees for clinicians and business managers
- scholarships for clinical coding staff
- clinical staff training forums.

In the past four years, Health Services have implemented a wide range of projects leading change in the ABF/ABM environment. Further information can be found at: http://activity/

2.0 WA Health Activity and Purchasing Priorities 2014-2015

2.1 Safety and Quality Programs to be funded through ABF/ABM Framework

The following safety and quality programs will operate in 2014-2015:
(i) Safety and Quality Investment for Reform (SQuIRe) Program
(ii) Performance-based Premium Payments Program
(iii) Safety and Quality Monitoring Systems

The WA Clinical Governance Framework (the Framework) continues to underpin the safety and quality objectives for ABF/ABM in 2014-2015. The Framework is to be used by hospitals and Health Services to ensure:

- high standards of healthcare
- continuous improvement of service quality
- creation and maintenance of an environment that supports clinical excellence.

The Framework is augmented by the following national programs:

- Australian Commission on Safety and Quality in Health Care Work plan 2013-2016
- National Safety and Quality Health Service Standards
- The new Australian Health Service Safety and Quality Accreditation Scheme
- Australian Safety and Quality Goals 2012-2017
- Australian Safety and Quality Framework for Health Care.

It is planned that the Framework will be updated in 2014-2015 financial year. For further information on the Framework please visit http://www.safetyandquality.health.wa.gov.au/

(i) Safety and Quality Investment for Reform Program

Health Services will continue to receive the funding for the SQuIRe program in 2014-2015 as part of their base funding. It is expected that Health Services will use this funding to:

- continue to develop and maintain clinical governance systems and processes
- incorporate safety and quality activities into permanent roles
- attain accreditation under the Australian Health Service Safety and Quality Accreditation Scheme
- implement state and national safety and quality policies and programs, including those initiatives developed by the ACSQHC and endorsed by the Standing Council on Health (SCoH)
- continue existing clinical governance activity and reporting arrangements in line with the WA Health Operational Plan 2014-2015 and the WA Strategic Plan for Safety and Quality in Health Care 2013-2017.

The SQuIRe reporting framework is being reviewed. Reporting templates and timeframes will be advised to Health Services by the Quality Improvement and Change Management Unit.

Current safety and quality indicators are being developed. For further information on SQuIRe please visit www.safetyandquality.health.wa.gov.au.

(ii) Performance-Based Premium Payments Program

The Performance-based Premium Payment Program (the Program) is designed to improve sustainability of clinical practice improvements within an ABF/ABM environment. The program was piloted in 2012-2013 with five payments and was continued in 2013-2014 with three payments. It is anticipated that these payments will be continued in 2014-2015 with no changes:

- Fragility Hip Fracture Treatment
- Stroke Model of Care
- Acute Myocardial Infarction

The program is open to ABF-funded hospitals. Participation is not mandatory; sites and services will be eligible for payment only if the required data is submitted. It has been designed to:

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

Clinical areas have been, and will continue to be selected for inclusion in the Program using the following criteria:

- a strong evidence base and clinical consensus on the characteristics of best practice
- high impact, i.e. variation in practice, gap between best evidence and current practice, high volumes or significant impact on outcomes
- availability and quality of data.

Each year, the Program and incentive models are reviewed and assessed for their effectiveness in creating and maintaining clinical practice improvements in high priority care areas. These reviews can result in adjustments to existing payments, and the introduction of new payments.

Details of the Program will be provided in the 2014-2015 Information Pack, which will be available at http://intranet.health.wa.gov.au/osqh/premiumpayments/

Please contact the Quality Improvement and Change Management Unit for suggestions and input in to the Program, at premiumpayments@health.wa.gov.au.

(iii) Safety and Quality Monitoring Systems

In 2014-2015 a number of monitoring systems will continue to complement ABF/ABM, including:

- analysis and reporting of national core hospital-based outcome indicators of safety and quality
- a cohort of safety and quality key performance indicators as part of the ABF/ABM Performance Management Framework (PMF). More details, see the 2014-2015 PMF at http://www.health.wa.gov.au/activity/publications

2.2 Health Activities Subject to Activity Based Funding

For 2014-2015 there will be an increase in health activity types subject to ABF. Health activity needs to be identified and counted in a standardised manner to be adequately funded. Establishing national standards for activity based data collection and analysis is a significant and ongoing work stream. The current classification system is shown in Table 2. More details can be found at http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/Classifications

Table 2: Health Activity and Relationship to Funding in ABF Environment in 2014-2015

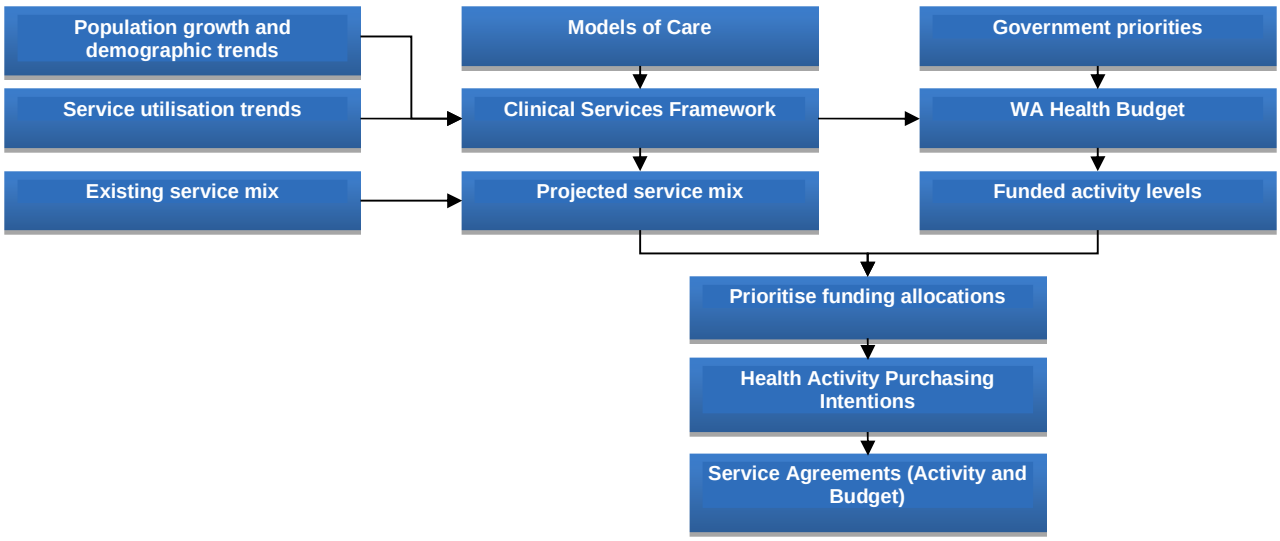
Health Activity Group	Classification System	Current Status
Inpatient Services	Australian-Refined Diagnosis Related Group (AR-DRG) V7.0	ABF
Emergency Department Services	Urgency Related Group (URG) V1.4 Urgency Disposition Group (UDG) V1.3	ABF
Non-Admitted Services	Tier 2 Outpatient Clinic Definitions V3.0	ABF
Subacute and Non-Acute Care Inpatient Services	Australian National Subacute & Non-Acute Patient (AN-SNAP) V3.0	ABF
Other Non-Hospital Products (Including Teaching, Training and Research, Public Health, Community Health, Special Purpose Funding, Election Commitments, EERC Decisions and NPAs)	Not applicable	Blocked Funded

Source: IHPA National Efficient Price Determination 2014-15 and WA Department of Health

2.3 Setting Health Activity Levels

Allocations to Health Services in 2014-2015 are consistent with budget parameters endorsed by the State Government through the budget process. Inpatient and emergency department activity targets were developed using the 2012-13 actual activity outcome escalated by the most recent Clinical Services Framework and the capacity demand modelling growth parameters across 2013-14 and 2014-15. For non-admitted activity, 2013-14 year-to-date actuals were used to develop the base activity escalated for growth in 2014-15.

Figure 5: Allocation of Activity under the WA Approach to ABF



2.4 Correct Classification, Counting and Coding of Health Activity

High quality data is an integral part of ABF/ABM. The correct classification, counting, coding and collecting of data contribute to ABF by providing information that can be used with confidence to:

- inform the setting of health activity levels, funding and budget allocations to Health Services
- support policy and purchasing decisions
- provide information to measure and assess performance
- provide information to national bodies (such as the IHPA, NHPA, ACSQHC, and AIHW) to guide national performance reporting, price setting, and funding allocation.

Importantly, in 2014-2015 health activity data will also directly inform the amount of Commonwealth funding to WA.

Information Governance

Information Governance provides a mechanism to continuously improve the classification, counting, coding and capturing of information. The State Health Information Steering Committee (SHISC) provides a mechanism for Health Service and Departmental coordination and input over definitions for data in WA Health. While the mechanism for communicating changes in definitions is Operational Directives, the consultation and sign-off of these items occurs through SHISC.

Metadata

A strong focus is placed upon definitions to ensure consistency of statistical collections, and interpretation. Performance Activity Quality Division (PAQ) has invested considerable effort towards establishment of metadata. Metadata is described as “data about data”. It is a detailed definition of the data, describing the concept that the data intends to measure, the collection systems and methods used to collect the data, and any coding associated with that data. Dataset Specifications (DSS) are being created for each Health Data Collection which will be available on METeOR (the Metadata Online Registry) and will be updated annually.

Manuals

PAQ also produces the Hospital Morbidity Data System (HMDS) Reference Manual. By providing a clear cut easy to understand information source on data which feeds into the HMDS, health service personnel have reference source to ensure consistency in data recording. A copy of the HMDS Reference Manual is located at:
http://www.health.wa.gov.au/healthdata/docs/Hospital_Morbidity_Data_System_Reference_Manual.pdf

Coding Education and Advice

High quality clinical coding is a key ingredient in the creation of robust and reliable DRG information, which in turn is critical for ABF. The Coding Education Team (the Team) within the Data Integrity Directorate works collaboratively with other PAQ directorates to improve the quality of coded information through the provision of education and advice. The Team supports all coders in WA by providing advice, education and training. This support is delivered via validation of individual coders, the answering of coding queries, the Coding Education Newsletter, and a suite of educational resources available on-line at:
www.clinicalcoding.health.wa.gov.au

Career advice is provided regularly by the Team to local, national and international enquirers. The clinical coding workforce has strengthened over the past few years with the increased

profile of clinical coding and the support of coding graduates by the Team. The Team represents WA on the National Coding Technical Group and liaises with the Australian Consortium of Classification Development (ACCD) which ensures WA has input in national coding decisions. The WA Clinical Coding Advisory Group, comprising of a cross-section of the WA clinical coding community assists the Team in providing expert advice.

Compliance with Data Collection
Improvements in health activity capture will influence revenues and purchasing. Health Services have an obligation to report activity in an accurate and consistent manner in order to ensure equitable and efficient resource allocation and funding.

Clinical coding staff and clinicians work together to ensure timely and accurate clinically coded information is available. Health activity is recorded through a number of electronic mechanisms across WA Health. These data collections are used to make decisions on purchasing, budgets and funding. Further information about the importance of coding, counting and clinical documentation is contained in the Clinical Casemix Handbook which is available at: http://www.health.wa.gov.au/activity/publications/

A particular area requiring improvement is tighter adherence to the Admission, Readmission, Discharge and Transfer (ARDT) Policy to ensure reliable activity data that is used for reporting, revenue and purchasing functions. The ARDT policy is the overarching framework for the rules and criteria that govern counting and labelling of inpatient activity across the State. It was launched in 2011 and is updated annually to reflect state and national changes.

Compliance and consistency with the ARDT Policy is highly important for two reasons:

- Firstly, consistent classification and tracking of activity within WA allows us to distribute funds efficiently and equitably across our vast health care system, achieve value for money and deliver the most benefit to patients and the community
- Secondly, it outlines the requirements for ensuring activity data complies with mandatory national reporting obligations as part of the National Health Reform Act. Is crucial to ensure the correct classification of the activity and appropriate funding. The most recent ARDT policy can be located at: http://www.health.wa.gov.au/activity/publications/

3.0 Pricing Health Activity in 2014-2015

3.1 The WA ABF/ABM Operating Model

The WA ABF/ABM Operating Model (the WA operating model) for 2014-2015 is the mechanism that sets out the budget activity levels for the delivery of activity based funded health services in WA public hospitals. The WA operating model has been developed to take account of the national ABF program which commenced across Australia from 1 July 2012.

The national ABF model developed by the Independent Hospital Pricing Authority (IHPA) is the mechanism that determines the Commonwealth's National Efficient Price (NEP), national Weighted Activity Units (nWAU) and thereby the overall quantum of Commonwealth funds which will be provided to states and territories. The IHPA model excludes activity for certain patient cohorts which are already Commonwealth funded.

The 2014-2015 WA operating model uses the Projected Average Cost (PAC) and nWAU developed by IHPA. The model however incorporates the specificities of the WA context and reflects the totality of the services delivered in WA hospitals.

Actual ABF and non-ABF funding allocations are dependent on the WA State Government budget; this is discussed further in Section 4.

3.2 Efficient Price and Cost Determination

National Efficient Price
The NEP for 2014-2015 is $5,007 per nWAU. The NEP underpins ABF for public hospital services. It has two key purposes: to determine the amount of Commonwealth funding for hospitals and to provide a price signal about the efficient cost of providing public hospital services. It can also be used as an independent benchmarking tool to measure efficiency. For example, it is possible to compare the cost of a hip replacement in two different hospitals and to identify the best practice and inform funding decisions. Further information on the national activity classifications and weightings can be located at http://www.ihpa.gov.au/

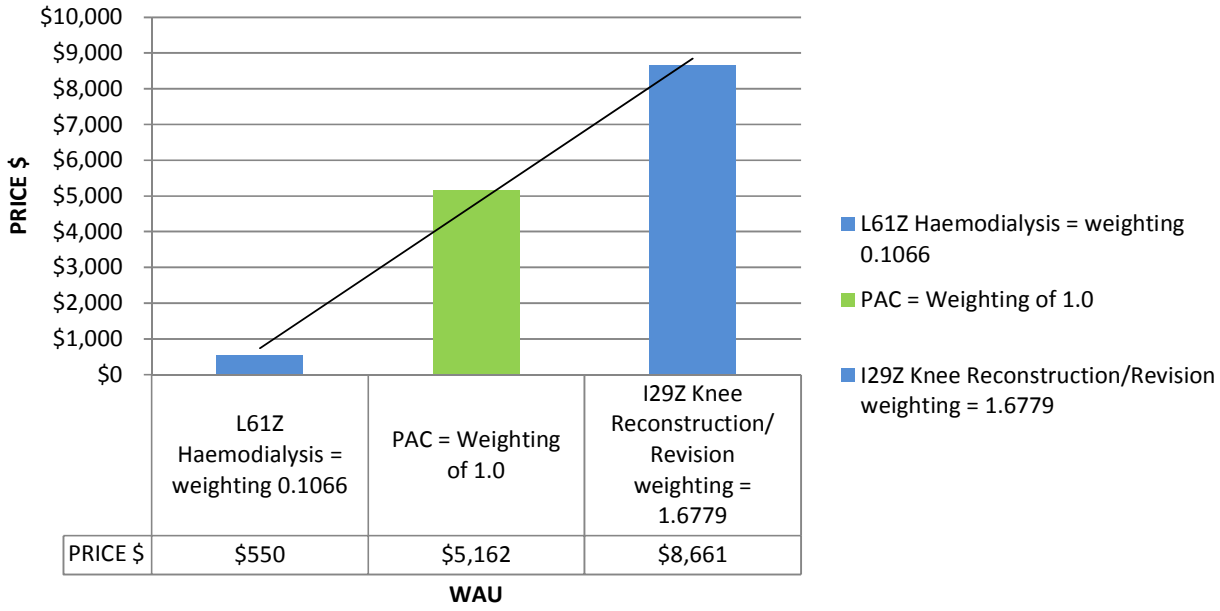
Projected Average Cost
An average cost is used to determine the activity cost. This is also referred to as the Projected Average Cost (PAC) which is derived from actual average reported costs of public hospital and is on average 3% higher than the NEP. The PAC provides a complete average price of activity based on a total expenditure regardless of the funding source. The PAC for 2014-2015 is $5,162.

WA Health refers to the PAC as the more correct comparator to the NEP ($5,007)[2]. This is due to in calculating the NEP, the following Commonwealth funded programs have been removed prior to determining the underlying cost data of the 2011-2012:

- Highly Specialised Drugs ($737.6 million)
- Pharmaceutical Reform Agreements – Efficient Funding of Chemotherapy ($106.0 million)
- PBS – Herceptin: Early Stage Breast Cancer ($19.5 million)
- Pharmaceutical Reform Agreements – PBS Access Program ($115.7 million)
- Where blood expenditure has been reported in the NHCDC, this has also been removed, as Commonwealth funding for this program is provided directly to the National Blood Authority. In 2011-2012 this amounted to $152.7 million.

[2] *WA Health 2014-15 Budget Submission and the 2014-15 WA State Budget Paper*

Figure 6: shows the PAC against less and more expensive health activities



Adjustments

As in previous years, it is recognised that there are legitimate and unavoidable variations in the costs in delivering health and hospital services. Some of these costs have been recognised by the IHPA in the NEP and NEC Determinations. Other costs specific to WA are reflected through the community service subsidy (CSS). IHPA is responsible for determining the national adjustments to the NEP. The 2014-2015 adjustments are outlined in Table 4.

Table 3: National ABF Adjustments 2014-15

Name	Amount to be applied
ICU Adjustment	0.0426 NWAU(14)/hour spent by that person within the Specified ICU
Indigenous Adjustment	Admitted Acute, Emergency or Non-admitted Patient: 4 % Admitted Subacute Patient: 17 %
Radiotherapy Adjustment	24 % (for all admitted patients with a specified ICD-10-AM 8th edition radiotherapy procedure code recorded in their medical record)
Outer Regional Adjustment	7 % (for all admitted patients)
Remote Area Adjustment	15 % (for all admitted patients)
Very Remote Area Adjustment	21 % (for all admitted patients)
Acute Admitted Paediatric Adjustment	Refer to column headed “Paediatric Patient Adjustment” in the tables of Price Weights (Appendix F, NEP Determination 2014-15, IHPA)
Admitted Subacute Paediatric Adjustment	196 %
Private Patient Service Adjustment	Refer to column headed “Private Patient Service Adjustment” in the tables of Price Weights (Appendix D, NEP Determination 2014-15, IHPA)
Private Patient Accommodation Adjustment	Refer to Appendix D, NEP Determination 2014-15,

Name	Amount to be applied
	IHPA for applicable discount
Specialist Psychiatric Age Adjustment (≤ 17 years)	40 % (except patients admitted to a Specialist Children's hospital, who will receive 30 %)
Specialist Psychiatric Age Adjustment (65 to 84 years)	5 %
Specialist Psychiatric Age Adjustment (≥ 85 years)	9 %

Visit http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/nep-determination-2014-15-html~adjustments to access a full list of national adjustments.

Community Service Subsidy
Due to the different circumstances and characteristics of the WA public health system, it is recognised that there is a gap between the PAC and the actual cost of providing the activity in the WA public hospitals. In the 2014-15 WA State Budget, Government has endorsed a strategy that seeks to close the gap between the PAC and the actual cost of delivering the activity in WA. The difference between the total cost of all hospital activity funded and the total cost of all hospital activity calculated at the PAC is called the Community Service Subsidy (CSS) payment. The CSS is discussed in detail in section 4.1.

National Efficient Cost
IHPA determines a national efficient cost (NEC) for health care services provided by public hospitals where the services are block funded. The NEC in 2014-2015 is $5.725 million. This represents the average cost of a national block funded hospital where the inpatient activity is less than 3,500 WAUs. Based on the total reported service volume and the Australian Standard Geographical Classification (ASGC), hospitals are categorised into groups and assigned a cost weight, the efficient cost of a particular hospital is then determined by multiplying the relevant cost weight for this hospital by the NEC. The NEC was determined by using the average in scope expenditure data for 2011-2012 reported to the National Public Hospital Establishment Database (NPHED) of $5.003 million indexed at 4.6% per annum.

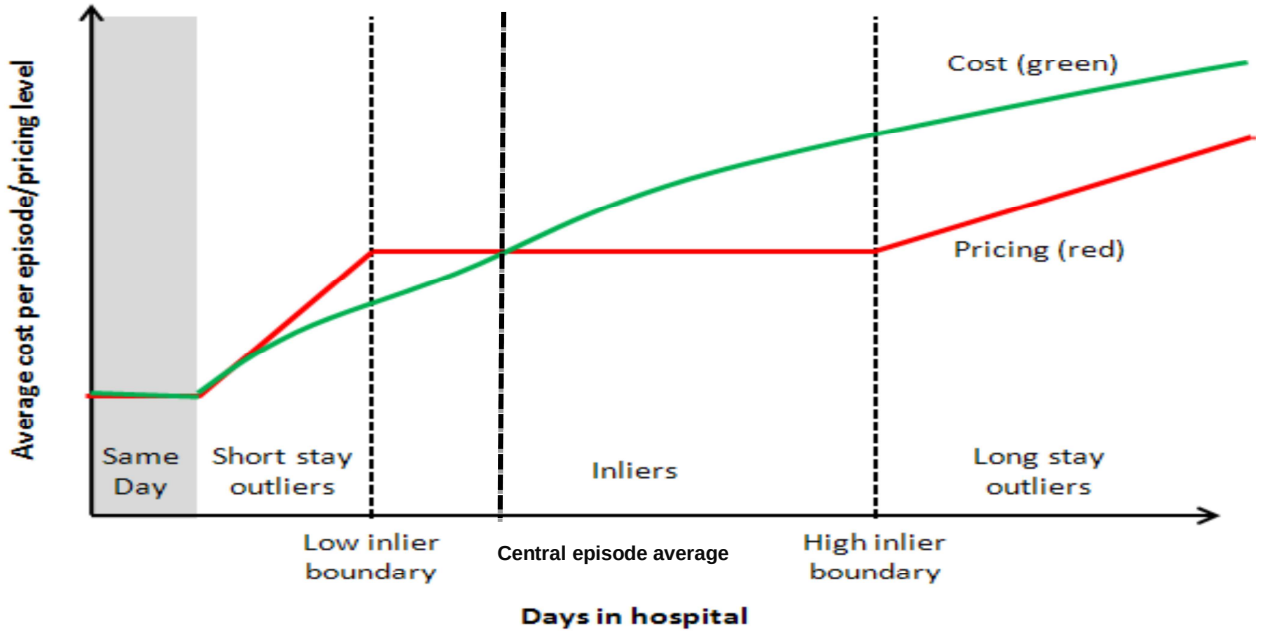
WA continues to analyse the suitability of the NEC for small rural hospitals. Due to the current volatility of the input data associated with the development of the NEC, the recently improved budgeting methodology and costing information reported by the WA Country Health Service will continue to be used to fund WA small rural hospitals in 2014-2015.

3.3 Inpatient Activity Schedule

The inpatient activity schedule for 2014-2015 is for inpatients, including subacute care inpatients who are not grouped to an AN-SNAP class. This is defined by Australian Refined Diagnosis Related Groups (AR-DRG) Version 7.0. The AR-DRG version 7.0 was released in July 2013 and contains 767 DRGs. For more information visit http://www.ihpa.gov.au/

Figure 7 illustrates the approach taken by IHPA in determining the NEP. This model has been adopted by the Department in the calculation of inpatient activity pricing. It describes the relationship between cost, price and days in hospital. An important key element in the national approach is the explicit distinction between the *cost* of health services and the *price* paid for health services.

Figure 7: Initial Parameters for the Assignment of Cost Weights



As illustrated in Figure 7 average costs per episode (the green line) will typically increase as length of stay increases. To establish an appropriate funding level, episodes within an AR-DRG are partitioned into the four categories described below and costs analysed to yield the relevant parameters. The resulting funding model is shown in the red line.

- *Same day payment AR-DRG episodes.* The mean cost per episode is applied.
- *Inlier episodes.* The mean cost per episode is calculated for each DRG.
- *Short stay outlier episodes*. These were split into:
  - Surgical AR-DRGs, where a 'fixed' cost component is calculated (using the operating theatre, special procedure suites and prostheses cost buckets) and a mean cost per day for 'variable' costs (all other cost buckets).
  - Medical and other AR-DRGs, where a mean cost per day is calculated and applied.
- *Long stay outlier episodes.* The mean inlier cost is assigned to each episode as a base amount. A per diem for each outlier day is also assigned using the results of a regression model in which length of stay was used to explain variation in cost. The model was estimated using all episodes including inliers and outliers, but excluding designated same day payment AR-DRG episodes. This model yielded estimates of the mean cost per day. These parameters have been determined from the costed data provided by health services across Australia.

There is a direct link between the length of a patient's stay in hospital and the costs to Health Services for providing that care. Episodes with above average length of stay will tend to be more costly than an episode with below average length of stay.

Central (Inlier) Episodes

As in previous WA ABF/ABM operating models, length of stay boundaries have been determined to enable exceptional episodes to be identified and appropriately funded. For each DRG the low boundary is set at one third of the average length of stay and the high boundary point is set at three times the average length of stay.

Central episodes have a length of stay within the low and high boundary points. Central episodes within each DRG will be funded at the same rate. Reduction in the length of stay for central episodes improves the cost efficiency of a hospital. The funding model for core activity has built-in incentives to encourage early patient discharge where appropriate. If a patient is discharged before the central episode average length of stay (to the left side of the intersection of the green and red curves in Figure 7 above) the health service “keeps” the credit for the full episode payment. On the other hand, episodes with above average length of stay to the right side of the intersection of the green and red curves in Figure 7 above will tend to be more costly than the episode payment.

3.4 Managing Efficiencies Influencing Cost and Price Determination

Nationally IHPA utilises health activity data from states and territories and health costing data from the National Hospital Costing Data Collection (NHCDC) to inform the NEP determination.

Figure 8: Health Activity and Costing Data inform the NEP Determination

From 1 July 2014, Commonwealth funding for WA will depend on the delivery of a volume of activity as agreed between the Commonwealth and State Government.

Table 4: Level of Commonwealth Funding to WA under National ABF program

	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015
Commonwealth Funding to WA	Guaranteed	Guaranteed	Guaranteed	Guaranteed	**Dependent On Activity**

The State, as system manager, can contribute above or below the price set by IHPA to take account of local conditions and requirements.

Patient level costing information is a powerful tool in the ABF/ABM. Costing information is used to set the NEP which informs Commonwealth funding flows to states. The NEP guides WA Health’s purchasing and funding decisions. Reviewing and questioning patient level costing information is a vital step to improving the quality of the data and in understanding where efficiencies can and cannot be made. Empowered with quality costing information Health Services can make more informed decisions and be in a much better position to negotiate for future State and Commonwealth funds.

It is important to understand why certain service lines may have a surplus or deficit of funds when comparing costs and revenue. Not all services delivered are expected to have a surplus. By focusing on efficiency, inefficiencies can be identified and addressed. As Commonwealth efficient prices are set it is important to understand why there may be a variance to the national benchmarks for costs. Differences identified as a result of cost disabilities may influence national changes or support local changes.

Figure 9: the variations in cost contributions for the same DRG across Health Services in WA.

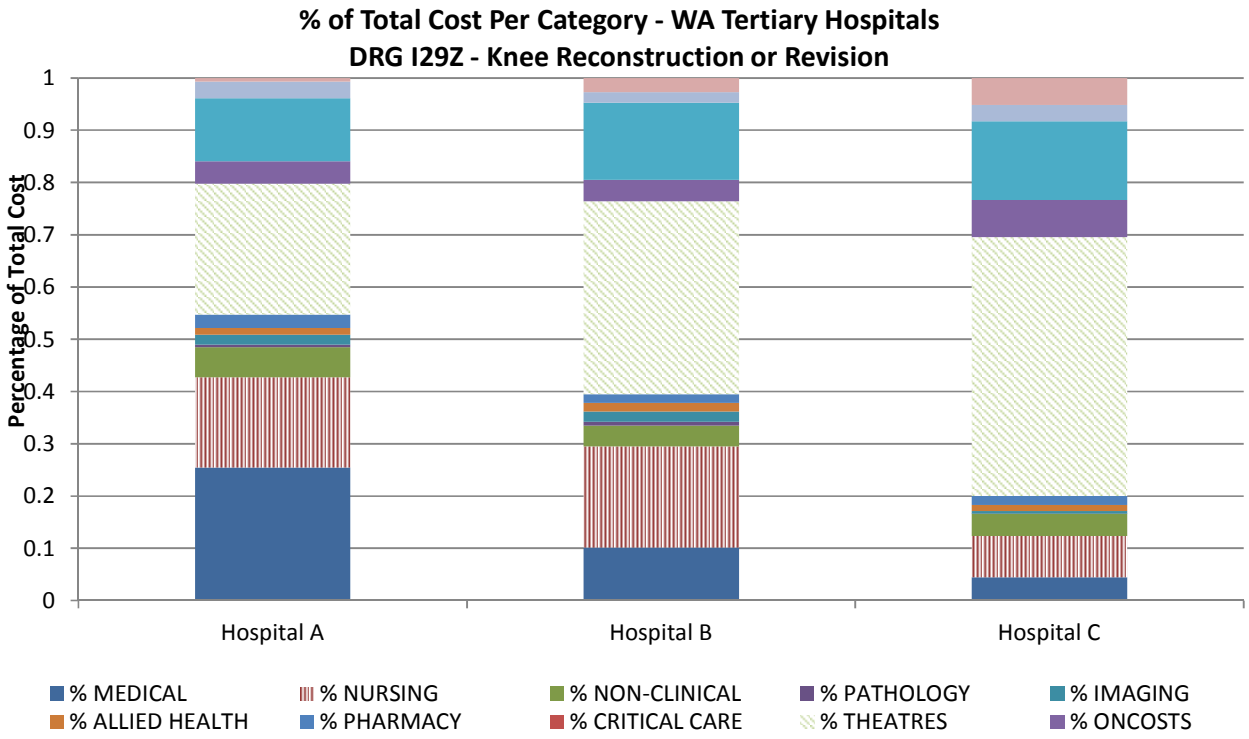


Table 5: Percentage Makeup of Cost Variations from Figure 9

ESTABLISHMENT	Hospital A	Hospital B	Hospital C
% MEDICAL	25.5%	10.2%	4.5%
% NURSING	17.3%	19.3%	7.9%
% NON-CLINICAL	5.8%	4.0%	4.3%
% PATHOLOGY	0.5%	0.7%	0.0%
% IMAGING	1.9%	2.0%	0.5%
% ALLIED HEALTH	1.3%	1.6%	1.2%
% PHARMACY	2.6%	1.7%	1.7%

ESTABLISHMENT	Hospital A	Hospital B	Hospital C
% CRITICAL CARE	0.0%	0.0%	0.0%
% THEATRES	25.0%	36.9%	49.5%
% ONCOSTS	4.3%	4.1%	7.1%
% PROSTHETIC	12.0%	14.7%	15.1%
% SPS	0.0%	0.0%	0.0%
% WARD SUPPLIES	3.2%	2.1%	3.1%
% HOTEL	0.6%	2.7%	5.2%

The extent of these variations may indicate inconsistency of costing processes and the possibility of lack of business review of such results. The variance could also be a result of errors relating to functions such as coding, clinical documentation or data input. There may be efficiencies made by further review of the cost component structure and by managing particular high cost components.

4.0 Funding Allocation and Budget Settings in 2014-2015

4.1 ABF Funding Allocation for Health Services

4.1.1 State Budget Overview

Under the NHRA, as System Manager, the State remains responsible for day-to-day hospital system operation, system-wide public hospital's planning and policy including setting activity levels across health services.

Activity growth built into the State budget for 2014-15 is based on population estimates from the WA State Government population projections (prepared by the Department of Treasury in collaboration with the Australian Bureau of Statistics and the Department of Planning) and data on the utilisation of hospital. Activity projections are generated by multiplying the age-specific utilisation rates and modelled using the 2011-2012 actual patient presentation by the population projections for each age group. The projections recognise that, as the population ages, demand for health services will increase at a faster rate than overall population growth.

There is a significant difference between the cost of providing hospital services in WA and the national PAC. The unit cost of providing hospital services in WA continues to exceed and increase at a higher rate than the national average. Currently WA's cost of delivering services is 8% higher than the national average per each weighted activity unit (WAU)[3].

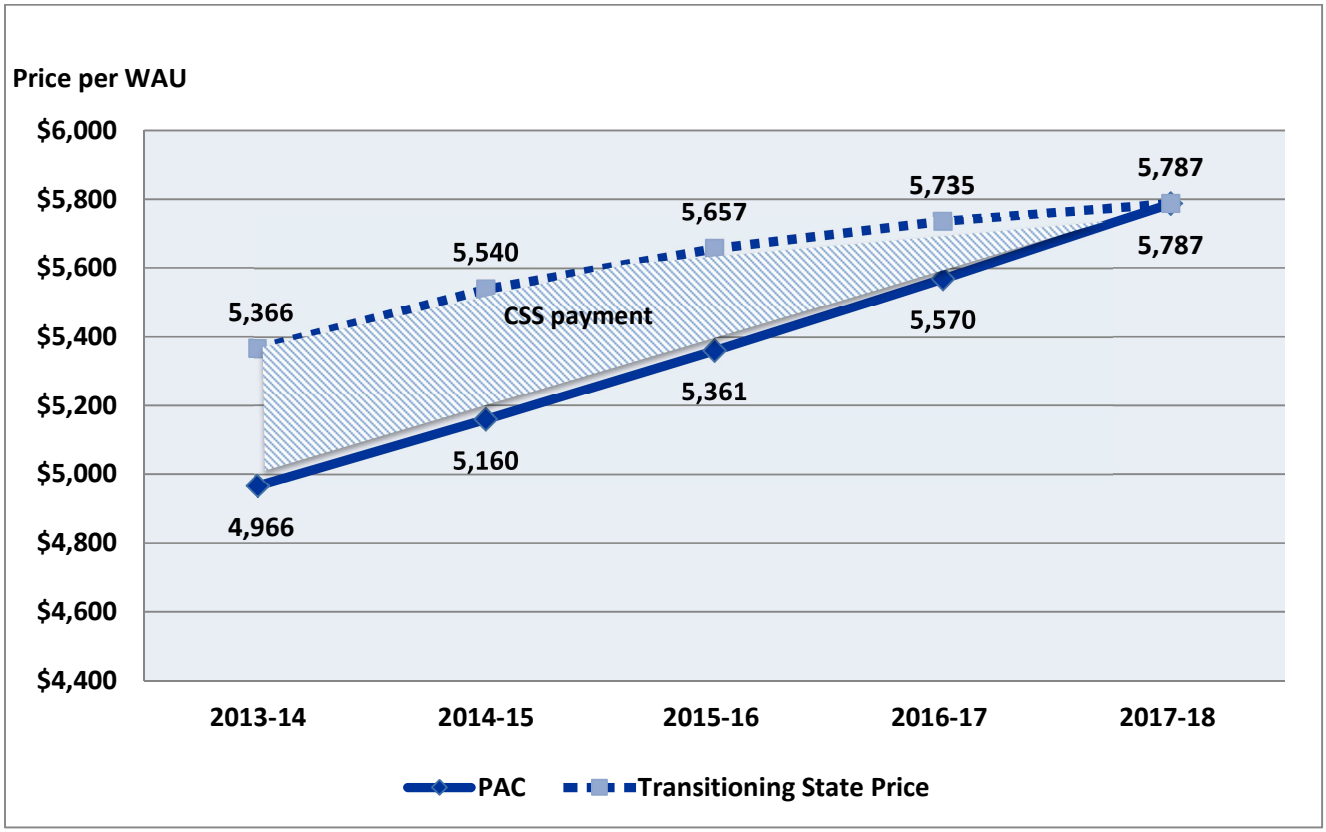
The Government budget strategy is to achieve convergence between the cost of delivering WA public hospital services and the national average cost (the PAC) in the next four years. This requires a substantial reduction in annual cost growth in hospital services from 2.7% in 2014-2015 to 0.9% by 2017-2018.

[3] *The 2014-15 WA State Budget Paper*

The 2014-2015 State budget sets the price to be paid for each WAU. The budget is built by describing volume in WAUs by PAC which is $5,162 for 2014-2015. The PAC does not include the fixed structural cost disabilities that WA Health Services incur.

The Government has endorsed a Transitioning State Price (TSP) to manage the difference between the PAC and the 'cost' of providing the activity in WA. The TSP for 2014-2015 is $5,540. The TSP provides an additional funding known as Community Service Subsidy (CSS) to manage the difference between the PAC and the TSP. It is a measure to assist WA Health to smoothly transit to the PAC by 2017-2018. The CSS payment also represents the Government's commitment to sustainable service delivery and health budget stability while pursuing better value for money health outcomes for WA. The TSP is only available from 2013-2014 to 2017-2018.

Figure 10: Projected Average Cost and Transitioning State Price



Adapted from the 2014-15 WA State Budget Paper

4.1.2 ABF Funding Allocation for Health Services

Within WA Health, for the purchasing plans to be achievable they must align with the delivery capacity of the health system. The total ABF funding allocation to Health Services is based on the WA ABF price and the activity levels set by the Department. The activity levels are informed by age weighted population growth rate (AWPGR) and the CSF growth rates for each Health

Services. The AWPGR and CSF are measures to align activity with capacity and have been endorsed by the State Government.

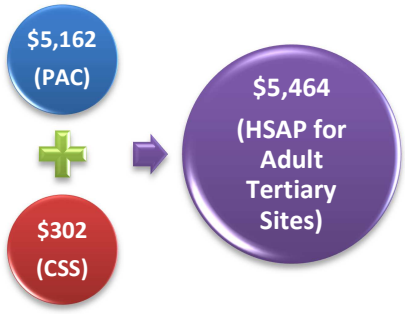
In the first year of ABF/ABM (2010-2011), the WA ABF price was based upon the average costs of activity across peer groups of hospitals for each category of activity. In 2011-2012, the first WA state efficient price (SEP) was introduced by applying efficiencies to the funding for high boundary patients and non-acute inpatient episodes. In 2012-2013 in line with IHPA's determination of a single NEP, a single SEP was developed by using the national classifications for inpatient, emergency department and hospital based outpatient activity. In 2013-2014, the WA ABF price was set on the national projected average cost (PAC) with adjustments related to the TSP.

In 2014-2015, the Health Service Allocation Price (HSAP) has been developed to provide equity, stability and sustainability in managing ABF funding allocation for WA Health Services. The HSAP is made up of the PAC and CSS payment.
There are two HSAP prices for 2014-2015 (See Figure 11):

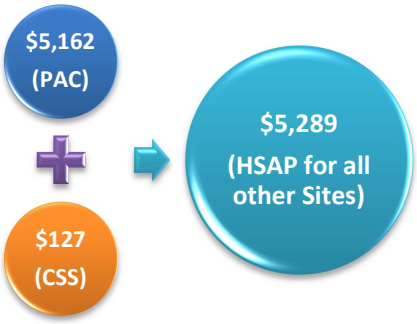
1) $5,464 for adult tertiary sites (Royal Perth Hospital, Fremantle Hospital, Fiona Stanley Hospital, Sir Charles Gardner Hospital and King Edward Memorial Hospital)
2) $5,289 for non-adult tertiary sites (or all other sites).

Figure 11: Health Service Allocation Price for 2014-2015

HSAP for Adult Tertiary Sites



HSAP for all other Sites



Thus the ABF allocation for Health Services is determined by multiplying the HSAP by the targeted activity volume, expressed as WAUs.

Figure 12: ABF Funding Allocation for Health Services in 2014-2015

Table 6: **PAC, CSS and HSAP allocation by volume of activity for Health Services for 2014-15**

	CAHS	NMHS	SMHS	FSH	WACHS	TOTAL*
Activity volume (WAUs)	55,041	230,028	272,708	58,893	146,154	762,824
PAC payment ($)	284,123,134	1,187,406,527	1,407,719,490	304,006,447	754,449,123	3,937,704,721
CSS Payment ($)	6,990,242	57,304,362	65,838,642	17,785,727	18,561,606	166,480,579
Total HSAP allocation ($)	**291,113,376**	**1,244,710,889**	**1,473,558,132**	**321,792,174**	**773,010,729**	**4,104,185,300**

*Total allocation excludes Joondalup Health Campus and Peel Health Campus

The transitioning arrangements are aimed at assisting the health system to successfully converge the cost of delivering hospital services in public hospitals in WA to the national PAC by 2017-2018. Transitioning the health system to a lower cost of delivering WAUs will require health services to drive efficiencies in the provision of health services, whilst ensuring that safety and quality of care are maintained at high standards. The allocation of any additional funding or price adjustments related to the CSS is outlined in individual service agreements of each Health Service Providers.

Work commenced in 2013-2014 to distinguish those components of the CSS payment which relate to genuine system and service delivery inefficiencies from cost premiums incurred due to structural inefficiencies and other non-discretionary costs. The Department continues to communicate with the Department of Treasury and IHPA regarding these issues. The work will also inform ongoing dialogue with IHPA to ensure that the national pricing regime adequately accounts for the unique cost and delivery challenges resulting from geographical dispersion and extreme remoteness, aged and primary care shortages, a high Aboriginal population and health workforce availability in WA.

4.2 Significant Updates to Health Activity Funding Allocations

Below is a summary of how each work stream will be treated in 2014-2015 under ABF. For technical details, please refer to the *National Pricing Model Technical Specifications 2014-15*. These documents can be located at www.ihpa.gov.au.

Emergency Care

For 2014-2015, emergency care services will continue to be funded using two proxy classification systems depending on the level of service:

- Urgency Related Groups (URGs) Version 1.4 will be used to classify emergency services at metropolitan hospitals, six regional hospitals and also Busselton Hospital. URGs require triage, disposition and coded Emergency Department (ED) diagnosis.
- Urgency Disposition Groups (UDGs) Version 1.3 will be used to classify emergency services at all other rural hospitals. UDGs require triage and disposition only.

Details of the URG and UDG classes and their respective price weights are provided in the National Efficient Price Determination published by the IHPA.

Based on a review of classification systems for emergency care that was undertaken in 2013, IHPA will progress the development of a new classification system in 2014 to replace URGs and UDGs for use across all Australian emergency departments and emergency services. The review recommended that the new classification system is based on diagnosis. The staged development and implementation of the new classification is expected to occur over a five year period.

Detailed information on access standards for a given level of ED presentations and ED target activity levels will be outlined in the Service Agreements for each Health Service. This includes the National Emergency Access Target (NEAT).

In response to recommendations made by the Office of the Auditor General (OAG), an ED Edits Program has been established by the Emergency Department Data Collection (EDDC) as a pro-active method of identifying incorrect record level data within the EDDC. Establishment of the ED Edits Program has resulted in the identification of incorrect and out of scope patient records. The Information Development and Management Team (IDM) of the Department has liaised with hospitals to have records corrected and re-captured them into the EDDC. This results in an improvement in the quality of the data within the EDDC and will improve the quality and accuracy of national and local reporting and data submissions.

Phase 1 of the ED Edits Program has been piloted at five metropolitan EDs. The program focuses on data quality issues that affect IHPA and local ABF Costing compliance. It is designed to enhance the quality of EDDC data so that all ED activity submitted to IHPA is compliant, and to ensure that Urgency Related Groups (URGs) are accurately determined and WA's funding maximised legitimately by recording accurate data.

Subacute Care Services

For 2014-15, subacute and non-acute care services will continue to be measured and classified using AN-SNAP Version 3 for in scope subacute care services. This includes admitted patients with a care type of rehabilitation, geriatric evaluation and management (GEM), psychogeriatric, palliative and maintenance.

Since 2013-2014, the WA ABF team has used the national proxy classification to determine funding levels for in scope subacute care services provided at Health Services. Where data is not groupable to an AN-SNAP class, an episode of care type per diem will be used. However, IHPA have indicated that from 2015-2016 ungroupable data will not be funded under the AN-SNAP classification. It is believed these episodes will be classified and funded under the DRG classification. IHPA have also commissioned a consultancy to develop AN-SNAP version 4, with the intention to implement from 2015/16.

The Department continue to work with sites to ensure that data quality is improved and activity data accurately reflects the care being provided in subacute care services. Training has been provided for clinical staff to obtain and report the Functional Independence Measure (FIM) for the AN-SNAP classification in rehabilitation and GEM wards.

Non-admitted Services
Hospital-based outpatient services will be funded using the Tier 2 Non-admitted Services Definitions Version 3.0 as a proxy classification. There are currently 137 outpatient clinics in this version (124 in-scope for ABF funding) for 2014-2015. This version also includes other non-admitted public hospital services (excluding mental health services), categorised into 16 main groups.

Based on a non-admitted classification review undertaken in 2013, IHPA has determined that the existing Tier 2 classification system is not considered appropriate as the long term non-admitted classification in Australia. IHPA will progress the development of a new Australian Non-admitted Patient Classification in 2014-15, which is expected to be patient-centric and will include diagnosis. WA supports this in principle; however a generous implementation timeline is essential, as significant modifications to WA's ICT systems will be required. The implementation timeline is being discussed between IHPA and the jurisdictions. Non-admitted services will continue to be measured and classified using the Tier 2 clinic list until the new classification is implemented.

Rehabilitation in the Home (RITH)
The clinical intensity of WA's current RITH model of care rarely represents inpatient substitution. To ensure compliance with national reporting requirements, from July 2013 RITH activity was classified as non-admitted and all activity recording was transferred to TOPAS and webPAS.

Hospital in the Home
Hospital in The Home (HITH) for public hospitals is considered 'admitted patient care' and funded accordingly. When a patient is transferred to HITH from in-hospital based care, this is considered continuous care. The criterion for admission that applies to the hospital component of their stay is also valid for the HITH component. It is expected that these patient types will be seen at least five times per week by clinical staff providing inpatient care. HITH patients not seen by any staff during any day are to be placed on leave for that day. It is accepted that patients may be on leave over the weekend and receiving care during weekdays. Where patients are on leave for more than two days consideration should be given to whether the patient continues to require inpatient care.

Mental Health Services
AR-DRGs are used for admitted mental health patients in designated units in 2014-15, but with modifications made to enhance the explanatory power of DRGs for these patients. IHPA will progress the development of a new Australian Mental Health Care Classification in 2014-15 with the aim of implementing it by July 2016, preceded by implementation trials planned for 2015-16. It is expected that a DSS for the new classification will be ready in time for data collection to commence from 1 July 2015.

In 2014-2015 the Department will continue to use the interim national pricing model for acute admitted patients in designated units, while a new classification is being developed. All subacute, emergency department and non-admitted patients requiring mental health care will continue to be treated consistent with the guidelines for these respective streams until the new Australian Mental Health Classification is implemented. Non-admitted mental health services will continue to be block funded. Please visit http://www.ihpa.gov.au for further information.

4.3 Block Funding Allocations

A number of services remain block funded in 2014-2015 including non-admitted mental health, small rural hospitals, teaching training and research and other non-hospital products. The budgets for block funded services are derived using the 2013-2014 approved budget and escalated by an approved state escalation factor, taking into account the specifics and nature of each service type.

Specific purpose programs, other direct services and financial/accounting products (such as depreciation and other accounting adjustments) are included as separate allocations.

Small Rural Hospitals

The budget development for small rural hospitals in WACHS will continue to be block funded. As described in section 3.2, WA Health continue to work to develop a more informed understanding of the suitability of the NEC for small rural hospitals and remoteness impact. This is important in the national context to ensure WA receives a fair price for these services. It is also important that relevant information is available that supports the delivery of efficient services in this sector.

Teaching, Training and Research

Based on work undertaken throughout 2011-2012 to 2013-2014 in consultation with stakeholders across WA Health, the payment for costs relating to Teaching, Training and Research has been calculated separately to the PAC in line with the national ABF program. TTR will continue to be block funded until 2017-2018. IHPA started work on developing a TTR activity data set specification (DSS) in 2013 with a best efforts collection of national activity from 1 July 2014.

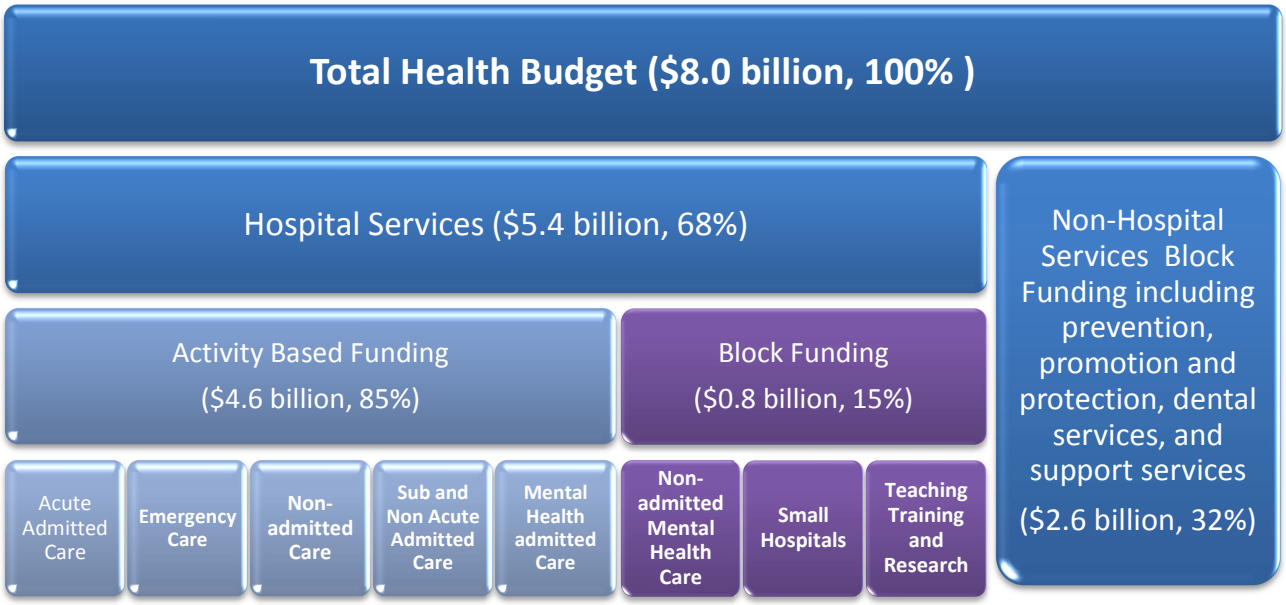
Non Hospital Products

A review of all services previously allocated to “non hospital products” (NHPs) is carried out each year. For metropolitan health services, all such programs are specifically identified and funded. These include public health and community based services, special purpose funding and financial products. Within these categories, further detail on each area of funding is included in the Service Agreement for each metropolitan and country Health Service (or LHN).

4.4 Setting and Distribution of the WA Health Budget

WA Health’s appropriated budget for 2014-2015 is $8.0 billion. The WA Health budget makes up 28% of the overall WA State Government budget. Health Services budget in 2014-15 is $5.4 billion. The ABF component of the Health Service’s budget is 85% of the total Health Service’s budget (refer to Figure 13).

Figure 13: The Distribution of WA Health's Budget for 2014-2015



Adapted from WA Health 2014-15 Budget Submission and the 2014-15 WA State Budget

As part of the 2014-2015 budget submission, the Department provided the State Government with advice as to the likely volume of weighted inpatient activity, emergency department activity, hospital based outpatient activity and block services expected for 2014-2015 and for each year of the forward estimates (2015-2016, 2016-2017, and 2017-2018). This approach allows the State Government to make informed decisions through the annual budget process about the quantum of activity to be delivered by WA Health within the available State resources.

Table 7: Total Health Services' projected 2014-15 Weighted Activity Units

	Estimated Actual	Budget	Forward Estimates		
	2013/14	2014/15	2015/16	2016/17	2017/18
Activity Projections (WAUs)	819,379	842,731	866,075	889,459	911,962
Growth rate (%)		*2.85%*	*2.77%*	*2.70%*	*2.53%*

Source: WA Health 2014-15 Budget Submission and the 2014-15 WA State

Methodology for Distribution of the WA Health Budget

(i) Health Services

For 2014-2015, the Department will continue to use an activity based allocation methodology aligned with the CSF for Health Services. In broad terms, this methodology includes:

- Activity based allocations continue to be based on the established growth outlined in the CSF and its demand and capacity modelling.
- This is adjusted for circumstances such as budget constraints; contracted privately-provided public hospital services; post-CSF arrangements and/or other relevant reasons.
- Block funded services, as mentioned earlier, are cost escalated and grown by an expected population growth factor.

(ii) Department of Health

The Department is comprised of: Office of the Director General; Office of the Deputy Director General, Resource Strategy Division; Performance Activity and Quality Division; Chief Medical Officer and System Policy and Planning, Office of Mental Health; Innovation and Health System Reform; Office of the Chief Psychiatrist and Public Health and Clinical Services Division.

For 2014-2015, the Department will continue to use a budget-to-budget methodology for Department divisions, this methodology includes:

- The starting point for the 2014-2015 budget for the Department divisions is the approved 2013-2014 budget. The 2013-2014 budget is adjusted to remove one-off items that will not occur in 2014-2015.
- The adjusted 2014-2015 budget is then further adjusted for known price movements such as cost of award changes and expected Consumer Price Index changes. The result is the status quo budget.
- The status quo budget is then adjusted to take account of other known changes, for example, new initiatives, organisational re-alignments or the cessation of activities that were previously carried out. All adjustments at this stage are done at the 2014-2015 cost level.

(iii) Statewide Support Service

The Statewide Support Service comprises the following entities: PathWest; Dental Health; Health Corporate Network; Health Information Network. 2013-2014 budgets for the Statewide Support Service will be set using a budget-to-budget construction, similar to the process set out above for the Department Divisions.

(iv) Mental Health Services

The Department and the Mental Health Commission have developed a joint purchasing framework for mental health services provided by WA Health. The *Purchasing Framework for Mental Health Services in Western Australia* was delivered in October 2012 and subsequently endorsed by both the Department and the Commission. It sets out the strategic purchasing intentions for public mental health services across the state.

In 2014-15, an over-arching annual Service Agreement between the Commission and the Department will be developed. The Performance Activity and Quality Division, the Office of Mental Health and the Mental Health Commission will be working closely to ensure alignment of relevant Service Agreements and associated schedules.

The continual development of clear processes and schedules will allow for more transparent funding allocations and monitoring at Health Service level in 2014-2015 and subsequent financial years. This will not replace the development of the over-arching annual Service Agreement with the Department, but will enable more direct and localised discussion regarding service delivery and activity between the Commission and the Health Services. This work will be supported by joint implementation of the Purchasing Framework, which embodies the principle that funding provided by the Commission for mental health purposes is quarantined and acquitted in a timely manner using a transparent and accountable process.

4.5 Public Hospital Funding Flows

The National Health Funding Pool Act 2012 gives effect to the State's commitments under the National Health Reform Agreement. The Act provides for:

- appointment of the administrator of the National Health Funding Pool
- flow of Commonwealth and State funds for public hospital services through State Pool Accounts and State Managed Funds
- consequential amendments to the *Hospitals and Health Services Act 1927, Lotteries Commission Act 1990.*

Further information and access to relevant legislation is provided at:
http://www.publichospitalfunding.gov.au/

Figures 14 and 15 show the State and Commonwealth public hospital funding flows and flow of these funds through payments to providers for both the ABF and non-ABF public hospital services.

Figure 14: State and Commonwealth ABF Funding Flows for Public Hospital Services

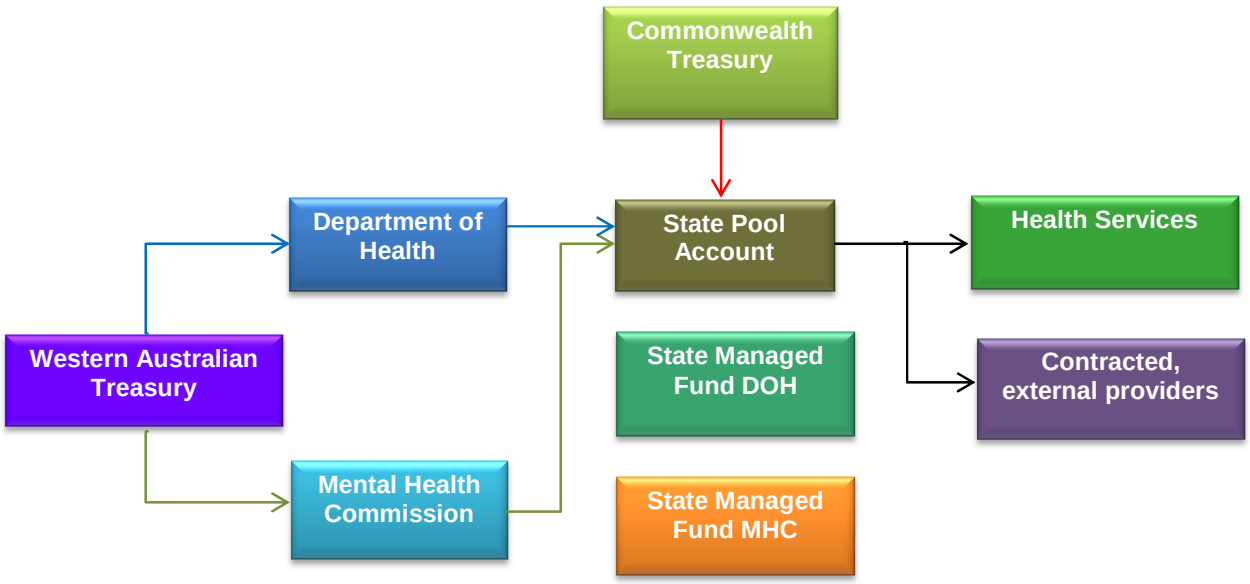
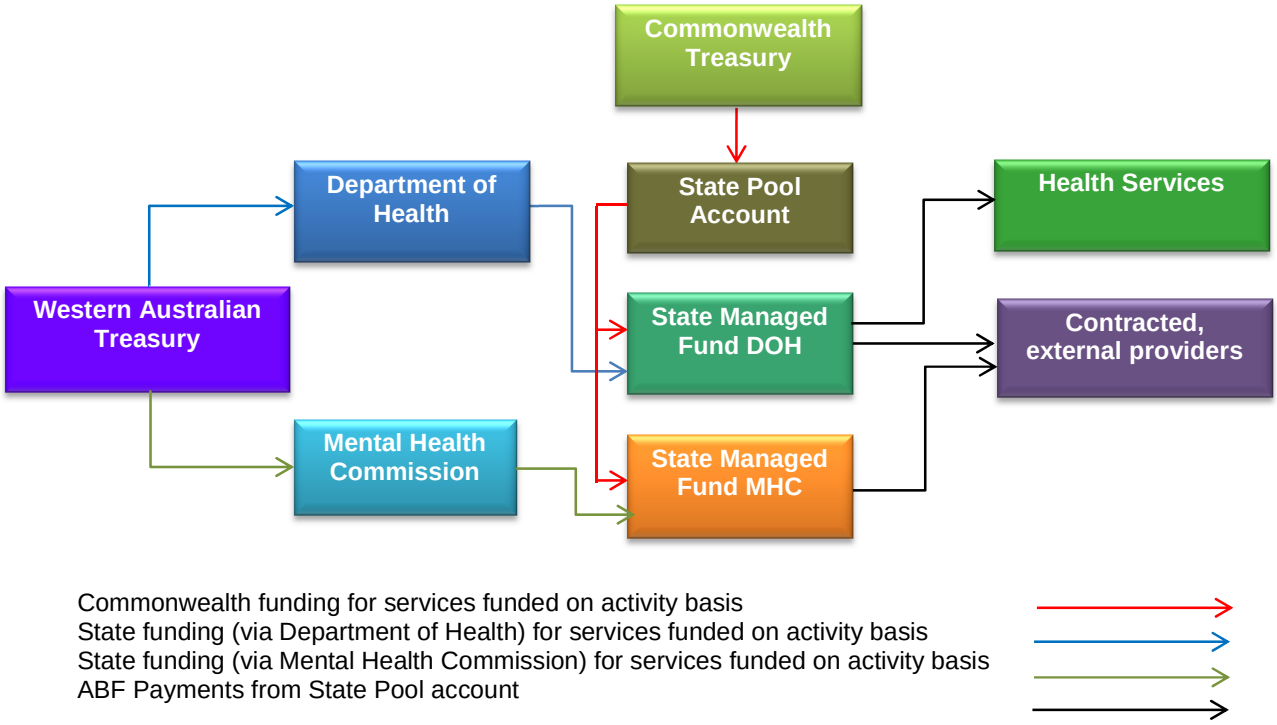


Figure 15: State and Commonwealth Block Funding Flows for Public Hospital Services



4.6 Commonwealth Government Hospital Funding Contribution

Under the NHRA, the IHPA is responsible for establishing frameworks for counting, classification and pricing of hospital services, including determining the NEP

The NEP and the State/Territory target activity levels are used to inform the amount of Commonwealth Government's hospital funding contributions to States and Territories via the National Health Funding pool, as determined by the administrator. In addition to the agreed funding, the Commonwealth Government also provides 45% of the NEP for new activity growth from 1st July 2014 and this additional funding contribution will increase to 50% after 1st July 2017.

5.0 Service Agreements & Health System Performance 2014-2015

5.1 Service Agreements: Department of Health and Health Services

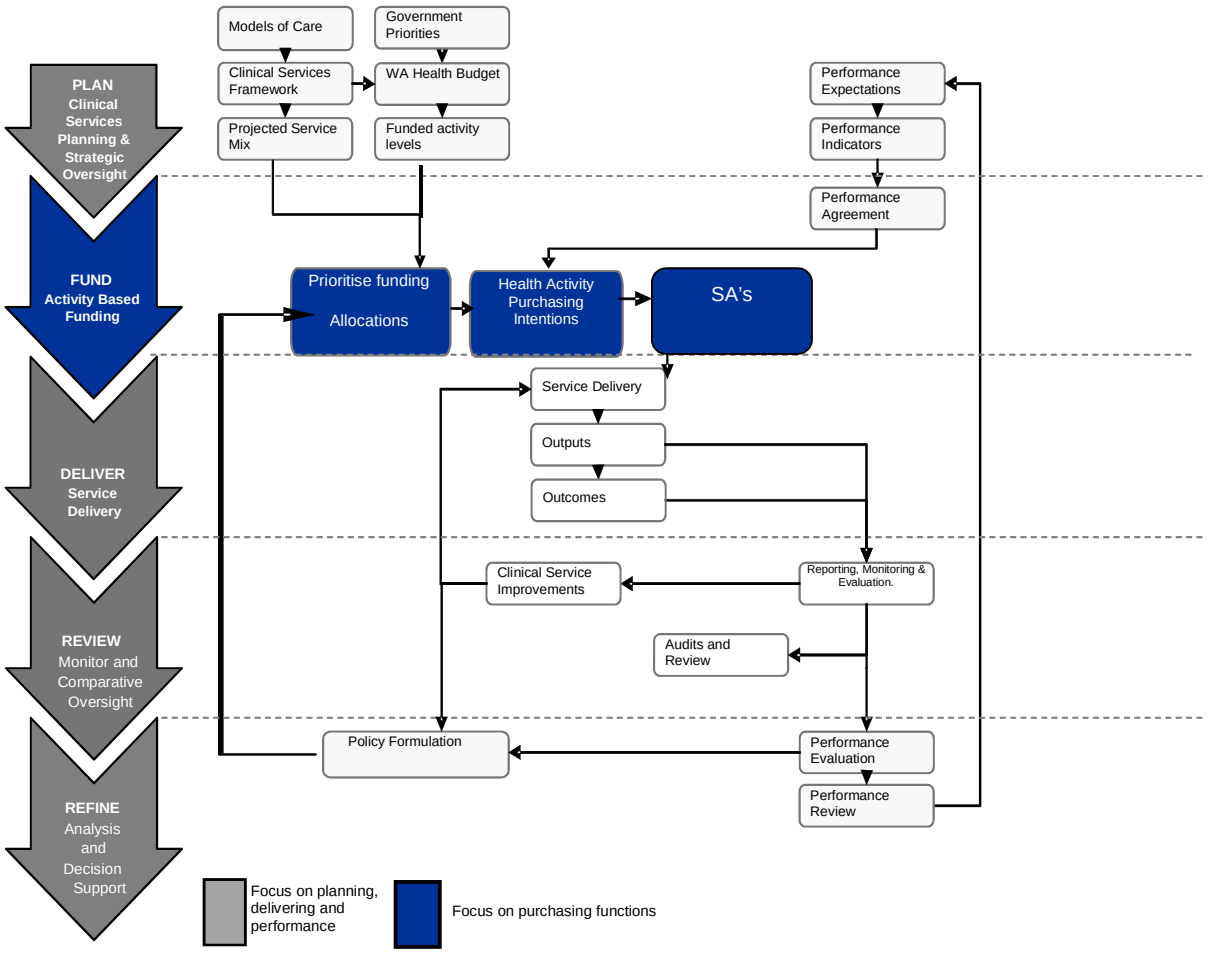
Service Providers will deliver the services set out in the Service Agreement (SA). The SA is the centrepiece of the ABF/ABM purchasing mechanism and is informed by:

- the CSF 2010-2020 informing the scope of services and target levels of activity for each facility
- price determinations and the ABF/ABM Operating Model
- other non-ABF purchasing and budget allocation methodologies.

The SA will ensure that the Government's policy objectives on service delivery and budget sustainability are clearly set out and provide the basis for both payment and evaluation of performance.

It is important to understand where the SA and purchasing functions sit together in the whole ABF/ABM matrix of key activity. Figure 16 shows the key activities in the ABF/ABM framework and gives context to all activities that contribute to, and/or are impacted by, the SAs and purchasing functions.

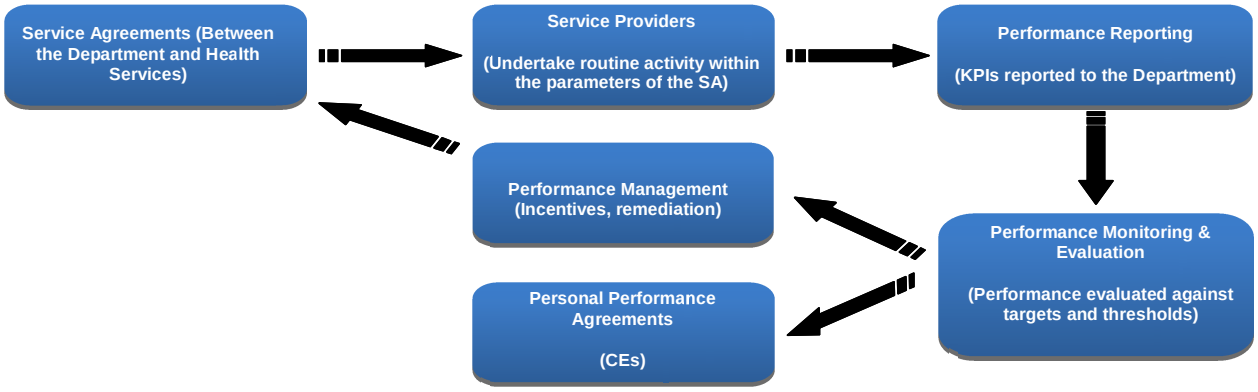
Figure 16: Purchasing Functions and SA in the ABF/ABM Framework



5.2 The WA Health System's Performance Management Framework

In 2014-2015, WA Health's activity purchasing will once again require the application of ABF and ABM which in practice requires an annual Performance Management Framework (PMF). The PMF for 2014-2015 details the specific operation of ABM across the WA Health system in 2014-2015 and has been developed concurrently with this document. The application of the PMF and SAs in ABM practice is shown in Figure 17. The 2014-2015 PMF can be located at: http://www.health.wa.gov.au/activity/publications.

Figure 17: Applying the PMF and SAs in ABM



The 2014-2015 PMF will continue as part of the SA between the purchaser and the provider of services and involves a system of reporting performance against specified Key Performance Indicators (KPIs) for each Health Service or Statewide Support Service. It establishes the KPIs to be used, the reporting obligations, the processes for monitoring and review of health service performance, and the thresholds for reward or potential remediation of poor performance during the operating year. The SA forms the basis of the personal performance agreements (PAs) between the Director General of Health (DG), Chief Executive (CEs) and Executive Directors who have a direct accountability for delivery of health services.

The implementation of the Annual PMF has progressed as follows:

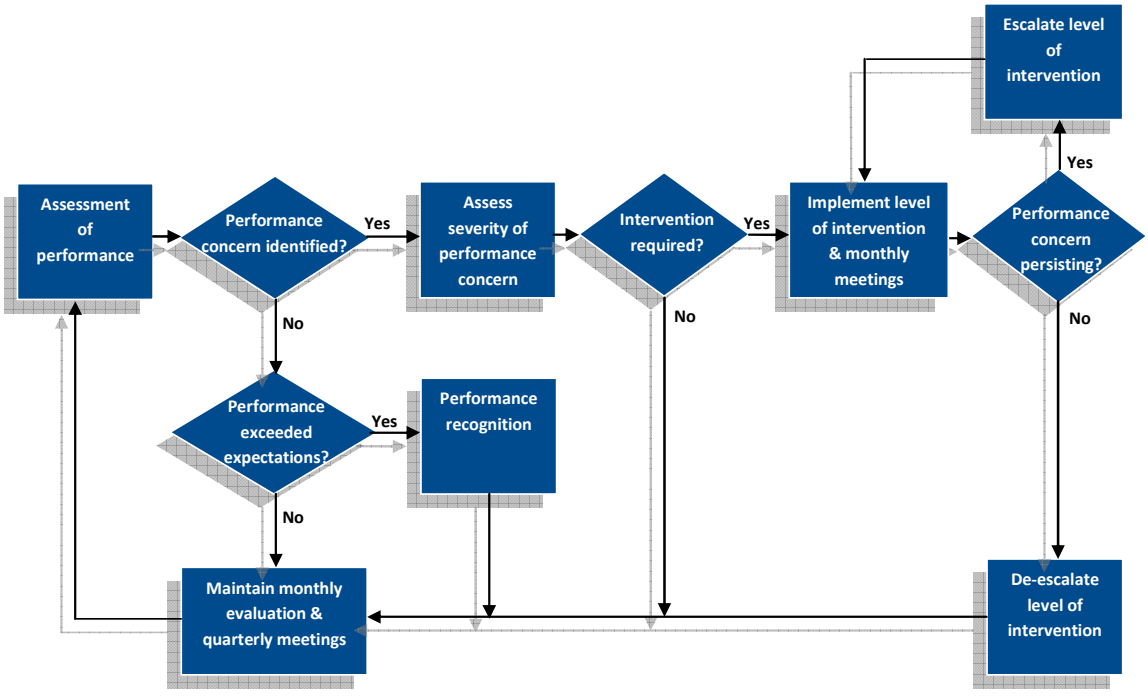
- For the first year of operation 2010-2011, the PMF included inpatients, ambulatory surgery initiative patients, and Emergency Department attendances, both for metropolitan hospitals, the WA Country Health Service Regional Resource Centres and Integrated District Health Centres.
- Dental Health and Public Health were included in the PMF in 2011-2012, which included: reporting obligations, performance monitoring and evaluation, Management interventions and governance.
- The Annual PMF for 2012-2013 covered the key elements of the PMF 2010-2011 and the PMF 2011-2012. In addition, it included Health Corporate Network (HCN); Health Information Network (HIN); the performance indicators from the National Health Performance Authority's (NHPA) Performance and Accountability Framework (PAF) and the national MyHospitals website. Please visit www.nhpa.gov.au/ to access the NHPA PAF and MyHospitals website. Whilst the layout of the PMF 2012-2013 continued to be classified under the existing five domains and eight dimensions the indicators were categorised and reported as Outcome Measures (as KPIs) and supporting Health Service Measures.
- The fourth year of the PMF maturity was progressed with a focus on consolidation, whilst continuing to align with state and national priorities. A Data Quality Statement and an Outcome Statement was developed for each KPI within the PMF to provide users with the necessary information to assist in facilitating improvements in performance management.
- In its fifth year the PMF will continue to progress its maturity with further consolidation. The introduction of vertical equity, the inclusion of private facilities providing public services and a clinical coding quality Health Service Measure within the Performance Management Report will ensure the PMF 2014-2015 continues to mature. In addition, the ongoing alignment to State and National priorities enables the PMF to maintain its relevance locally and nationally

Performance Reporting, Monitoring, Evaluating and Management

Reporting on the performance of Service Providers against the PMF KPIs and Health Service Measures is produced on a regular basis. This takes the form of an online interactive scorecard, with four levels of performance assessed against agreed targets. The four level performance results are used to calculate an overall 'Performance Score' for facilities and Health Services. The 'Performance Score' provides an indicative summary of performance across all KPIs for a facility or Health Service. The Performance Score will be complemented by three composite scores that focus on key priority areas. The three composite scores will comprise the Quality Composite Score, the Emergency Department Access Composite Score and the National Elective Surgery Target Composite Score.

The performance of Service Providers is monitored regularly against the KPIs, benchmarks and thresholds specified in the PMF in conjunction with the 'Performance Score'. Service Providers (or their nominees) will meet regularly with the Department's representatives to discuss the performance of their health service and the facilities within it. Performance concerns are identified when the facility and/or a health service 'Performance Score' is below a certain level. If performance concerns are identified, these meetings occur more frequently. Figure 17 below shows schematically how performance management operates.

Figure 18: Operation of WA Health System Performance Management



Please note that the PMF 2014-15 is subject to review by the Finance, Purchasing and Performance Group under the leadership of the Director General of Health

5.3 Better Health Outcomes for Aboriginal People Performance Targets

Table 8: Key Aboriginal Health Initiatives and Health Service Measures 2014-2015

Key Strategy	Health Service Measures
Aboriginal Workforce	1. Develop and implement an Aboriginal Workforce Plan consistent with the refreshed Aboriginal Workforce Strategy 2014-2024. 2. Implement targeted Aboriginal employment programs, including: • Recruiting 2 Aboriginal School based trainees. • Recruiting 2 Aboriginal Trainees. • Recruiting 2 Aboriginal Cadets. NOTE: Aboriginal people employed through these employment programs will be supported to remain in the health sector upon successful completion of their traineeship/cadetship. WA Health aims to increase the number of Aboriginal people employed by 100 every financial year until the Public Sector Commission's 3.2% Aboriginal staffing ratio across Public Sector Agencies is achieved. The target of increasing Aboriginal staff by 100 for WA Health has been apportioned for each budget holder, based on the proportion of WA Health employees within each budget holder (Baseline = headcount as at June 2014 and to be updated-when data available in June 2014) The 30 June 2015 target for Health Services is an additional (No) of Aboriginal staff compared with the same time in the previous year. Separate advice will be provided by the Office of Aboriginal Health.
Aboriginal Cultural Learning	1. Develop and implement an Aboriginal Cultural Learning Plan consistent with the Aboriginal Cultural Learning Framework 2012–2016. 2. Implement targeted Aboriginal cultural learning activities, including: • 75% of all new employees and 50% of existing employees have completed on-line cultural e-learning. • Implement the Aboriginal Health Impact Statements in the development of all revised and new strategies, policies and programs. • Implement the national standard Indigenous status question and recording categories on data collection forms and information systems.
Aboriginal Leadership	1. Develop and implement an Aboriginal Leadership Plan consistent with the Aboriginal Leadership Strategy 2012–2015. 2. Implement targeted Aboriginal Leadership programs in each area health service. 3. Inclusion of Aboriginal health as a standing item at executive level forums, supported by the most senior Aboriginal employee.

Endorsed by the Director General, the Aboriginal Cultural Learning Framework requires WA Health to continue to develop its capacity to respond to the needs of Aboriginal communities in Western Australia.

The Framework highlights key strategies and collaborative partnership opportunities that underpin WA Health's focus and include:

- Aboriginal Workforce
- Cultural Learning
- Aboriginal Leadership

The Framework and key strategies are embedded in WA Health's Operational Plan Reporting Structure and Director General's Performance Assessment.

In recognition of the WA public health system's commitment to improving the health of Aboriginal people, in 2014-2015, it is expected that the Health Services will develop an ongoing dialogue with the Department of Health to progress and report against the key initiatives and health service measures outlined in Table 7.

In 2014-2015 it is expected that each Health Service work with the Department of Health to assist with the refinement of health service measures to move towards performance targets and key performance indicators for 2015-2016 and future years.

The monitoring and reporting of the Aboriginal workforce data will be reported on a monthly basis at a health service level with targets set for each health service. This indicator is currently monitored and reported on a quarterly basis at a statewide level with a statewide target.

6.0 Community Services Procurement 2014-2015

The important role of the community services sector in delivering improved health outcomes for the WA community is valued and recognised within WA Health. WA Health purchases a range of community based health care services from the community services sector.

Community service procurement and contract management functions are devolved within WA Health and performed by the Community Services Procurement Directorate (CSPD) and Health Services contracting units.

With the release of the *Delivering Community Services in Partnership* (DCSP) Policy in 2011 the WA Government has sought to significantly reform the procurement of community services. This reform will ensure that Government pays a fair and appropriate price for community services from the not-for-profit sector, and that purchased services achieve demonstrable outcomes for the WA community.

For WA Health, this reform will mean:

- developing an outcomes based community services contracting framework for WA Health
- collaboratively co-designing current Service Agreements to ensure the service outcomes are clear, and the service contributes to WA Health's strategic outcomes
- building productive working relationships with Service Providers based on trust, collaboration, and accountability
- working alongside all relevant stakeholders to identify needs and create opportunities for flexibility and innovation in service design and delivery
- promoting sustainable service delivery
- reducing the administrative burden of contracting with WA Health.

Glossary of terms used in this document

Activity refers to WA's adoption of a broad definition of activity that includes everything that a health system does for, with and to patients, residents, clients and their families and carers, and the community. Activity can include community care grants, chronic disease programs, preventative health programs, shared maternity care, sub–acute care, step down care, living well when older and education, training, research and supervision.

Activity Based Funding (ABF) is the way that health service providers are funded for their activity.

Activity Based Management (ABM) is the management approach used by WA Health to plan, budget, allocate and manage activity and financial resources to ensure delivery of safe high quality health services to the WA community.

Allied Health includes the following health professions identified by the Chief Health Professions Officer: Physiotherapy, Podiatry, Occupational Therapy, Clinical Psychology, Pharmacy, Medical Imaging Technology, Radiation Therapy, Nuclear Medicine Technology, Audiology, Dietetics, Medical Librarian, Orthoptics, Orthotics and Prosthetics, Social Work, Speech Pathology, Biomedical Engineering, Clinical Perfusion, Exercise Physiology, Medical Physics, Medical Science, Respiratory Science, Sonography, Sleep Technology.

Ambulatory Surgery Initiative (ASI) is an innovative program that allows doctors to do additional work in hospitals with public services in order to improve patient access to minor procedures.

Procedures done under the ASI are bulk billed, and incur no out-of-pocket expenses for the patient.

Australian Commission on Safety and Quality in Health Care leads and coordinates national improvements in safety and quality in health care across Australia.

Average Length of Stay (ALOS) is the average number of days a patient might expect to spend in hospital for a particular procedure or diagnosis.

Casemix is the range and types of patients (the mix of cases) treated by a hospital or other health service. This provides a way of describing and comparing hospitals and other services for planning and managing health care. Casemix classifications put patients into manageable numbers of groups with similar conditions that use similar healthcare resources, so that the activity and cost-efficiency of different hospitals can be compared.

Clinical Governance is the term applied to collecting all the activities that promote, review, measure and monitor the quality of patient care into a unified and coherent whole. In WA, it has been defined as a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes.

Clinical Services Framework (CSF): The WA Health Clinical Services Framework 2010–2020 (CSF 2010) sets out the planned structure of public health service provision in WA over the next 10 years. It is an important tool for strategic statewide planning and will assist Health Services in developing localised clinical service plans.

Council of Australian Governments (COAG) is the peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association.

Diagnosis Related Group (DRG) is classification system for hospital admitted patients that groups patients that are clinically similar and are expected to use the same level of hospital resources.

Emergency Department (ED) means the dedicated area in a hospital that is organised and administered to provide a high standard of emergency care to those in the community who perceive the need for, or are in need of acute or urgent care, including hospital admission.

Forward Estimates provide a mechanism for projecting the budget revenue, expenses and financial position on the assumption that existing revenue and expenditure policies are maintained and that the Government's planned objectives continue to be pursued; that is, on a 'same policy basis'. Therefore, the Forward Estimates represent the likely budget outcomes if the same levels of service were to be provided in each of the three years following the budget; the existing regime of taxes and charges continues, but reflects previously announced changes in tax policy; expectations of the level of Australian Government transfer payments are realised; and assumptions underlying the economic parameters are realised. The existing regime for government charges is also assumed to be unchanged.

Health Corporate Network (HCN) provides Human Resources, Supply, Finance and Reporting and Business Systems services to WA Health.

Health Information Network (HIN) is established to drive the Information, Communications and Technology reform program, provides a focus on the importance of health information in our system and enables efficient and integrated technology services.

Health Service (HS) WA has four Health Services - North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS), WA Country Health Service (WACHS); and the Child and Adolescent Health Service (CAHS). The metropolitan and country health services are responsible for the management and delivery of services in their locales. The wide range of services managed includes the hospitals, mental health, community and public health services and health services for older people. CAHS is responsible for the statewide provision of services for children and adolescents including the running of Princess Margaret Hospital. To add to this system–wide planning and control, on 1 July 2012, WA officially established five new Health Service Governing Councils made up of community members and clinicians selected by the Minister for Health.

Health Service Measures describe the activities, goods or services WA Health deliver to achieve outcomes. They provide an indication of progress towards an outcome.

Historical Funding Methodology Traditionally, health services in WA, and in some other jurisdictions across Australia, have been funded on a historical basis. This means that budgets are based on last years budget and/or expenditure, plus an increase to cover expected growth in costs or activity.

Independent Hospital Pricing Authority (IHPA) established in December 2011 to provide independent and transparent advice in relation to funding for public hospitals by determining the national efficient price for health care services provided by public hospitals

Inpatient is any patient whose care requires a stay in a hospital.

National Partnership Agreement (NPA) since its establishment in 1992, the Council of Australian Governments (COAG) has settled and signed a number of intergovernmental agreements (IGA). An IGA is an overarching framework for the Commonwealth's financial relations with the States and Territories (the States). Each State and Territory receives funding from the IGA via five Specific Purpose Payments (SPP) – Healthcare, schools, skills and workforce development, disability services and affordable houses. Each SPP is associated with a National Partnership Agreement (NPA).

National Health Performance Authority (NHPA) established in October 2011 to report on the performance of all local hospital networks, public and private hospitals and primary healthcare organisations.

Non-Admitted Patient refers to a patient who does not undergo a hospital's formal admission process. There are three categories of non-admitted patient: Emergency Department patient, Outpatient and other non-admitted patient (treated by hospital employees off the hospital site - includes community/outreach services).

Non Hospital Products are services provided by Health Services that are not directly related to inpatient care or outpatient services e.g. community health services, public health services.

Outcomes Measures describe the effects, impact results or consequences which WA Health activity is expected to have on community wellbeing. Outcomes should be expressed as concise, unambiguous and realistic statements that focus on the end result being sought by WA Health, rather than the means for achieving it. In principle, progress in achieving outcomes should be measurable, even if the required data are not readily available.

Outpatient refers to non-admitted, non-emergency department patients registered for care by specialist outpatient clinics of public hospitals.

Purchaser is an organisation which procures health services. The purchaser acts on behalf of the Government, the community, and patients, to progress the Government's objectives relating to health.

PSOLIS is the mental health clinical information system used by public mental health services in WA.

Research is an activity where the primary aim is the advancement of knowledge through: observation, data analysis and interpretation, or other means that are secondary to the primary

purpose of providing patient care and/or activities associated with patient care where additional components or tasks exist (for example, the addition of control group in a cohort study).
State Health Executive Forum (SHEF) is an advisory body to the Director General of Health (DG) and assists the DG to manage the WA Government Health System through discussion, and provision of advice to the DG on strategic service, policy and administrative issues affecting WA Health Services.

Statewide Services consists of Health Information Network (HIN), Health Corporate Network (HCN) and Industrial Relations

Subacute Care is specialised multidisciplinary care in which the primary need for care is optimisation of the patients functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction. It is available to people of all ages on an admitted or ambulatory basis and may follow an admitted episode, ambulatory care or directly from the community. Subacute Care patients should receive care that is:

- delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record

All admitted patients with episodes in the following Care Types are considered Subacute:

1. Rehabilitation Care
2. Geriatric Evaluation and Management
3. Psychogeriatric Care
4. Palliative Care

Teaching Hospital is a hospital that provides clinical education and training to doctors, nurses, and other health professionals, in addition to delivering healthcare to patients. Teaching hospitals may also be involved in research and development activities.

Teaching is any activity where the primary aim is to transfer clinical knowledge for ongoing professional development via a teacher or mentor to a student or candidate in a recognised program/course that will result in either qualifications that may meet registration requirements; or other admission to a specified discipline where the right to practise in that discipline requires completion of the program or course.

Training is the planned and organised activity to impart skills, techniques and method to employers and their employees to assist them in:

- Supporting staff retention through career pathways;
- Professional development activities;
- Establishing and maintaining employment and a place of employment which is safe and healthy;
- Improving health knowledge through keeping staff up to date with health industry trends and new technologies; and
- Reducing health costs through improved ways of working.

Technical Efficiency occurs when the minimum amount of resources are used to produce a particular activity or set of activities, thereby avoiding waste.

Table of commonly used acronyms & abbreviations

ABF	**Activity Based Funding**
ABM	Activity Based Management
ACSQHC	Australian Commission on Safety and Quality in Health Care
AN-SNAP	Australian National Subacute & Non-Acute Patient
ARDT	Admission, Readmission, Discharge and Transfer Policy for WA Health Services
AR-DRG	Australian Refined Diagnosis Related Group
CAHS	Child and Adolescent Health Service
CSF	Clinical Services Framework
CSS	Community Service Subsidy
COAG	Council of Australian Governments
DRG	Diagnosis Related Group
ED	Emergency Department
eWAU	Emergency Weighted Activity Unit
HAPI 5	Health Activity Purchasing Intentions, 5th Ed.
HSAP	Health Service Allocation Price
IHPA	Independent Hospital Pricing Authority
iWAU	In-patient Weighted Activity Unit
KPI	Key Performance Indicator
LHN	Local Hospital Network
NEAT	National Emergency Access Targets
NEC	National Efficient Cost
NEP	National Efficient Price
NHCDC	National Hospital Costing Data Collection
NHPA	National Health Performance Authority
NHRA	National Health Reform Agreement 2011
NMHS	North Metropolitan Health Services
NPA	National Partnership Agreement
NSQHS	National Safety and Quality Health Service
nWAU	National Weighted Activity Units
PAC	Projected Average Cost
PMF	Performance Management Framework
SAs	Service Agreements
SEP	State Efficient Price
SMHS	South Metropolitan Health Services
SQuIRe	Safety and Quality Investment for Reform Program
The Commission	Mental Health Commission
The Department	The Department of Health
WA	Western Australia
WA Health	The Department of Health and Area Health Services or the WA public health system
WACHS	WA Country Health Services
WAU	Weighted Activity Unit

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