



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

WA Health Funding and Purchasing Policy Guidelines 2015-16



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Contributors

Special thanks to all who contributed to the development of this document and in particular to the representatives from WA Department of Health and WA Health Service Providers.



Please Read First:

An electronic version of this document is available to all users and can be found at <http://ww2.health.wa.gov.au/About-WA-Health/Service-agreements>. Please use this electronic version to navigate to resources referenced.

WA Health Funding and Purchasing Policy Guidelines

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Purpose of the Funding & Purchasing Policy Guidelines

The Western Australia (WA) Health Funding & Purchasing Policy Guidelines 2015-16 (the Guidelines) inform stakeholders of how governing frameworks, strategic policy and service delivery planning influence WA Health budget settings and funding allocations for 2015-16. The aim is to describe the Department of Health (the Department) treatment (as 'System Manager') of the budget and resource allocation process for the WA's health system.

The Guidelines act as a reference tool, underpinning the Service Agreements that are signed with each Health Service Provider at the beginning of the financial year.

1.0 Introduction

WA has a good public health care system by national and international standards. WA Health has invested over \$7 billion in new hospitals, new technology, and new Medical Research Centres. WA's performance in elective surgery compares well with other States, and as a system we have lead the nation in implementing reforms to Emergency Department (ED) care through the Four Hour Rule program.

The WA health system provides high quality health services to almost 2.6 million people across 2.5 million square kilometres and leads innovative reforms to enhance the health and wellbeing of our population.

However, drivers such as changing community health needs and expectations are placing more complex demands on the WA health system. This is in part due to WA having the fastest growing state population coupled with an increasing, aging population and burden of chronic illness. Furthermore inequities in health status persist, particularly in the Aboriginal population. Despite increasing health care costs continuing to grow the WA Health system must continue to provide access to best practice medical technology and practices. The State Government is working to meet these challenges in our health sector, while facing increasing costs of delivering health services, alongside a declining State revenue base. Subsequently, continued reform and innovation by WA Health are essential to ensure the quality and performance of our health system is sustained.

In response to the impact of these drivers, the WA health system is undergoing a significant transition phase via:

- commissioning of major new metropolitan and country hospitals
- increasing operational efficiency and system effectiveness through associated health service reconfiguration
- movement towards a more devolved governance model where the Department will provide system leadership and planning in the role of *System Manager*
- strengthening the *Purchaser/Provider* relationship within the WA health system for transparent resource allocation and setting performance expectations in relation to funds provided to the Health Service Providers
- implementation of key national Activity Based Funding (ABF) reform initiatives, including the transition of the State Price (SP) to the Projected Average Cost (PAC) for public hospital services by 2020-21.

1.1 The Case for Reform

WA Health has commenced an integrated program of reform that ensures we make the most of the investments and address the challenges. This reform aims to achieve greater efficiency in the delivery of services and management of health resources as well as maintain a high level of quality and safe health care.

The WA Health Reform Program (the Program) consists of a series of projects that will be rolled out in two phases:

- Phase 1 is underway and involves projects related to system governance, system performance, support services, procurement and contract management.
- Planning is beginning for Phase 2 projects that will support patient safety and quality, workforce planning, develop leadership, and promote partnerships. The Program involves a system-wide effort to sustain and improve quality health care and staff will be critical to its success.



The WA Health Transition and Reconfiguration Steering Committee (the Steering Committee) was established to oversee the implementation of approved health reform initiatives. The WA Health Reform Program Board was established in 2015 to provide the Program with a solid governance structure and reports directly to the Steering Committee.

The Program intends to:

- transition the WA health system to a more devolved governance model that will allow the Health Service Providers to be more autonomous in responding to the changing needs of local communities and will allow the Department to provide system leadership and planning as a *System Manager* in a more integrated and sustainable health system
- improve performance of the system through transparent allocation of resources, and holistic management of clinical and financial performance
- improve our support service functions to assist WA Health to deliver quality health care while demonstrating value for money
- implement standardised and consistent approaches to procurement and contract management across the system, driving better value and sound decision making
- continue commitment to development of leadership capability, excellence in clinical safety and quality, workforce planning and identifying opportunities to improve the way WA Health engages with external stakeholders.

It is expected that as a result of the Reform Program, WA Health will:

- better meet the needs of the community through increased local engagement in decision making
- improve system leadership including strategy, policy and system planning
- improve ability for clinicians and front-line staff to improve patient outcomes and deliver evidence- based, best practice treatment
- have improved clinical and financial performance
- be a more engaged, responsive, accountable and sustainable health system.

1.2 Funding and Policy Guidelines

The Guidelines inform all stakeholders (the public, Health Service Providers, the Department budget-holders, and the Mental Health Commission) about budget development, the resource allocation processes, and service performance and accountability for WA Health.

The 2015-16 Guidelines are aligned with the Program and build on the previous 2014-15 Guidelines. They are based on the principle of achieving a streamlined, open and transparent process with respect to data inputs, communication and methodologies employed throughout the Budget and Resource Allocation (B&RA) Process, achieved by:

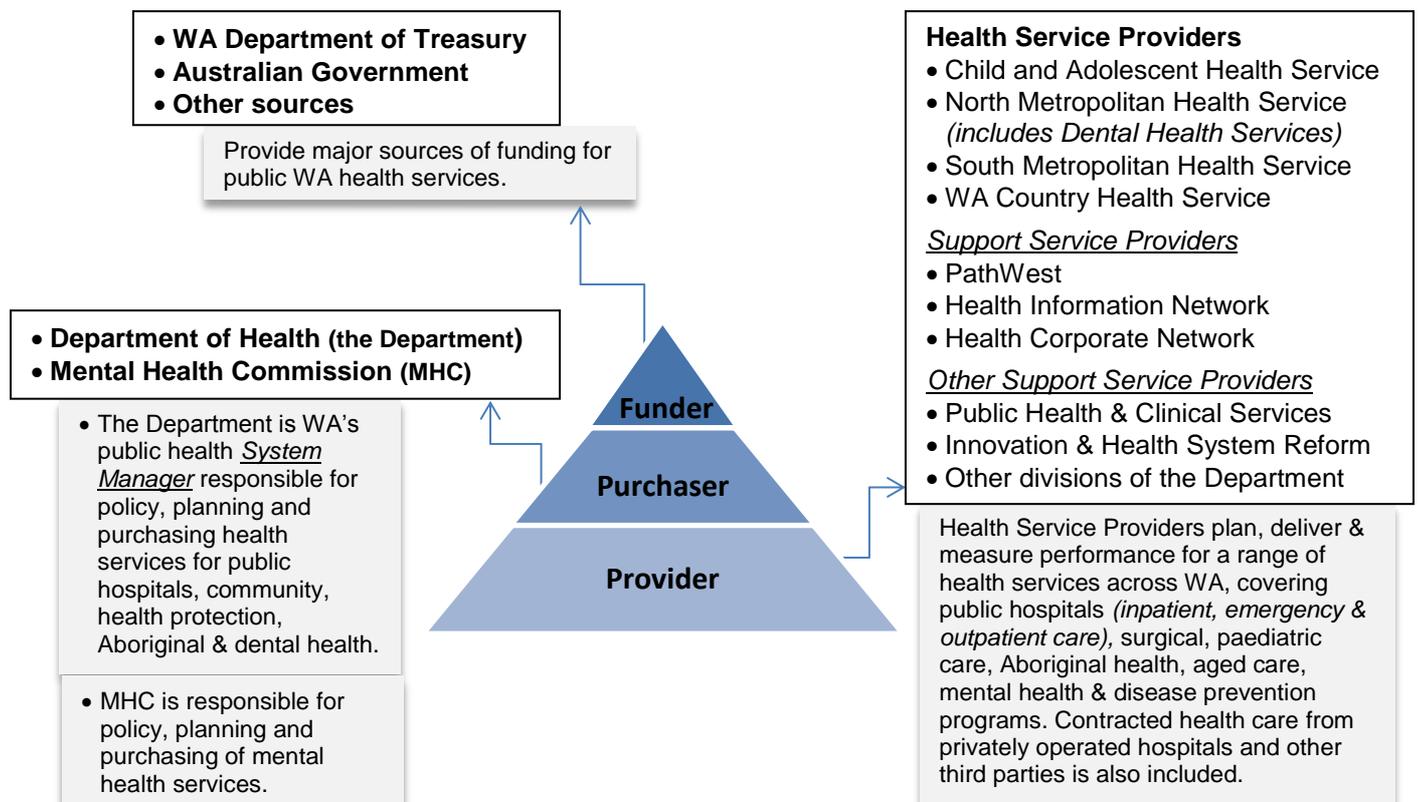
- ensuring that the assumptions in the WA Health Budget are clearly articulated
- explaining the funding principles and models underlying the budget allocations across WA Health with a particular focus on the operation and implementation of ABF and Activity Based Management (ABM)
- introducing resource efficiencies while working towards a planned convergence to the PAC over the reconfiguration period 2020-21
- increased collaboration with Health Service Providers and other key contributors to encourage further feedback opportunities
- providing the public with information on performance and accountability in relation to Health Service Providers' budget allocations.



These Guidelines are an important tool in the management of the *Purchaser/Provider* relationship between the Department and the Mental Health Commission (MHC) as joint Purchaser, Health Service Providers and state-wide Support Service Providers. A fundamental element of the WA Health Reform Program is to develop legislation that will clearly define the roles, responsibilities and accountabilities of the Department, the Health Service Providers and system-wide Support Service Providers.

Figure 1 below provides a brief definition of key stakeholder roles. Further detail regarding policy arrangements between the *Funder, Purchaser and Provider* functions is addressed in [Section 2 Roles and Responsibilities](#).

FIGURE 1: Funder, Purchaser and Provider Role Clarity



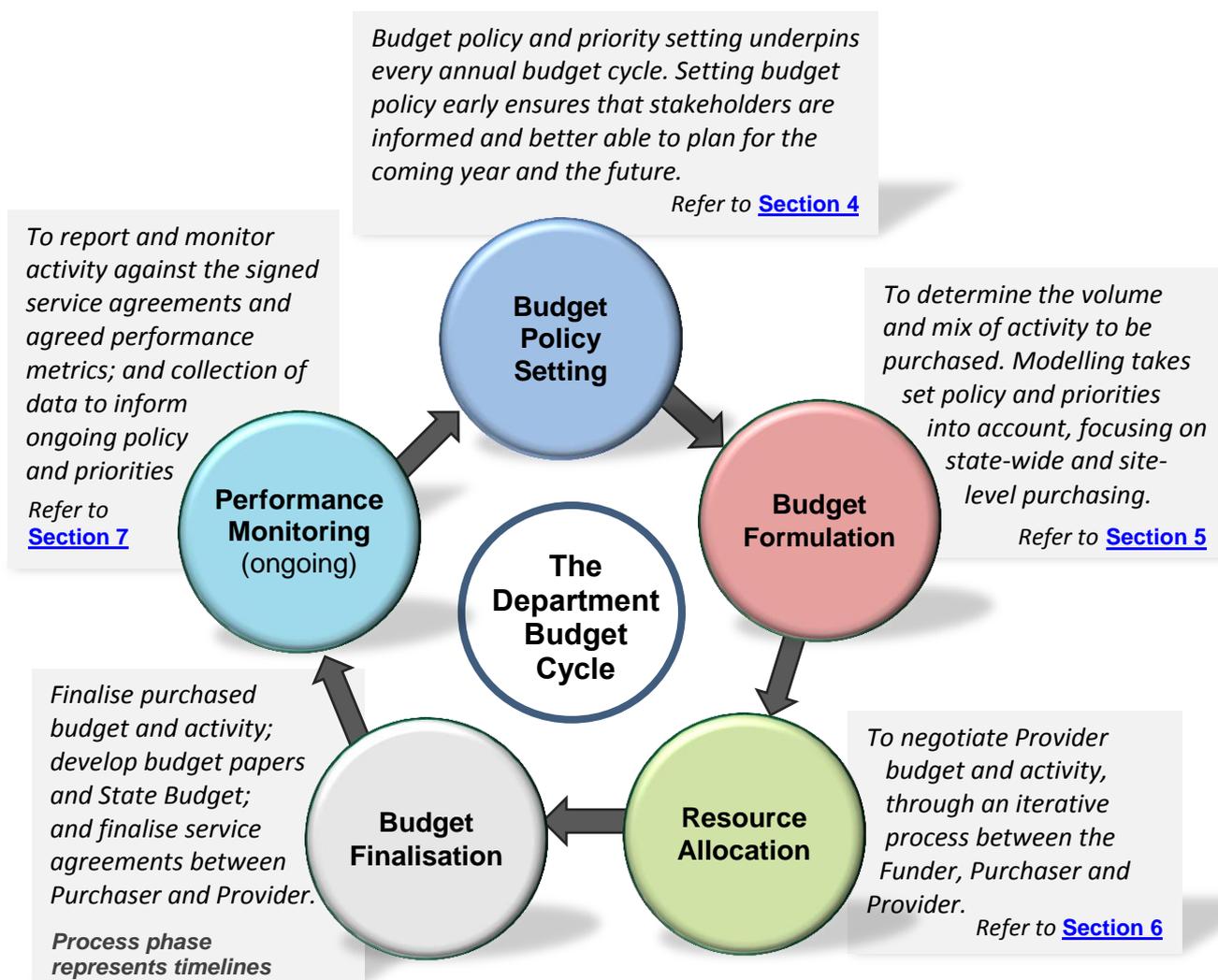
The Guidelines include new and enhanced information, notably in the context of WA Health's B&RA Process in relation to *Funder/Purchaser* policy and *Provider* strategy, as detailed in [Section 3 Key Policy Settings](#). Also, a key element incorporated within the Guidelines is the content from the previously published *Health Activity Purchasing Intentions* document.

It is envisaged that through greater transparency and stronger engagement between the *Purchaser/Provider* functions throughout the B&RA Process, Health Service Providers will be enabled to enhance financial and service planning frameworks to deliver better care and better value for all Western Australians.

1.3 Budget and Resource Allocation Process

The annual B&RA Process is made up of five key phases within the Department Budget Cycle, illustrated below in *Figure 2*. Four of these phases are discussed in detail from Section 4 through to Section 7 within the Guidelines.

FIGURE 2: Phases of WA Health’s Budget and Resource Allocation (B&RA) Process

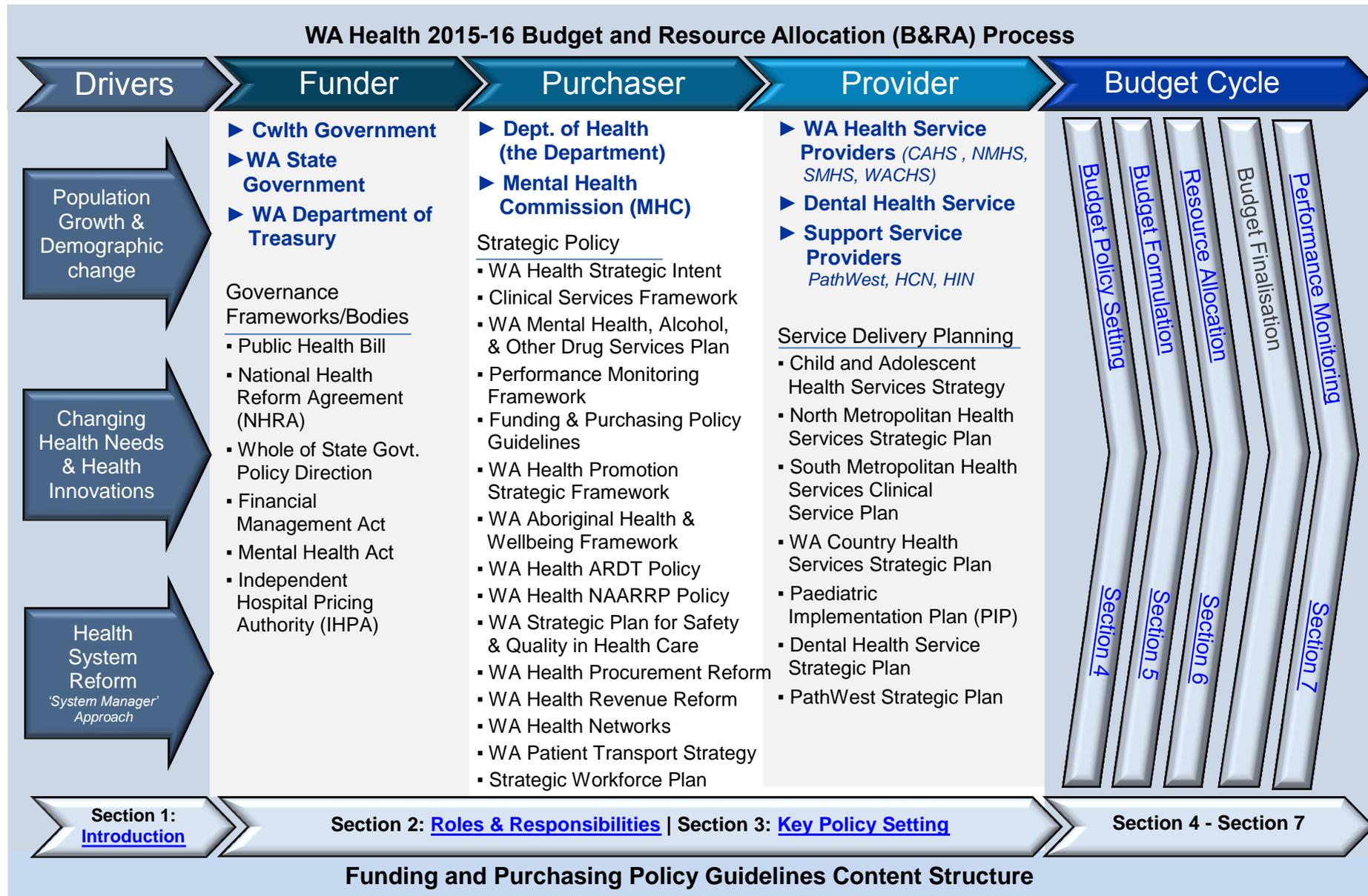


1.4 Governance Frameworks, Strategic Policy and Service Delivery Planning Influencing the B&RA Process

On the following page, *Figure 3* depicts the B&RA Process in a diagram view to define the broader context of WA Health’s operating environment within the *Purchaser/Provider* relationships. This figure identifies how the B&RA Process, including purchasing and performance management are impacted by various governance frameworks, strategic policy and service delivery planning instruments.

A key feature of *Figure 3* is the link between the Guidelines content structure to the B&RA Process, and specifically the Department Budget Cycle reflected in the section titles (e.g. [Sections 4 through to 7](#)).

FIGURE 3: Governance Frameworks, Strategic Policy and Service Delivery Planning Influencing the WA Health B&RA Process



1.5 Key B&RA Highlights for 2015-16

These Guidelines signal a new direction for WA Health, the Department operating in alignment with the *System Manager* approach. This is part of a continued commitment, developed with advice and input from both the Department and Health Service Providers, to help translate strategic policy and priorities into purchasing and performance management.

The key highlights and financial policy outcomes for Health Service Providers resulting from the 2015-16 budget and resource allocation process include:

- **Purchaser/Provider Collaboration**

As System Manager, the Department engaged with Health Service Providers early to create a streamlined and transparent process. Consultation involved development of *Preliminary Activity Profiles for each Health Service*, three rounds of *Provider Budget and Activity Schedules*, and feedback from Health Service Providers captured in the Health Services *Purchasing Issues Register*.

- **Price Convergence**

Key savings and corrective measures are instruments that will enable WA Health to enhance efficiency and achieve price convergence by 2020-21 (refer to [Sections 4.2.3 Transitioning to National Pricing](#) and [6.1.3 Pricing Principles](#)). To achieve price convergence the key policy outcomes that will support this are identified as *procurement savings*, *efficiency dividend*, *Targeted Separation Scheme* (TSS) and the *Workforce Renewal Policy* (WRP) which are discussed further in [Section 6.2.7 Key Financial Considerations](#).

- **Internal Revenue Generation Systems**

The focus of *Revenue Reform* project is to enhance WA Health financial performance capabilities through avenues not already fully optimised, for instance establishing internal revenue generation systems, reduce *Bad Debts* and drive efficiencies through *Own Source Revenue* (OSR) Targets that are now in place for Health Service Providers. These initiatives are further explained in [Section 6.2.7 Key Financial Considerations](#).

- **Role Delineation**

With the *Purchaser/Provider* role delineation, and fully functional Fiona Stanley Hospital (FSH), planned reconfiguration activities have changed the way Mental Health and Paediatric Services are being delivered. Actual paediatric activity (across all service categories) will be monitored by the Department to examine the progress of the paediatric reconfiguration across all Health Service Providers.



For more info on **Efficiency Dividends & Procurement Savings** go to [page 56](#)



Go to [page 57](#) for more info on the **Targeted Separation Scheme (TSS) & Workforce Renewal Policy (WRP)**



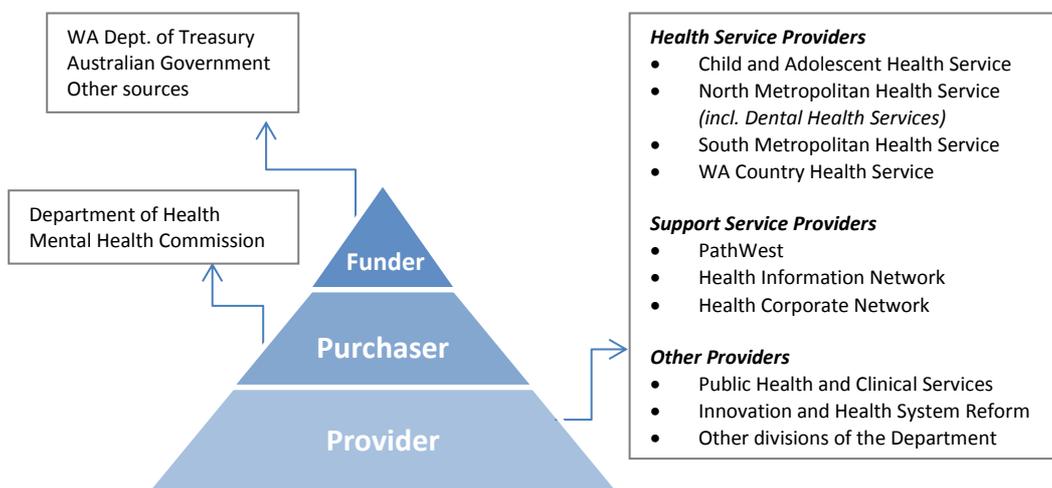
You will find more info on **Revenue Reform, OSRTargets & Bad Debts** on [pages 55 and 56](#)

Ultimately, the Guidelines articulate the broader interactions impacting on budget and resource allocation between the WA Health budget strategy and purchasing activities. This is achieved by creating transparency around the Department reporting and performance management framework aligned with national and State priorities. It is envisaged that future editions of the Guidelines will build upon the 2015-16 Guidelines.

2.0 Roles and Responsibilities

This section outlines the key elements of the *Purchaser / Provider* relationship for the delivery of public health services. The three key roles are depicted in the *Figure 4* below:

FIGURE 4: Purchaser/Provider Relationship for the Delivery of Public Health Services



2.1 Funder Roles and Responsibilities

The major sources of funding for public health services in WA are the WA Government, through the Department of Treasury (WA Treasury), and the Australian Commonwealth Government (e.g. Department of Veterans' Affairs, Medicare Benefit Schedule, ABF).

Additional funding is also received from other sources including private health insurance, workers' compensation, motor accident insurance, cross-border arrangements and others.

2.1.1 Western Australian Government through WA Treasury

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

2.1.2 Australian (Commonwealth) Government

The Australian Government allocates funding to the State and Territory Governments to provide health and hospital services. The Australian Government funds hospital services through the National Health Reform Agreement (NHRA).



Handy Tip:

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



Click here for more information on the [National Health Reform Agreement](#)



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

2.2 Purchaser Roles and Responsibilities

The Department and the MHC are the Purchasers of public health and mental health services, respectively, in WA.

The Department is the public health *System Manager*. The Department purchases public hospital and community health services; health protection through public health service providers and disaster preparedness management; dental health services, including school dental health and public community dental services; and Aboriginal health services.

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

2.3 Provider Roles and Responsibilities

Key providers within the public health system are as follows:

- Health Service Providers:
 - North Metropolitan Health Service (NMHS) (includes Dental Health Services)
 - South Metropolitan Health Service (SMHS)
 - WA Country Health Service (WACHS)
 - Child and Adolescent Health Service (CAHS)
- Support Service Providers:
 - PathWest
 - Health Corporate Network (HCN)
 - Health Supply Network (HSN)
 - Health Information Network (HIN)

2.3.1 Health Service Providers

North Metropolitan Health Service (NMHS)

The NMHS catchment area covers almost 3,000 square kilometres, with a population of almost 950,000, of whom 1.4 per cent are Aboriginal. The NMHS provides public hospital, community, and mental health services to approximately one million people living in Perth's northern and north-eastern suburbs. NMHS also oversees the provision of contracted public health care from the privately operated Joondalup Health Campus, and the new privately operated public hospital at the Midland Health Campus which is currently under construction. The population in the NMHS catchment area represents more than 40 per cent of WA's total population and is projected to grow to more than 1.1 million by 2020.

South Metropolitan Health Service (SMHS)

The SMHS provides a comprehensive range of medical, surgical, critical care (emergency & ICU), mental health, rehabilitation, aged care, ambulatory and primary health services. This includes specialised state-wide services to patients from across WA, as well as



Click here for more information on [North Metropolitan Health Service](#)



Click here for more information on [South Metropolitan Health Service](#)

tertiary, secondary and community-based services to people living in Perth's southern suburbs. In October 2014, WA opened the \$2 billion Fiona Stanley Hospital (FSH). FSH provides planned surgical management for diseases of the heart, lungs, oesophagus and chest, as well as emergency services for patients requiring immediate cardiothoracic care. SMHS covers an area of 4,227 square kilometres with a population of almost 902,000, of whom 2.1 per cent are Aboriginal. The SMHS population represents more than 37 per cent of WA's total population and is projected to increase to more than one million by 2020.

WA Country Health Service (WACHS)

The WACHS is the largest country health service in Australia covering 2.5 million square kilometres. WACHS provides health care to more than 515,700 people, including nearly 50,000 Aboriginal people who live in rural and remote communities across WA. WACHS services include inpatient, emergency and outpatient care at six regional hospitals, 15 district hospitals and 50 small hospitals. WACHS also provide primary health care, child and maternal health services, allied health services, mental health services, aged care, and disease prevention programs.

Child and Adolescent Health Service (CAHS)

The CAHS encompasses Princess Margaret Hospital (PMH), Child and Adolescent Community Health (CACH), Child and Adolescent Mental Health Services (CAMHS) and the Perth Children's Hospital (PCH) Project. The PCH is scheduled to open in 2016. The PCH is planned to have 298 beds and house the State's only paediatric trauma centre. The new PCH will provide tertiary and key secondary health services including inpatient, emergency and outpatient care.

PMH is the State's sole tertiary paediatric hospital that treats children and adolescents up to 16 years of age. The 250 bed facility provides tertiary and quaternary care for children with complex health needs as well as providing secondary services to those children that reside within its local catchment. Each year, PMH has approximately 70,000 presentations to its Emergency Department and 275,000 patient visits (inpatient and outpatient).

Dental Health Services (DHS)

DHS is an entity under the NMHS, which promotes and improves the oral health of all people in WA by providing adult and school dental services to eligible patients as well as dental health education.

DHS key accountabilities include:

- policy setting
- budget planning, purchasing negotiations and budget finalisation performance monitoring
- manage to budget, revenue, activity and other performance targets



Click here for further information on [WA Country Health Service](#)



Click here for more information on [Child and Adolescent Health Service](#)



Did you want more information on DHS?
Click here [Dental Health Service](#)

- sustainable workforce capacity and mix aligned with quality, access and budget expectations.

2.3.2 Support Service Providers

PathWest

PathWest Laboratory Medicine WA, is the single public pathology service in WA. PathWest provides diagnostic services across the full range of pathology disciplines. PathWest services both metropolitan and regional WA through a network of over 50 branch laboratories and collection centres.

Health Corporate Network and Health Information Network

In May 2015, the Supply Directorate of Health Corporate Network (HCN) and the Strategic Procurement Team from Health Information Network (HIN) were amalgamated to create an independent Health Supply Network (HSN).

HCN provides Recruitment Services, Payroll Services, Finance and Corporate Business Systems Services to WA Health.

HIN provides Information and Communication Technology services to the Department and Health Service Providers (excluding some aspects for WACHS). These services include: service desk support, clinical and some corporate systems application support, Information and Communications Technology (ICT) infrastructure support, ICT policy setting, national eHealth liaison and the delivery of identified areas of the ICT Strategy 2015-2018.

HSN is responsible for the supply chain for WA Health and the management of Whole of Health contracts.

Through the WA Health Reform program there will be improvements in our support services functions to assist WA Health to deliver quality health care while demonstrating value for money.



Click here for further information on [PathWest](#)



For more information on **Costing Study for Pricing of HIN and Support Services** go to page 57

TABLE 1: Key Accountabilities of the Funder, Purchaser and Provider

	Funders		Purchasers	Providers		Support Service Providers	
	WA Treasury	Australian Commonwealth	The Department and MHC	Health Service Providers	Dental Health Services	PathWest	HCN/HIN
Policy Setting, Budget Planning, Purchasing & Negotiation	<ul style="list-style-type: none"> Manage competing State Government priorities for funding by calculating expenditure limits and funding conditions (type of activity to be delivered, quality and access performance measures) at the start of the Budget Cycle and passing through adjustments throughout the Budget Cycle Intergovernmental relations to provide certainty around available Australian Government funds Value for money – in conjunction with the Purchaser, ensure that the Providers deliver optimal clinical cost effectiveness from base and growth funding Recommend a Health Budget position to the <i>Economic and Expenditure Reform Committee</i> (EERC) to inform budget decisions 	<ul style="list-style-type: none"> Notify WA Treasury of funding intentions and conditions for ABF services (including equity, access and quality targets) and conditions for specific purpose funding (as these arise throughout the budget cycle) Set policies regarding funding intentions, based on the determination of the National Efficient Price/ National Efficient Cost by the Independent Hospital Pricing Authority (IHPA) Review capital project funding proposals under the Health and Hospitals Fund. 	<ul style="list-style-type: none"> Develop budget policy and priorities, coordinate consultation and sign-off Liaison between the Department and the MHC as the co-Purchasers (throughout the Budget process) Maximise revenues, including Third Party Revenue, and identify efficiencies. Model Provider allocations in line with agreed policy, and communicate outcomes to the Funder and Provider entities, to inform the Budget Submission and draft Provider budget and activity Ensure Australian Government funding conditions are factored into purchasing decisions Purchase value-for-money services, based on optimising clinical cost effectiveness from base and growth funding 	<ul style="list-style-type: none"> Cost and demand forecasting to inform budget policy Coordinate clinical engagement to inform policy setting Provide information to the Purchaser to develop Budget Submission Notify private providers of activity levels for 2015-16 Fiona Stanley Hospital commissioning and service reconfiguration Optimise revenues, including Third Party Revenue, and identify efficiencies. 	<ul style="list-style-type: none"> Cost and demand profiling to inform budget policy Coordinate clinical engagement to inform policy setting 	<ul style="list-style-type: none"> Inform price setting for internal charging arrangements (fee for service, delivered to health services) – based on cost, revenue and activity forecasting Inform policy setting for private patient revenue 	<ul style="list-style-type: none"> Expenditure forecasting to inform budget policy and strategy Supporting the development of price setting for internal charging arrangements in the 2016-17 financial year
Budget Finalisation	<ul style="list-style-type: none"> State Budget Coordination State Budget Papers 	<ul style="list-style-type: none"> Coordinate Australian Government Budget 	<ul style="list-style-type: none"> Development of Health Budget Papers (for the Department) Input into Health Budget Papers (for MHC) Negotiation of final service agreements 	<ul style="list-style-type: none"> Review iterations of the draft budget for cost, revenue and activity. Also negotiate site level allocations, ABF streams, non-ABF services, new initiative funding and efficiency dividends (<i>in the case of WACHS, the treatment of rural and remote services</i>) Negotiate service agreements with NGO and private providers Align service and workforce expectations for 2015-16 with activity targets 	<ul style="list-style-type: none"> Review draft budget and activity against internal forecasts Value for money – achievement of clinical cost effectiveness in prioritising and delivering oral health services Participate in clinical network to inform policy setting. 	<ul style="list-style-type: none"> Review iterations of draft price, revenue and activity and negotiate with the Purchaser Value for money – achievement of clinical cost effectiveness in pathology services 	<ul style="list-style-type: none"> Review draft budget and activity against internal forecasts Value for money in purchasing services
Performance Monitoring	<ul style="list-style-type: none"> Monitor reported activity with the Purchaser Coordinate Mid-Year Review 	<ul style="list-style-type: none"> Monitor delivery of activity to trigger payments under the National Health Reform Agreement Monitor delivery of services for specific purpose funding under National Partnership Agreements 	<ul style="list-style-type: none"> Provider performance monitoring against service agreements Track and report activity to the WA Treasury Ensure Australian Government reporting requirements are met Monitor national targets - NEAT and NEST Performance Management process is specified in the Annual PMF for 2015-16, refer to Section 7 of The Guidelines 	<ul style="list-style-type: none"> Manage cost, revenue, activity and quality to the service agreement Manage contracts with NGO and private providers Monitor service agreement requirements (e.g. activity targets) by service stream, achievement of National Emergency Access, Elective Surgery Targets (NEAT and NEST) and patient revenue Manage requirements for specific purpose funding from the Australian Government and other sources Communicate with the Purchaser for future policy and priority development Sustainable workforce capacity and mix aligned with quality, access and budget expectations. 	<ul style="list-style-type: none"> Manage to budget, revenue, activity, quality and other performance targets Sustainable workforce capacity and mix aligned with quality, access and budget expectations. 	<ul style="list-style-type: none"> Meet quality, cost, revenue and other performance targets Sustainable workforce capacity and mix aligned with quality, access and budget expectations 	<ul style="list-style-type: none"> Manage expenditure to budgeted amounts Meet service level agreements Report expenditure to the Department Produce financial statements for WA Health (for HCN only) Manage contracts with external suppliers Ensure that technology projects are delivered according to approved scope, time and budget and to expected quality standards

Source: Table 1 adapted from material developed as part of the B&RA

TABLE 2: List of WA Health ABF Hospitals

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

**Excludes small hospitals*

<p>Section 1 Introduction</p>	<p>Section 2 Roles & Responsibilities</p>	<p>Section 3 Key Policy Settings</p>	<p>Section 4 Budget Policy Setting</p>	<p>Section 5 Budget Formulation</p>	<p>Section 6 Resource Allocation</p>	<p>Section 7 Performance Monitoring</p>
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3.0 Key Policy Settings

This section provides an overview of the overarching policy framework impacting on WA Health budget and resource allocation. These policy settings are organised as:

[3.1 Funder Policy](#)

[3.2 Purchaser Policy](#)

[3.3 Provider Strategy](#)

3.1 Funder Policy

Public Health Bill 2014

This Bill is to protect and promote the health of all Western Australians has been introduced to parliament. The development of the *Public Health Bill 2014* is a major public health initiative and regulatory reform project for WA, meeting a strong need for contemporary public health legislation.

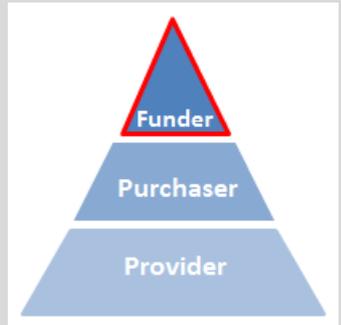
The Bill repeals much of the outdated *Health Act 1911* and provides for the implementation of modern law that has the flexibility to deal with both known and emerging public health risks.

If passed, the Bill will strengthen the WA's capacity to deal with public health emergencies, including pandemics and bio-terrorism, and provide the framework to manage other public health risks, including preventable disease.

National Health Reform Agreement (NHRA)

The NHRA was agreed by the Commonwealth, States and Territories in August 2011. The NHRA seeks to improve:

- patient access to services and public hospital efficiency through the use of ABF based on a National Efficient Price (NEP)
- sustainability of funding for public hospitals by increasing the Commonwealth's share of public hospital funding through an increased contribution to the costs of growth
- transparency of public hospital funding through a National Health Funding Pool and a nationally consistent approach to ABF
- standards of clinical care through the Australian Commission On Safety and Quality in Health Care (ACSQHC)
- performance reporting through the establishment of the National Health Performance Authority
- accountability through the Performance and Accountability Framework



For more information on the **Public Health Bill** visit the Department [Public Health website](#)



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



Activity Based Funding (ABF) means an activity comprising in-scope public hospital services which will be funded by the Commonwealth in the 2015-16 financial year in the manner described at clause A32(c) of the NHRA.

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

Source: Independent Hospital Pricing Authority (IHPA) [Online Glossary](#)

- local accountability and responsiveness to the needs of communities through the establishment of Local Hospital Networks and Medicare Locals¹
- provision of general practitioner (GP) and primary health care services through the development of an integrated primary health care system and the establishment of Medicare Locals²
- aged care and disability services by clarifying responsibility for client groups.

The NHRA also seeks to ensure that each State and Territory provides health and emergency services through the public hospital system based on certain key principles and acknowledges the Commonwealth's lead role in primary care.

3.2 Purchaser Policy

WA Health Strategic Intent 2015-2020

The Strategic Intent defines WA Health's overarching vision, values and priorities. It outlines a vision of *delivering a safe, high quality, sustainable health system for all Western Australians*.

WA Health's Code of Conduct identifies the values that are fundamental in how employees perform their work and describes how these values translate into action. The six values are; *Quality Care, Respect, Excellence, Integrity, Teamwork and Leadership*.

WA Health's strategic priorities are focused on a continuum of care to support and guide health care through integrated service delivery from prevention and health promotion, early intervention, primary care through to diagnosis, treatment, rehabilitation and palliation.

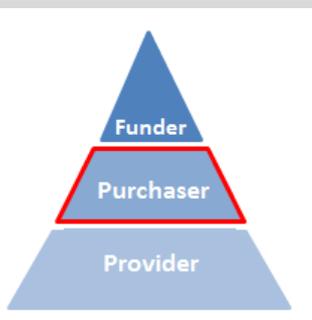
Ensuring people in WA receive safe, high quality and accessible health services underpins the strategic priorities. This includes delivering health services that are patient-centred, based on evidence and within a culture of continuous improvement.

WA Health Clinical Services Framework 2014-2024

The WA Health Clinical Services Framework (CSF) is the principle, government endorsed clinical service planning framework document for the WA public health system. The CSF is designed to describe medium to long-term horizons and the strategic parameters that can be used by individual health service providers, hospitals and non-hospital service providers to inform and guide their individual clinical services plans.

¹ Primary Health Networks (PHNs) are being established around Australia to operate from 1 July 2015. They will replace Medicare Locals, which will cease operations on 30 June. For more information about this Australian Government policy decision go to [Primary Health Networks website](#)

² *ibid*



Click here for more information on the [WA Health Strategic Intent 2015-2020](#)



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

The CSF is refreshed at least every five years and provides a blueprint for the whole health system in planning for services, workforce, infrastructure, technology, and budgeting in line with the strategic intent of WA Health and with consideration of the challenges of changing demographic profiles, increasing complexity of disease, environmental factors, service capabilities and government policy.

[Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025](#)

The *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* was released for consultation in late 2014. The Plan sets the direction for mental health, alcohol and other drug service provision in WA from 2015 to 2025. The Plan outlines the Government's expectations about the changes needed to build on, and enhance the improvements made in recent years.

The Plan outlines an optimal service mix for mental health, alcohol and other drug services, providing a roadmap for investment to 2025. A key element of the plan is a rebalancing of the mental health service mix away from the current reliance on acute care settings towards greater investment in community support.

The Plan utilises a person-centred, whole-of-sector approach and evidence-based national modelling tools. The investment pathway is staged over ten years and key action areas are identified.

[Western Australian Strategic Plan for Safety and Quality in Health Care 2013–2017](#)

The *Western Australian Strategic Plan for Safety and Quality in Health Care 2013–2017* articulates the vision and system-wide priorities for safety and quality improvement in WA Health and provides a focus for detailed discussions, planning and action at all levels of the health system.

The strategic plan is based upon four principles, with a number of strategies identified in relation to each principle. The principles are focused on ensuring health care services delivered by the WA Health Service Providers are:

1. consumer and carer centred
2. driven by information
3. organised for safety
4. lead for high performance.

The strategic plan aligns with national and state safety and quality priorities and policies, and stresses the importance of WA health facilities and services meeting the ten National Safety and Quality Health Service Standards. Delivery of safe, quality health care is enabled through: a *Clinical Governance Framework*; an *Annual Performance Management Framework*; and *Activity Based Funding and Management*. The strategic plan also sets out key governance roles, responsibilities and accountabilities.



Click here for more information on the [Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025](#)



Did you know the Mental Health Commission's budget represents approximately 7% of the total WA Health Budget.



Click here for more information on the [WA Strategic Plan for Safety and Quality](#)



Click here to find out more information on the [Clinical Governance Framework](#)



Click here for more information on the [Annual Performance Management Framework](#)



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



For more information on the **NAARP** click here [Non-Admitted Activity Recording and Reporting Policy](#)



Click here for more information on the **HPSF** [WA Health Promotion Strategic Framework 2012-2016](#)

WA Health Admission, Readmission, Discharge and Transfer (ARDT) Policy for WA Health Services

The *ARDT Policy for WA Health Services* provides a framework, detailed rules and criteria to enable admitted activity to be recorded and reported correctly. As such, it seeks to ensure that high-quality, robust data is available to support ABF/M of health services. The ARDT Policy applies to the counting, classification, recording and reporting of admitted care activity at all hospitals and health care facilities where publicly funded care is delivered.

WA Health Non-Admitted Activity Recording and Reporting Policy (NAARRP)

WA Health has an obligation to record and report non-admitted activity in a meaningful and consistent way. The NAARRP provides a framework as well as a set of rules and criteria to assist in achieving this outcome.

The NAARRP aims to:

- enable effective and efficient activity recording practices
- improve the consistency and completeness of activity recording and reporting
- improve the understanding and adoption of consistent business practices for non-admitted outpatient services
- align State practice with national requirements.

The NAARRP applies to all hospitals and health care providers that deliver publicly funded non-admitted outpatient care. Hospitals are responsible for ensuring that appropriate procedures and records are maintained to facilitate accurate recording of non-admitted outpatient activity and to enable justification of the recorded activity.

WA Health Promotion Strategic Framework (HPSF) 2012-2016

The *HPSF 2012–2016* sets out WA Health’s strategic directions and priorities for the prevention of avoidable chronic disease and injury. The goal of the HPSF is to lower the incidence of avoidable chronic disease and injury in WA by facilitating improvements in health behaviours and environments. The main target populations for the HPSF are people who are currently well, and those who may be at risk of developing disease or experiencing injury.

These groups are reached by adopting a whole of population approach. The HPSF sets broad strategic priorities to achieve the greatest health gain for the WA community, but decisions regarding appropriate interventions will differ between organisations and settings, depending on their responsibilities and priorities.

WA Aboriginal Health and Wellbeing Framework 2015-2030

The *WA Aboriginal Health and Wellbeing Framework* (The Framework) is a high-level policy document outlining a set of strategic directions to improve the health and wellbeing of Aboriginal people in WA in the next 15 years.

The Framework has been developed for Aboriginal people by Aboriginal people and was informed by an extensive state-wide consultation program.

The Framework's purpose is to embed a long term strategic outlook, and identify the guiding principles and priority areas that will guide and inform the way forward for Aboriginal health in WA. It has a strong focus on prevention and acknowledges culture as a key determinant of health. Health Service Providers will seek to improve outcomes in Aboriginal health by aligning their activity with the directions of the Framework.

WA Health Procurement Reform

WA Health Procurement Reform aims to deliver structural, policy, process and procedural improvements to ensure WA Health undertakes procurement activity in a manner that complies with legislation, achieves value for money and ensures the principles of transparency and fair process are upheld. The Office of the Chief Procurement Officer (OCPO) was established in February 2014 to develop and oversee a sustainable and effective procurement function across the state-wide WA Health portfolio and is driving WA Health Procurement Reform in partnership with key stakeholders across the system.

The OCPO intranet page provides a range of tools to improve understanding of procurement policy and process requirements (including templates, guidelines and training).

WA Health Networks Models of Care

Health Networks are a collaborative mechanism to engage clinicians, consumers and carers, policy makers, planners and researchers across public and private domains of health. With over 4,000 members across 16 Networks, they enable the sharing of expertise and experience to identify a common vision for health reform and to improve service quality and care.

Health Networks have developed 58 Models of Care, which together with the *WA Health Clinical Services Framework 2014-2024*, provide the foundation for service and facility planning for specific care processes across the continuum of care. They also inform the prioritisation of funding allocations and purchasing intentions. Additionally, Health Networks Directorate manages the Better Health Improvement Program which provides \$4.6m per annum to improve services for people with chronic conditions and \$2.0m per annum for the Perth mobile GP service and associated projects.



More information on the new framework is available here
[WA Aboriginal Health and Wellbeing Framework 2015-2030](#)



Click here to improve your understanding of WA Health
[Procurement policy & process requirements](#)



Click here for more information on
[WA Health Networks](#)



Further information is available here on the [Western Australian Patient Transport Strategy 2015-2018](#)



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

Over the next five years, Health Networks key areas of action include:

- strengthening care in community
- clinical pathways to improve the patient journey
- collaboration to influence system change.

WA Patient Transport Strategy 2015-2018

Patient transport services in WA include: emergency, non-emergency, and non-acute patient transport provided via road and air; and travel subsidies provided through the Patient Assisted Travel Scheme. These services are critical to WA's health system and delivered through a variety of arrangements, from contracted state-wide service providers to hospital-based volunteers. In 2013-14 WA Health spent nearly \$200 million on patient transport services to ensure that the WA community had access to the right mode of patient transport at the right place and in the right timeframe.

The *Western Australian Patient Transport Strategy* outlines how patient transport services will be sourced over the short term, from 1 July 2015, and identifies a three year action plan to enhance WA Health's procurement and provision of patient transport services.

WA Health Strategic Workforce Plan

The development of the Health Workforce Framework, which includes a 10-year strategic workforce plan that is linked to the CSF 2014 and integrated with activity, financial and infrastructure planning, will provide a focus on the need to monitor, identify and risk-manage workforce issues that may impact service delivery.

WA Health Activity Based Management Strategy

The implementation of ABM across WA Health is part of a wide ranging Health Reform Program that will enable the delivery of better health services and care for the WA community. ABM is an approach to management that enables clinicians and other managers to use accurate and timely information about the cost and quality of health services to continuously improve those services. In other words, ABM is an enabler of continuous improvement.

Since 2010, WA Health has invested in a program of work to build the foundations for ABF and ABM. During this period, the proportion of WA public hospital services purchased using the ABF methodology reflects 85 per cent of Health Service Provider budgets. In 2015-16 this proportion is expected to increase to approximately 87 per cent. Areas for continued improvement include coding and classification, costing, business intelligence, and training and education.

3.3 Provider Strategy

Each Health Service Provider and Support Services seeks to provide and fund health services on a basis that is equitable, accessible, integrated and sustainable for the population in their catchment area.

The purchasing priorities are:

- to provide safe and quality care
- to put the patient first and provide appropriate care closer to where people live
- to increase the emphasis on more cost-effective primary and community care to reduce the demand for hospital services to deliver quality and accessible services within available resources
- to achieve performance targets for emergency, inpatient, outpatient, ambulatory and elective surgery
- for Health Service Providers to sustainably deliver clinical quality and financial performance.

Child and Adolescent Health Service (CAHS) Clinical Service Plan (2009–2018) and Strategic Plan 2013-2016

The CAHS Clinical Services Plan outlines how CAHS currently delivers, and plans to deliver services to the children and adolescents of WA until 2018. The plan builds upon the health reform agenda outlined in the 2004 report of the Health Reform Committee, *A Healthy Future for Western Australians*, as well as the subsequent work of the Health Reform Implementation Taskforce and the Department.

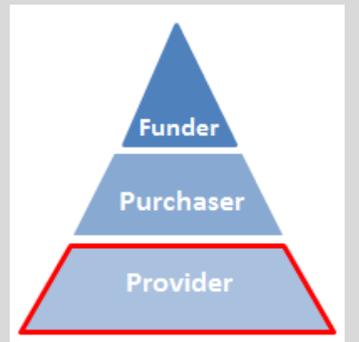
The Plan aims to analyse the scope and range of current child and adolescent health services and develop a strategic blueprint for meeting current and future health service needs. The Clinical Services Plan complements the *CAHS Strategic Plan 2013-2016*, and focuses on achieving six key outcomes:

- service improvement for child and family centred care
- leading best practice care, patient safety and quality systems
- maximising research opportunity
- build partnerships to advocate for and deliver care for those who need it most
- support and strengthen an engaged workforce
- focus on fiscal sustainability and drive revenue generation.

Paediatric Reconfiguration - Paediatric Implementation Plan (PIP)

Paediatric reconfiguration refers to the safe transition of secondary paediatric activity and services from the State's tertiary paediatric hospital, PMH, to the appropriate metropolitan hospital with a paediatric role designated and corresponding infrastructure.

The aim of reconfiguration is to develop sustainable paediatric service units at all hospital sites where paediatric activity is specified in the CSF, addressing two key reform principles: care closer to home and economic service efficiency. Paediatric reconfiguration will ensure the future activity for PCH will be tertiary and quaternary care and only local catchment secondary care.



Click here to find more information on the [CAHS Vision, Mission & Values](#)



For more information on **Paediatric Reconfiguration** go to page 57



Find more Paediatric info click here [Child and Adolescent Health Service \(CAHS\)](#)



Click here for more information on the [North Metropolitan Health Service Strategic Plan](#)

North Metropolitan Health Service (NMHS) Strategic Plan

The 2012-2015 NMHS Strategic Priorities and Goals are based on WA Health's four Strategic Intent Pillars and the NMHS Mission, and include:

- clinical reform and reconfiguration
- quality and safety
- community and partnerships
- people and workplace culture
- resourcing for sustainability.



Click here for more information on the [South Metropolitan Health Service Clinical Service Plan](#)

South Metropolitan Health Service (SMHS) Clinical Service Plan

SMHS is committed to providing seamless access to innovative, safe, high-quality health care through its vision of:

- *One Focus* – patient and community-focused care in the right place at the right time; minimising the patient journey; ensuring a positive patient experience; seamless access via coordinated pathways; and safe-quality outcomes
- *One Team* – working collaboratively and developing partnerships; building skills and expertise; encouraging innovation and excellence in education; training and research; using resources efficiently; minimising duplication and waste; and striving for performance and improvement
- *One Service* – hospitals and health services without walls; comprehensive care via integrated services; area-wide approach to service planning and development; integration within SMHS and across metropolitan Perth and country WA; and sustainable services within an activity based funding framework.



Click here for more information on [WA Country Health Service \(WACHS\)](#)

WA Country Health Service (WACHS) Strategic Plan

WACHS want every client to experience high quality, kind, compassionate and safe care that meets their individual needs every time they use country health services.

Strategic Priorities for 2013-2015 are focused on:

- quality health services for all
- improving the health of Aboriginal people and those most in need
- a fair share for country health
- supporting our team – workforce excellence and stability.



Click here for more information on [PathWest's Mission & Vision](#)

PathWest Strategic Plan

The PathWest strategic plan aims to guide the development of diagnostic pathology services to support the future clinical service needs of all West Australians, as well as enhance activities in translational research and teaching to ensure PathWest stays at the forefront of all facets of diagnostic pathology.

Service provision aims to be efficient, effective and sustainable and delivered in a patient centric fashion via the three PathWest networks that support the Clinical Services Framework. Efficiency is achieved through standardisation, consolidation and technology. Effectiveness is supported by our continued quality accreditation and clinical engagement. Commissioning new Information Technology Systems, including a new Laboratory Information System, is seen as essential to sustainability and providing the service capability required to meet the pathology service demands of the future.

Health Corporate Network Provider Strategy

HCN's strategies to improve customer services and client interaction include:

- engaging clients in strategic forums
- improving responsiveness to clients' needs
- refining HCN performance measures
- identifying opportunities for engagement on major health reforms
- benchmarking HCN activity with other shared service centres to facilitate continuous improvement in processes.

HCN will develop staff capabilities by:

- expanding the understanding and application of business improvement techniques across HCN
- fostering and developing leadership capability throughout HCN and encouragement of future leaders
- strengthening the management capability of middle managers through formal and informal training and development
- establishing and applying core competencies in the selection, performance management and development of team leaders and coordinators.

HCN aims to optimise the use of technology by:

- finalising the introduction of an internet based forms solution
- ensuring HCN's view of requirements and input are considered in the purchase and design of new clinical and corporate systems
- optimising the use of an electronic document record management system for all corporate records and transactions
- ensuring technologies are smoothly integrated.

In addition, HCN will seek to influence WA Health's revenue reform program by maximising the benefits of the billing system through effective partnering with stakeholders.

Health Supply Network Strategy

The aim of HSN is to drive better value and sound decision through improved procurement and contract management for WA Health.

In 2015-16 this newly established organisation will prioritise:

- the successful implementation of a single HSN that supports the operations of the new Support Services
- the identification of efficiencies through improved contract management and a realigned organisation
- an accepted and tested whole of health contract management service to support better care and deliver better value for money for WA Health.

Health Information Network Strategy

The aim of HIN is to deliver and support ICT systems that assist WA Health to achieve safe and high quality patient care and more efficient business operations.

In 2015-16, HIN's strategies and priorities include:

- reshaping the organisation as a customer focussed service provider delivering high quality, cost-effective services to WA Health
- continuing to support the delivery of ICT to newly commissioned health facilities
- stabilising network/data centre infrastructure and fully implementing the Technology Refresh Program
- implementing improved project management to ensure ICT projects are delivered on time and on budget
- increasing the capability and capacity of staff to provide ongoing support to WA Health's ICT systems.

Dental Health Service Strategic Plan

Oral health plays an important role in a person's overall well-being. The Department and the State Government recognise not only the benefits oral health delivers to the individual but also the benefits a strong focus on oral health offers to the wider health system. The vision statement in the strategic plan iterates the importance of oral health to overall health.

In WA, people with lower socio-economic backgrounds, experience significant challenges in their ability to access timely oral health care. The impacts on the individual and flow on effect on the broader health system are significant. An important part of delivering an effective health care system includes a Dental Health Service that can work with young people to develop strong oral health habits and assist adults that struggle to access affordable oral health care.

Accountability, efficiency, effectiveness and professionalism are the cornerstones of this plan. The plan identifies the need to look to different forms of service delivery to ensure the service is delivering the best possible outcome for the client in the most efficient and effective manner. For more information refer to the *Dental Health Services Information Statement*.



Click here for more information on the [Dental Health Services Information Statement](#)

4.0 Budget Policy Setting

4.1 Overview

The WA public health system has a proven record of delivering quality health care services held against national and international benchmarks. This has been achieved by significant investments to improve WA's health outcomes over the last decade, reflected by:

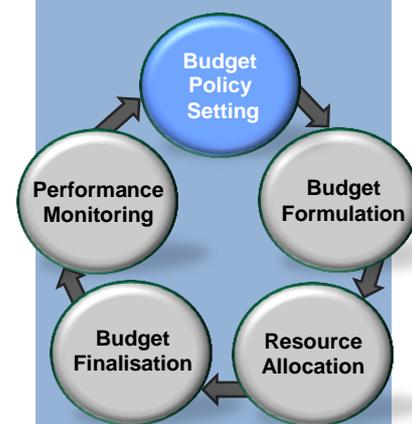
- WA's infant mortality rate³ decreasing from 4.1 per 1,000 live births in 2003 to 2.4 per 1,000 live births in 2013, the lowest rate amongst all jurisdictions
- WA's median life expectancy⁴ for both males and females increased 1.7 years over the past decade between 2003 and 2013.
- following intensive efforts immunisation rates against vaccine-preventable diseases for WA children at one, two and five years of age have risen to greater than 90 per cent, for the first time as at 31 March 2014
- in 2013-14, WA ranked first above all States and Territories with the highest proportion (79.5 per cent) of presentations to emergency departments completed in four hours or less⁵ compared to the national average (72.7 per cent). WA's performance is a direct result of more than five years of sustained effort in ensuring patients are seen and admitted, transferred or discharged in a timely manner.

Maintaining this performance into the future will be challenging in the face of a growing and an ageing population, the growing burden of chronic diseases and increasing financial constraints.

4.2 Challenges Influencing Budget Policy

4.2.1 A Growing and Ageing Population and the Increasing Burden of Chronic Illness

Population growth rates in WA have continued to be consistently above the national average between 2009-10 and 2013-14. This increase in population is further challenged by an ageing population factor. Over the last decade from 2004 to 2014, the percentage of population aged 65 years and above has increased in WA from 11.6 per cent to 12.9 per cent⁶.



³ Infant deaths per 1,000 live births. Australia Bureau of Statistics, *Infant deaths and infant mortality rates, Age at death – 2003 to 2013* (cat. no. 3302.0).

⁴ Australia Bureau of Statistics, *Median age of death, Year of occurrence, State and territories – 2003 to 2013* (cat. no. 3302.0).

⁵ Australian Institute of Health and Welfare, *Australian hospital statistics 2013-14 Emergency department care*, Australian Government.

⁶ Australian Bureau of Statistics Report, *Australian Demographic Statistics*, June 2014 and June 2010 (cat. no. 3101.0).



The **DALY** is defined as the key amount used to measure the total burden of disease and injury and it describes the amount of time lost due to both fatal and non-fatal events, that is, years of life lost due to premature death coupled with years of 'healthy' life lost due to disability.

Compounding the challenges of an ageing population is the increase in the burden of disease and injury measured using the 'disability-adjusted life year' (**DALY**) for adults aged over 65 years, where the DALY is the highest (38.9 per cent) compared to all other age groups. The total number of DALY's in WA is projected to increase 14 per cent from 249,000 in 2006 to 284,151 in 2016, across all age groups⁷.

The high overall burden of disease for elderly people coupled with inadequate access to primary health care, places additional pressure on the WA public hospital system. WA's total Medicare services per capita is the lowest compared to other jurisdictions over the last five years. Other jurisdictions have significantly increased the number of total Medicare services per capita while WA's number of services has remained stable between 11.5 per cent in 2009-10 and 11.9 per cent in 2013-14⁸.

4.2.2 A Challenging Fiscal Environment

General Government Revenue - The WA 2015-16 Budget notes that the State is experiencing the most challenging economic and fiscal environment of the last two to three decades. General government revenue is forecast to decrease by 2.7 per cent in 2015-16 to \$26.3 billion after an estimated reduction of 3.3 per cent in 2014-15, representing a decrease in revenue of \$1.6 billion relative to the actual level of revenue in 2013-14. This is the first time the State has faced declining revenue since 1996-97. The revenue growth beyond 2015-16 is projected to recover to an average of 8.4 per cent per annum over the period 2016-17 to 2018-19, underpinned by a forecast increase in GST revenue.

FIGURE 5: General Government Revenue

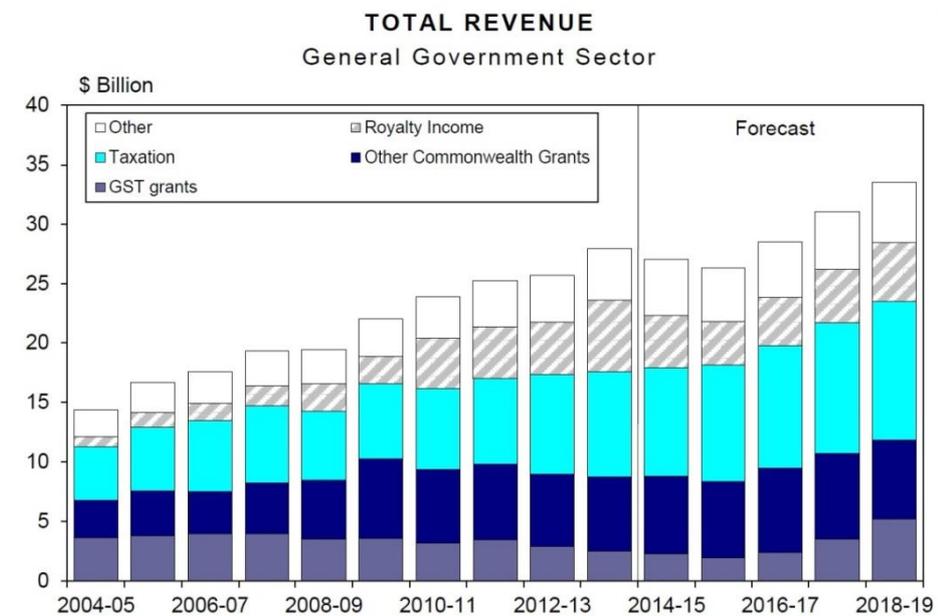


Figure 5 Source: 2015-16 State Budget Papers (Budget Paper No. 3)

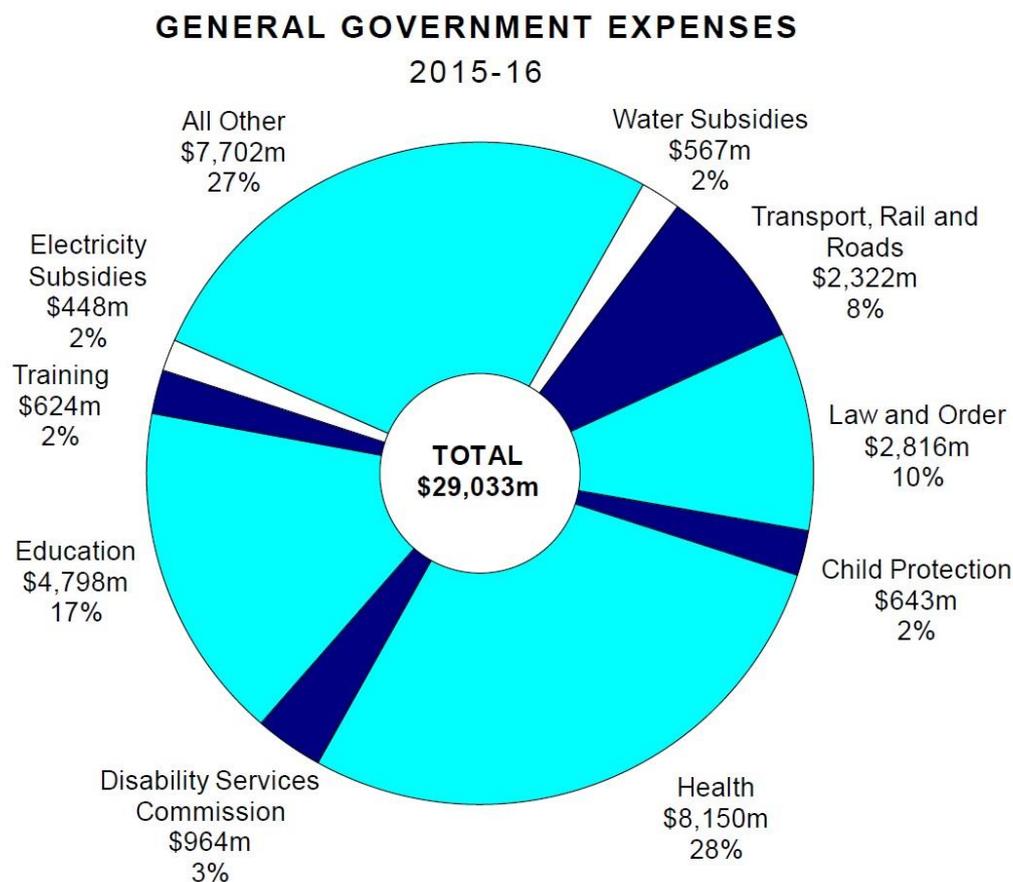
⁷ Hoad V, Somerford P and Katzenellenbogen J, 2010. The burden of disease and injury attributed to preventable risks to health in Western Australia, 2006. Department of Health, Western Australia.

⁸ Department of Health, *Annual Medicare Statistics, Financial Year 2007-08 to 2013-14*, Australian Government. Excludes data for 'Dental Benefits Schedule (Teen Dental)' and 'Child Dental Benefits Schedule'.

General Government Expenditure - General government expenses are budgeted to increase by 2.5 per cent in 2015-16. Expenditure growth is projected to average less than 3.0 per cent per annum over the forward estimates period– well below the average growth of 7.9 per cent over the previous decade.

This low expense growth is largely due to the Government restraining growth in salaries expenditure. In 2013-14, the general government salaries grew by 5.2 per cent, the lowest rate in 13 years. In 2015-16, the salary expense growth rate, for whole of government, is expected to reduce to 1.8 per cent and to an average of 2.4 per cent over the forward estimates.

FIGURE 6: General Government Expenses

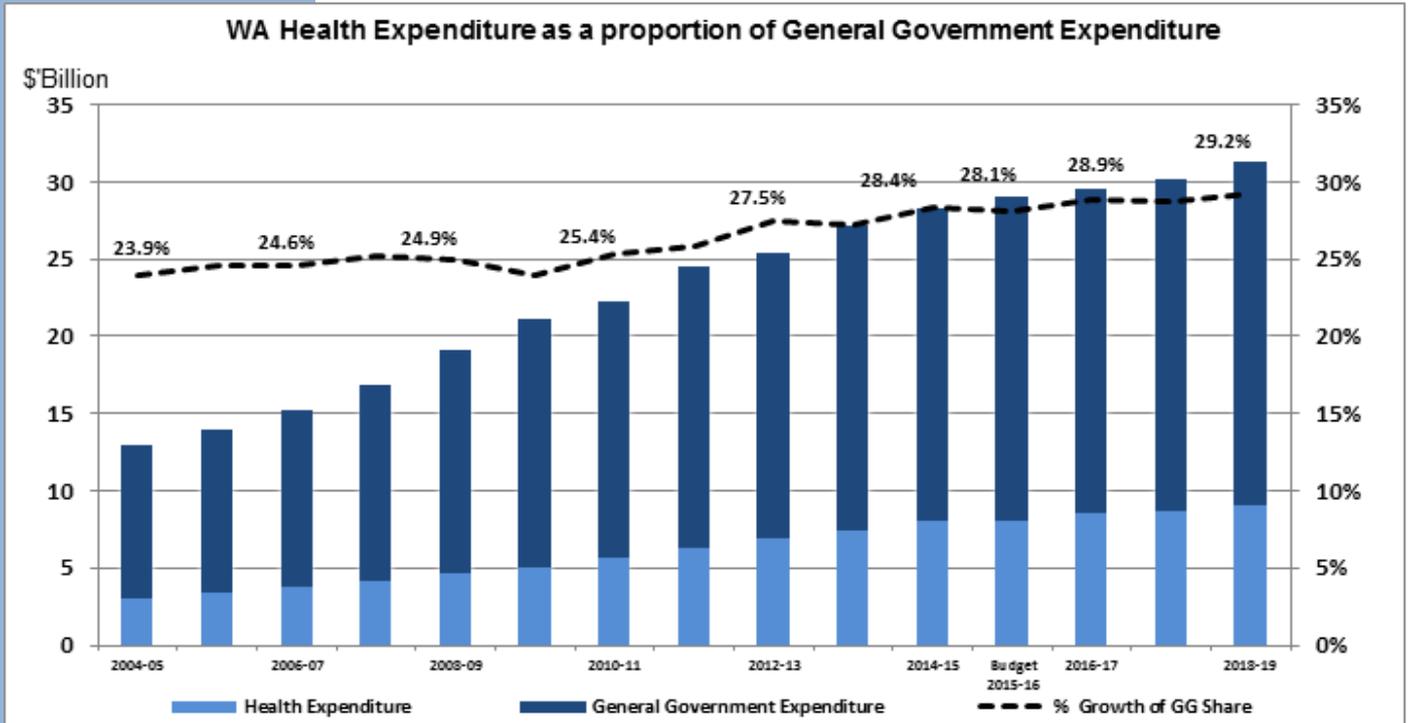



[Click here for further information on the State Budget Papers](#)

Figure 6 Source:
2015-16 State Budget Papers (Budget Paper No. 3)

In 2015-16, health funding constitutes 28 per cent of total government expenses, compared to 17 per cent for education and 10 per cent for law and order, the next two largest shares of general government expenditure.

FIGURE 7: WA Health's proportion of General Government Expenditure



Impact of the Challenging State's Fiscal Policy on WA Health –

Health spending in WA has grown faster than inflation and the economy as a whole for many years. Over the past decade the WA Health's budget has grown by an average of ten per cent per annum (see Figure 8), with WA Health as the largest single expenditure in the WA State Budget.

FIGURE 8: WA Health Expenditure

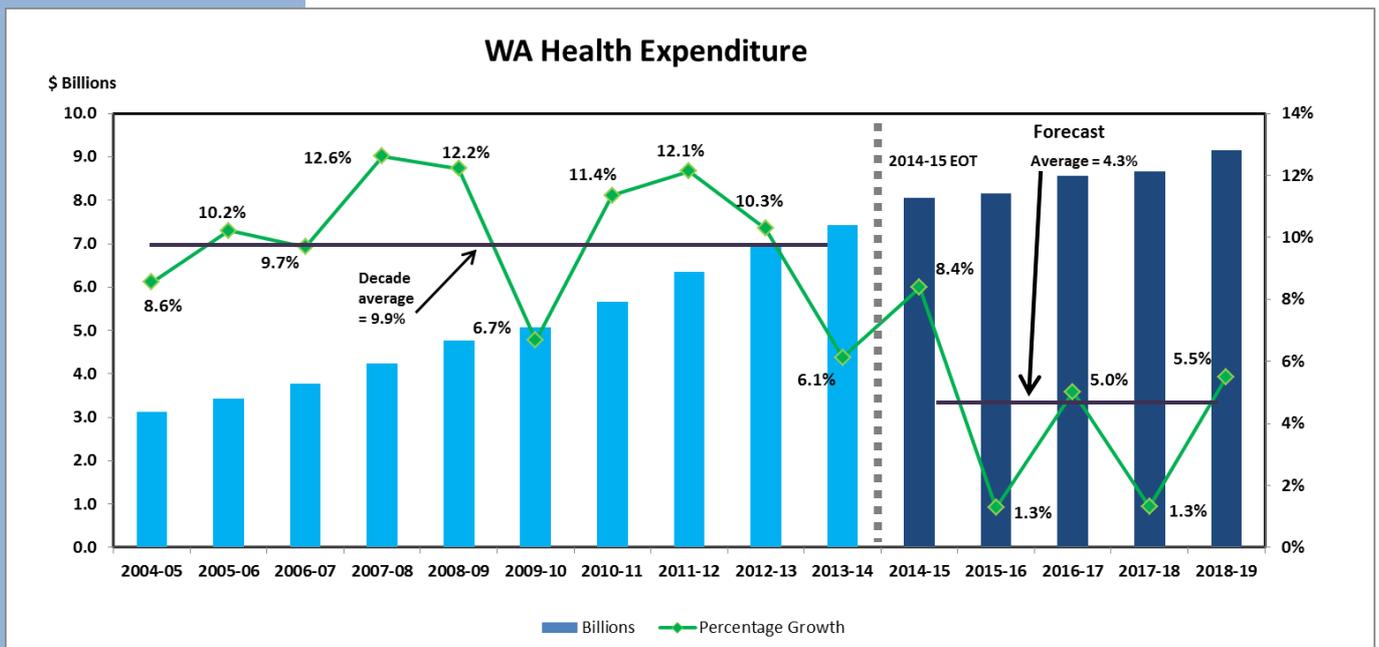


Figure 8 Notes: These figures represent WA Health's Actual Expenditure recast to remove the impact of the MHC and the Drug and Alcohol Office (DAO) on total Health expenditure. The MHC was established as its own entity in March 2010, and the DAO in January 2012, prior to which they existed as divisions of WA Health.

Growth in WA Health’s budget is more subdued than has been the case in recent years. The Health system cannot rely on continued strong increases in funding from year to year. As the State enters a more challenging fiscal environment, it is essential that WA Health increases the efficiency of resource management, and health service delivery to meet rising health care demand while maintaining and improving quality of care.

4.2.3 Transitioning the Health System to National Pricing Benchmarks

Recognising the need to position the WA Health system to meet the ongoing financial sustainability challenges, the public hospital system budget settings are set on a transition path to converge the cost of providing public hospital services in WA to the PAC in 2020-21. Under this convergence policy the health system must reduce the cost growth in hospital services from 2.1 per cent in 2014-15 to 1.2 per cent by 2018-19.

TABLE 3: State Price Growth

2014-15	2015-16	2016-17	2017-18	2018-19
2.1%	1.8%	1.6%	1.4%	1.2%

The difference between the cost of providing public hospital services in WA and the national average is recognised by the State Government through the provision of a Community Service Subsidy (CSS), however this price convergence strategy is reliant on WA Health successfully identifying and implementing significant efficiencies and cost growth reductions over the forward estimates.

This challenge is further compounded by declining trends in the PAC, a reflection of other States reducing their unit costs at a rate faster than WA.

4.2.4 Changes to the Commonwealth’s Financing Arrangements

The WA public health system budget policy is also influenced by the Commonwealth’s decision to withdraw from major commitments under the NHRA, including guarantees for public hospital funding and the continuation of ABF from 2017-18 onwards.

Since the Commonwealth’s withdrawal announcement in the 2014-15 Federal Budget, the funding estimates published under the NHRA have been declining. The State Government has since substituted the funding shortfall resulting from these changes to the Commonwealth’s financing arrangements. This has been critical to ensuring quality health service continuity and to maintain the integrity of the ABF framework underpinning WA Health’s budget settings.

The Commonwealth's ongoing development of two Reform White Papers could have major implications on health funding for the State and WA Health. A White Paper on the Reform of the Federation (Federation White Paper) will seek to clarify roles and responsibilities of different levels of government, and will be accompanied by a White Paper on the Reform of Australia's Tax System (Taxation White Paper). Within the Federation White Paper process, several Issues Papers (including a Health Issues Paper) are being developed for consultation.

4.2.5 Managing System Transition

During 2015-16 and 2016-17, WA Health will be required to achieve significant reductions in unit cost growth while managing a major reconfiguration of the health system resulting from the commissioning of new hospital developments. Key elements of this reconfiguration include:

- embedding the reconfiguration of SMHS, including the first full year of operations of FHS in 2015-16 resulting in the bed capacity downsizing and change in role delineation at Fremantle Hospital and Royal Perth Hospital, as well as other metropolitan hospitals
- the opening of Midland Public Hospital in late 2015 and associated reconfiguration within the NMHS, including the closure of Swan District Hospital
- the opening of PCH, scheduled for 2016, transitioning from the closure/decommissioning of PMH.
- a major increase in bed capacity at Joondalup Health Campus through redevelopment largely completed in 2014.

Whilst the investment in new infrastructure will support improved service delivery through contemporary, fit-for-purpose facilities; and strengthen WA Health's capacity to respond to increases in demand for hospital services, considerable work will be required in 2015-16 and beyond to mitigate and manage financial risk associated with system reconfiguration and to harness greater efficiencies in service delivery enabled through the newer, more efficient infrastructure.

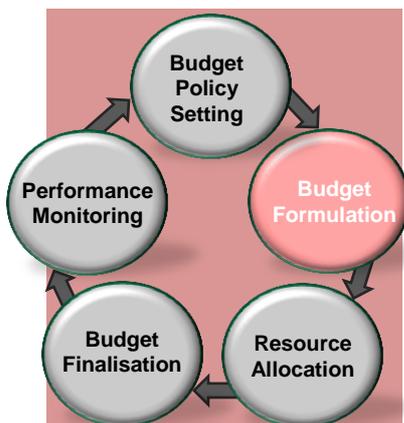
4.3 Budget Reform Impacts

As previously mentioned, WA has a good public health care system by national and international standards. WA Health has invested over \$7 billion in new hospitals, new technology, and new Medical Research Centres. WA's performance in elective surgery compares well with other States, and as a system WA Health have lead the nation in implementing reforms to ED care through the Four Hour Rule program. An integrated reform program will ensure we make the most of these investments.

Each issue outlined in [Section 4.2 Challenges Influencing Budget Policy](#) represents a considerable challenge to WA's public health system. The fact that they all must be addressed in tandem presents an overwhelming case for reform to achieve greater efficiency in the delivery of services and management of health resources. This requirement strengthens the case for reform, as discussed in [Section 1.1 The Case of Reform](#).



Section 1 Introduction	Section 2 Roles & Responsibilities	Section 3 Key Policy Settings	Section 4 Budget Policy Setting	Section 5 Budget Formulation	Section 6 Resource Allocation	Section 7 Performance Monitoring
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5.0 Budget Formulation

For more information on the budget formulation and approval processes refer to [Appendix A – State and WA Health Budget Framework](#).

5.1 Budget Highlights

State Government spending on health care, as outlined in the 2015-16 Budget, is directed at ensuring that the people of WA continue to receive sustainable and ongoing health services. This will be achieved through the provision of state-of-the-art infrastructure facilities, skilled and efficient workforce, strong financial management and the boosting of key system enablers.

To ensure that Western Australians have access to safe and quality health care, delivered in world class health facilities, approximately \$7 billion has been committed for over 100 asset investment projects. This includes the upgrade and redevelopment of WA hospitals and health related facilities.

To ensure the community has continued access to safe, quality and cost effective health and hospital services, WA Health’s total approved expense limit⁹ for the WA public health system in 2015-16 is \$8.15 billion. This accounts for 28.0 per cent of the State’s total expenditure for general government services and represents a 1.3 per cent increase over the estimated out-turn for 2014-15.

5.1.1 Expense Limit Settings

WA Health’s approved expense limit and expense growth parameters for 2015-16 and the forward estimates are shown in *Table 4* below.

TABLE 4: Approved Expense Limit

	2015-16 \$'000	2016-17 \$'000	2017-18 \$'000	2018-19 \$'000
Approved Expense Limit	8,149,524	8,558,132	8,669,907	9,147,411
<i>Growth</i>	1.3%	5.0%	1.3%	5.5%

The expenditure limit tabled above has been impacted by the corrective measures announced by the State Government in 2014-15, including the 1.0 per cent efficiency dividend savings, the 15 per cent reduction on all non-essential procurement and the Workforce Renewal Policy. These savings measures are discussed further under [Section 5.1.2 Corrective Measures](#).

⁹ The total approved expense limit was approved in the 2015-16 State Budget. The 2015-16 approved expense limit is a point in time estimate, and is subject to ongoing State Government decisions during 2015-16, in particular those which may be made during the 2015-16 MYR and 2016-17 Budget processes.


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


For more information on **Workforce Renewal Policy** go to page 55

In addition to the savings measures noted above, the State Government has provided a Targeted Voluntary Redundancy Program in 2014-15.

Underlying Expenditure Growth - 'Headline' expenditure masks the impact of material one-off expenditures WA Health has received in the past, and over the forward estimates, which has the effect of depressing and fluctuating the year-on-year growth.

Table 5 below outlines WA Health's underlying expenditure growth after removing material one-off adjustments, and these include in 2014-15:

- FSH Final Deed of Agreement to Facilities Management Contract with Serco
- Renegotiation of FSH Facilities Management Serco Contract
- SMHS Reconfiguration
- Sale of Kaleeya Hospital
- a Pre-RiskCover Insurance claim
- Separation payment under the Targeted Separation Scheme (TSS)

Abstracting from these above one-off items the 'underlying' growth in expenditure for WA Health in the 2015-16 Budget is around 3.8% as shown in Table 5.

TABLE 5: WA Health – 2015-16 Budget Underlying Expenditure Growth*

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Growth %	7.5%	7.5%	5.7%	3.8%	5.2%	1.4%	5.5%

*One-off items have been removed from the headline expenditure growth from 2012-13 through to 2018-19 to ensure comparability

This underlying growth rate compares favourably with expenditure growth in other WA general government agencies including, the Department of Education, WA Police, and the Department of Child Protection and Family Support.

The declining trend in the underlying growth in expenditure over the forward estimates since 2013-14 is consistent with the price convergence strategy underpinning WA Health's budget settings, but is also reflective of the financial constraints that are in effect across Western Australia's General Government sector for the most part in 2015-16.

The declining growth in 2017-18 is impacted by:

- Cessation of election commitments funding (approximately \$30 million)
- An expectation that leave liability expenditure will plateau in 2017-18 with 0% growth compared to a growth of 9% in 2016-17 resulting a reduction in expenditure in the region of \$46.5 million compared to 2016-17
- Timing issues related to recurrent National Partnership Agreements funding/expenditure with a decrease of 1% 2017-18,



For more information on the **RiskCover Premium** go to page 54

and compared with a growth of 6% in 2016-17, as a result of the general policy of only including signed agreements in the forward estimates

- Royalties for Regions (RfR) funding/expenditure not being as substantial in 2017-18, including the South Inland Health Initiative funding which will drop by approximately \$36 million in 2017-18.

The 5.5% growth rate in 2018-19 is attributable to population of the new forward estimates year, which is subject to refinement and changes in subsequent budget processes.

5.1.2 Corrective Measures

In response to the declining fiscal outlook over the forward estimates and efforts to achieve fiscal targets, the State Government announced new savings measures in the 2014-15 Mid-Year Review (MYR), as well as the 2015-16 Budget Process.

Corrective measures that have been applied to WA Health's current budget settings are summarised in *Table 6*:

TABLE 6: Impacts of Corrective Measures on Budget setting for Health

	2014-15 \$'000	2015-16 \$'000	2016-17 \$'000	2017-18 \$'000	2018-19 \$'000	TOTAL \$'000
Efficiency Dividend	-34,817	-47,405	-48,208	-48,627	-47,661	-226,718
Procurement Savings	NA	-39,193	-37,883	-39,142	-40,120	-156,338
Asset Investment Program Savings	-13,503	-21,446	-15,581	-11,685	NA	-62,215
Public Sector Workforce Renewal	-5,272	-43,448	-89,257	-137,677	-154,558	-430,212

The nature of the savings measures is discussed briefly below and further information on these initiatives can also be found in the State Budget Papers:

- Efficiency Dividend - This saving measure provides for a one per cent efficiency dividend from 1 October 2014 based on the cash service appropriation provided to WA Health in 2014-15
- Procurement Savings - This savings measure provides for a 15 per cent reduction in non-essential procurement, targeting expenditure on administration, communication, consultants, consumables, equipment repair and maintenance, staff travel and 'other' expenses
- Asset Investment Program Savings - The Asset Investment Program (AIP) efficiency savings implemented in the 2014-15 Budget were extended by Government for a further five per cent in the 2015-16 Budget.



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

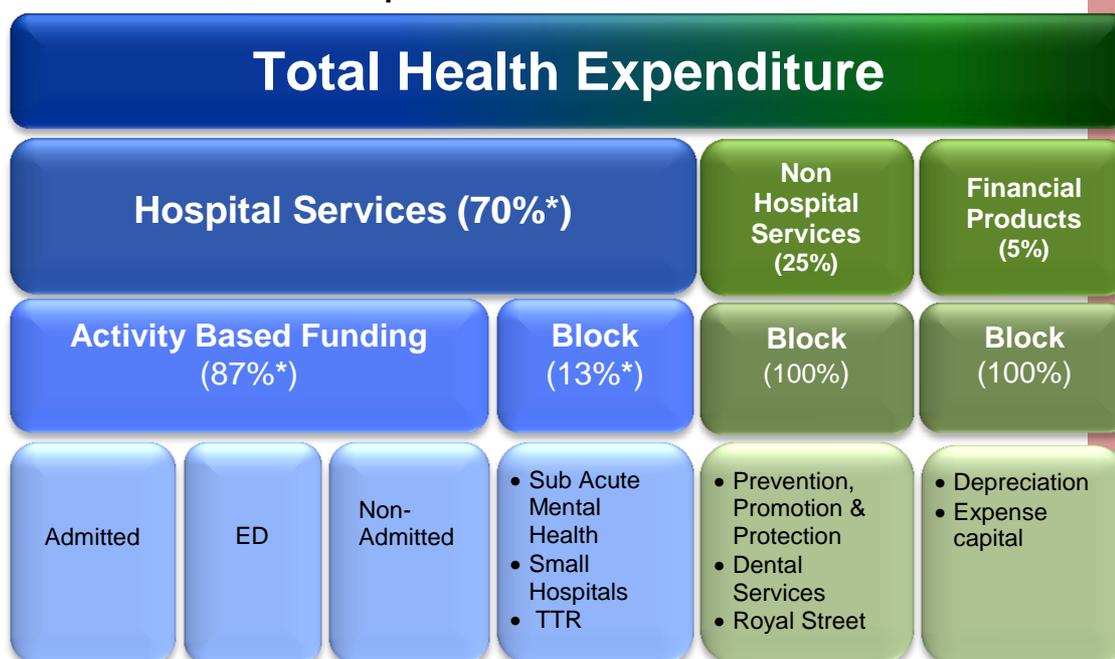
- Public Sector Workforce Renewal - Effective from 1 January 2015, this corrective measure aims to address the impact of 'classification creep' and generate significant salary related savings (\$1.27 billion across the State's public sector) over the forward estimates by returning to consolidate revenue a proportion of the salary (and on-costs) when an employee leaves through resignation or retirement.
- Targeted Separation Scheme - Cabinet approved a Targeted Separation Scheme for 1,500 public sector employees, of which 419 separations are expected to be found within WA Health. The outcome of this redundancy program is expected to be finalised by 30 June 2015, after which the savings across the forward estimates will be incorporated into individual agency budgets.


Click here to find out more information on the [Targeted Separation Scheme](#)

5.2 WA Health's Expenditure Budget Settings

WA Health's Budget Settings are framed using the categorisation shown in the *Figure 9*:

FIGURE 9: Total Health Expenditure



*Percentages are approximated

The classification of Hospital Services applied by WA Health is consistent with the National Pricing Framework for Public Hospitals issued by the IHPA and includes:

- all admitted programs, including Hospital in the Home programs
- all ED services
- non-admitted services that meet the criteria for inclusion on the General List.


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

Non-Hospital Services which comprise approximately 25 per cent of WA Health's total expenditure consist of:

- Community and Home Care Services
- Emergency Patient Transport and Rural Patient Travel Assistance Services
- Dental Services, Pathology and Diagnostic Services and External Services provided by Health Services
- Health Care Delivery Programs
- Preventative and Public Health
- Support Services (Department of Health, Health Corporate Network and Health Information Network).

Financial Products include:

- depreciation
- expensed capital
- borrowing costs
- resources received free of charge.

5.2.1 Hospital Services

Hospital Services include Activity Based Services and Block funded services discussed below.

5.2.1.1 Activity Based Services

Activity based services include inpatient, ED and non-admitted patient services:

- inpatient services comprise care services provided to admitted patients (acute and sub-acute) in public hospitals (including specialised mental health), and to public patients treated in private facilities under contract to WA Health
- ED services describe the treatment provided in metropolitan and major rural hospitals to those people with a sudden onset of illness or injury of such severity and urgency that they need immediate medical help which is either not available from their GP, or for which their GP has referred them for treatment
- non-admitted patient services include clinics for pre- and post-surgical care, allied health care and medical care.

Since 2013-14, the State Government's funding contribution to public hospitals has been determined on an activity basis, with the Government endorsing the purchase of Weighted Activity Units (WAU) at an agreed SP that converges to the PAC over a defined period of time. The difference between the PAC and the cost of delivering public hospital services in WA is funded by the State Government through a CSS.

Activity Settings - WA Health approved budget settings provide for the following volumes and growth in WAU encompassing public hospital inpatient, ED, and outpatient services.



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

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

The demand is forecast using the WA Treasury's age weighted population growth rates (AWPGR), and data on utilisation of hospitals services by separate age cohorts.

TABLE 7: Approved Activity Settings

	2014-15 WAU	2015-16 WAU	2016-17 WAU	2017-18 WAU	2018-19 WAU
Total WA Health Activity Volume	843,028	864,778	887,608	911,573	937,097
<i>2015-16 AWPGR</i>	-	2.58%	2.64%	2.70%	2.80%

Included in WA Health's activity settings in 2015-16 is the MHC activity for specialist mental health inpatient services. *Table 8* provides details of the budget settings for mental health activity.

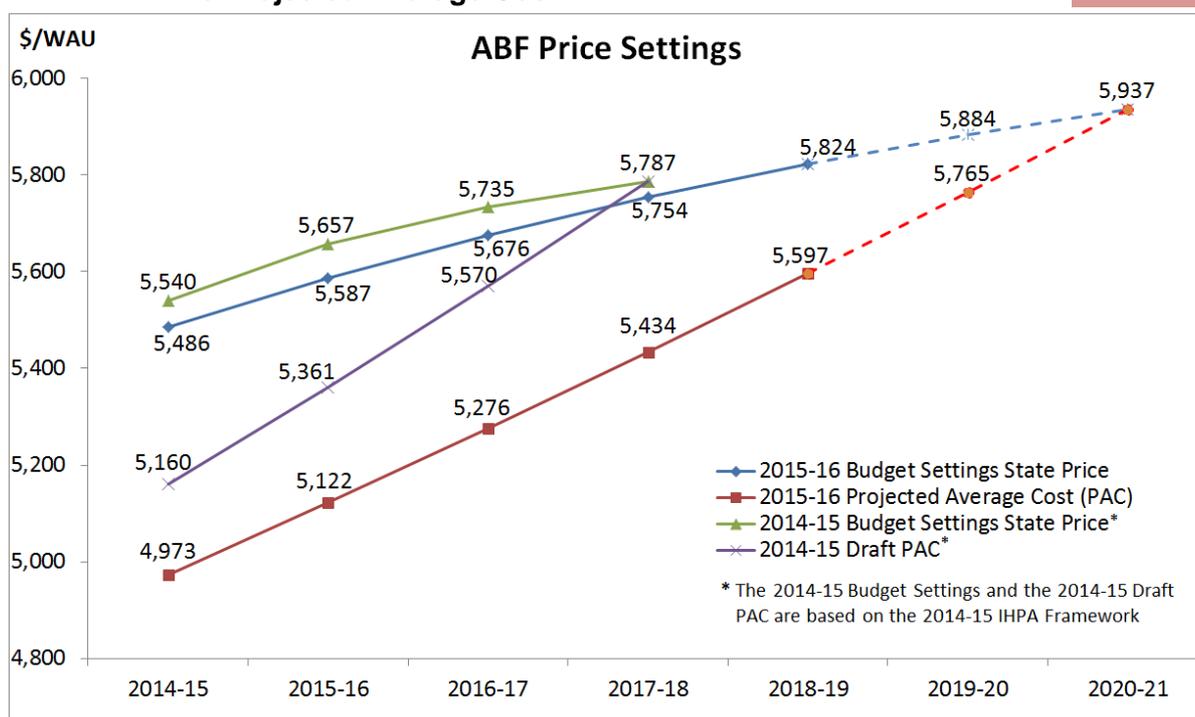
TABLE 8: Approved Mental Health Activity Settings

	2014-15 WAU	2015-16 WAU	2016-17 WAU	2017-18 WAU	2018-19 WAU
Total Mental Health Activity Volume	53,437	54,538	55,710	56,925	58,268
<i>2015-16 Mental Health AWPGR</i>		2.06%	2.15%	2.18%	2.36%

Price Settings - As noted earlier, the purchase of WAU by the State Government is determined using a SP that converges to the PAC over a defined period of time.

Figure 10 provides a comparison of the SP per WAU endorsed in the 2014-15 Budget to the SP endorsed through the 2015-16 Budget. A comparison of the two demonstrates that the variance is marginal, reflecting the overarching budget policy of maintaining budget stability for hospital services.

FIGURE 10: 2014-15 State Price compared to 2015-16 State Price and the Projected Average Cost



ABF: What is meant by 'activity'?

Activity means services provided to and for patients and their families. WA Health's definition includes services that are currently activity based funded and block-funded:

- Activity based funded services include acute admitted care, subacute and non-acute admitted care, mental health admitted care, emergency care and non-admitted care.
- Block-funded services include non-admitted mental health care, small rural hospitals and teaching training and research.



Community Service Subsidy (CSS)

is the difference between the PAC and the cost of delivering public hospital services in WA.

Table 9 highlights the current divergence between the approved SP and the PAC in 2015-16¹⁰.

TABLE 9: State Approved Price Settings

	2014-15 \$ per WAU	2015- 16 \$ per WAU
State Price (SP)	5,486	5,587
<i>Growth Rate</i>		1.8%
Projected Average Cost (PAC)	4,973	5,122
<i>Growth Rate</i>		3.0%
Community Service Subsidy (CSS)	513	465

Work is ongoing to further investigate and analyse the difference between the current approved SP and the PAC. It is noted that the national average cost may not be sufficiently reflective of significant cost disabilities or 'legitimate and unavoidable costs' which may be unique or specific to the delivery of health services in individual States. Some of the factors unique to WA are:

- high wages for health system workforce following the 'mining boom'
- aged care bed shortages
- significant Indigenous population
- growing population particularly in the regions
- extreme remoteness
- high socio-economic disadvantage particularly in the regions
- high reliance of EDs, due to shortfalls in primary care
- health workforce shortages
- lack of private sector alternatives.

An independent study¹¹ commissioned to understand the difference between the State's average cost of providing hospital services and the national average cost showed that salaries and wages accounted for approximately 38 per cent of the difference.

Further work and analysis done by WACHS also noted that the ABF model in its current form does not recognise the additional costs associated with delivering services in rural and remote locations. For example, additional location based costs associated with attracting and retaining a skilled workforce to deliver care closer to home.

In 2015-16, WA Health will continue to undertake further work to address the major components of the cost differences between the cost of delivering health services in WA compared to the national average cost.

¹⁰ Both the PAC and the approved SP are subject to annual change. The PAC is dependent on the annual pricing determination and framework released by the IHPA, while the approved price is subject to WA Government policy.

¹¹ Ernst and Young, July 2014 "State Price Analysis".

5.2.1.2 Block Funded Activity Based Services

Under the national ABF model, block funding is provided to support:

- non-admitted mental health services
- teaching, training and research
- health service activity in integrated and small rural hospitals.

Non-admitted mental health services include outpatient mental health services provided by medical officers, nurses and allied health staff (including clinical) for pre- and post- hospital based treatments.

The Teaching, Training, and Research (TTR) expenditure profiles are consistent with the national costing guidelines.

Small hospitals in rural areas often have fluctuating activity that would result in unpredictable revenue if funded on the basis of activity and hence the national model specifically provides for small rural hospitals to be block funded to ensure certainty of funding irrespective of activity. Integrated hospitals however, are funded through the ABF methodology under the WA Health model.

The State framework for block funded activities is constructed on the same principles with projections derived through the application of relevant demand and price escalators.

The cost and demand escalators underpinning WA Health budget settings for 2015-16 for Activity Based Block Funded Services are outlined in *Table 10*.

TABLE 10: Approved escalators underpinning Block Funded Hospital Services

Description		Escalator	Notes
Small Hospitals	Cost	4.90%	2015-16 IHPA National Efficient Cost Growth Rate
	Demand	2.58%	2015-16 Age Weighted Population Growth Rate
Teaching Training and Research	Cost	3.00%	2015-16 IHPA National Efficient Price Growth Rate
	Demand	2.06%	2015-16 Mental Health Activity AWPGR
Non-Admitted Mental Health	Cost	3.00%	2015-16 IHPA National Efficient Price



Further information on these initiatives can be found by clicking here:

[2015-16 IHPA National Efficient Cost \(NEC\)](#)

[2015-16 IHPA National Efficient Price \(NEP\)](#)

[Cost indexation as per the 2015-16 IHPA Price Determination](#)

5.2.2 Non Hospital Services

The cost and demand escalators underpinning the budget settings for non-hospital services are as per *Table 11* on the following page.

TABLE 11: Approved escalators underpinning Non Hospital Services

Description		Cost Escalator *	Notes
Non-Hospital Products	Demand	2.00%	Population growth rates from WA Treasury population projections
	Cost	3.10%	2015-16 Non-Government Human Services Sector Indexation Policy (NGHSS) comprised of 80% wage price index and 20% Consumer Price Index**
	Cost	2.25%	Consumer Price Index applied for 2015-16

* Cost escalators applied depend on the nature of service provided.

**The NGHSS is based on 2014-15 MYR aggregates, consistent with Treasury's Indexation policy, to update the rates during the Mid-year Review

5.3 Additional Service Delivery Initiatives

The State Government has committed an additional \$49.4 million over the next three years to continue programs funded under the 'Footprints to Better Health' initiative. Further funding has also been identified by WA Health to ensure the range of 'outstanding', 'very good' and 'good' Aboriginal health programs identified in the Holman Review¹² will continue. This will result in a total allocation of \$88.7 million over three years for these programs.

Further information on all service delivery initiatives can be found in the State Budget Papers.

5.4 Infrastructure Highlights

As noted under [Section 5.1 Budget Highlights](#), the successful delivery and commissioning of infrastructure projects is a key cornerstone of the 2015-16 WA Health Budget.

In October 2014, WA opened the 783-bed Fiona Stanley Hospital, including a 140-bed purpose built State rehabilitation facility. The \$2 billion facility opened across four distinct phases which commenced in October 2014 and concluded in February 2015.

In 2015-16, construction on two additional metropolitan hospitals, will be completed. The \$1.2 billion 298-bed PCH co-located on the Queen Elizabeth II Medical centre site is expected to be commissioned in the first half of 2016. The \$360.2 million Midland Public Hospital (jointly

¹² Holman Review - Emeritus Professor D'Arcy Holman, former Professor of Public Health at the University of Western Australia was commissioned in May 2014 to evaluate the effectiveness of all State-funded Aboriginal health programs, focusing on the measurement and achievement of clinical health outcomes.



More information on the **Footprints to Better Health** initiative can be found in the [State Budget Papers](#)

funded by the State Government and the Commonwealth Government) is scheduled to open in November 2015.

The 2015-16 Budget provides additional funding of:

- \$11.4 million for critical maintenance at Royal Perth Hospital
- \$3.0 million per annum from 2016-17 to 2018-19 towards the Minor Works Programs.

Funding of \$2.4 million, sourced from savings within the capital works program, has also been allocated for the procurement and implementation of an automated infection surveillance system.

Further information on all infrastructure investments can be found in the State Budget Papers, Budget Paper 2 (pages 139-142).

5.5 Royalties for Regions

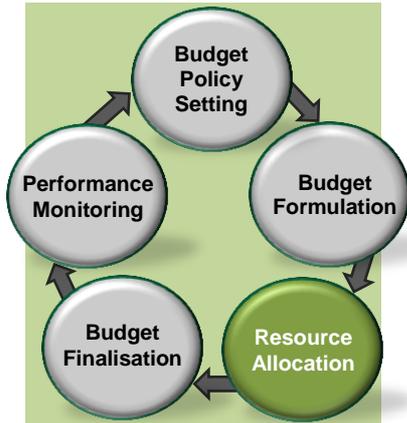
The Royalties for Regions (RfR) program is facilitating significant regional hospital infrastructure developments including the Albany Health Campus, Busselton Health Campus, Kalgoorlie Health Campus, Karratha Health Campus, as well as the North West Health Initiative.

The program also supports WA Health with service delivery programs such as Pilbara initiatives, Remote Aboriginal Clinics, St John Ambulance, Royal Flying Doctors, Patient Assisted Travel Scheme and Southern Inland Health Initiatives. In total, the RfR program provides WA Health with more than \$100 million per annum.



Click here for further information on
RfR
[Royalties for Regions](#)

Section 1 Introduction	Section 2 Roles & Responsibilities	Section 3 Key Policy Settings	Section 4 Budget Policy Setting	Section 5 Budget Formulation	Section 6 Resource Allocation	Section 7 Performance Monitoring
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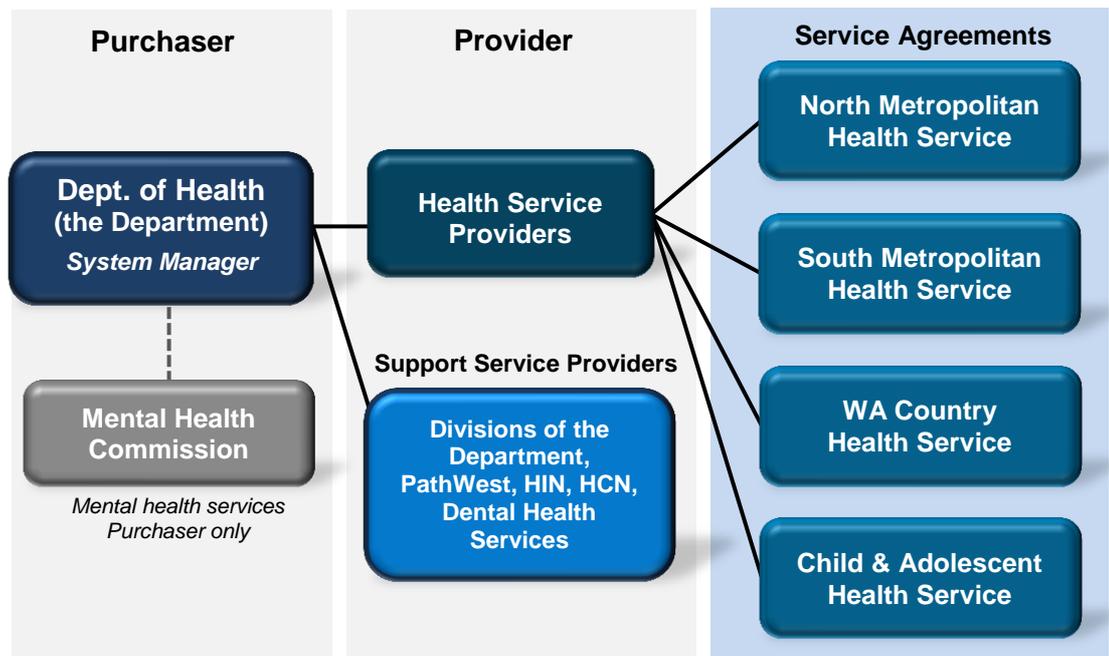


6.0 Resource Allocation

The WA ABF Operating Model for 2015-16 is the mechanism that sets out the budgeted activity levels for the delivery of activity based funded health services in WA public hospitals. Actual ABF and non-ABF funding allocations are dependent on the WA State Government budget. The WA Operating Model has been developed to take account of the national ABF program which commenced across Australia from 1 July 2012.

The ABF methodology is based upon the principle of clear delineation of the roles of the purchaser (the Department) and provider (the Health Service Providers), as outlined in [Section 2 Roles and Responsibilities](#) of these Guidelines. The clarity of roles and delineation is one of the key advantages of ABF over other funding methodologies.

FIGURE 11: WA Health Purchaser/Provider Structure for ABF/ABM Implementation 2015-16



Activity Based Management (ABM)

is the management approach used by WA Health to:

- capture accurate and consistent information on activity and costs of delivery
- create an explicit relationship between funds allocated and services provided
- strengthens management's focus on outputs, outcomes, quality and safety
- manage variation in costs and practices to improve efficiency and effectiveness
- provide mechanisms to reward good practice and support quality and safety initiatives
- provide value for money for the community.

6.1 Funding Principles and Models

The 2014-15 to 2015-16 WAU targets in the State Budget were set in conjunction with WA Treasury AWPGR to deliver activity growth rates. The activity growth rate for 2015-16 is 2.58 per cent. The ABF model utilised to calculate and fund WAU is the national model developed by the IHPA. This is detailed in the *National Efficient Price (NEP) Determination 2015-16*. The WA ABF model is closely aligned with the IHPA ABF model; however differences are referred to in [Section 6.1.2 Local WA Modifications](#).

The national ABF model is updated annually with improvements and changes to the classification systems for public hospital services. These changes can introduce 'scaling' effects between years that need to be taken into account in the overall budget setting process with WA Treasury.

6.1.1 Method for the Allocation of Activity

The 2015-16 preliminary activity profiles mark the first year a consultative approach has been taken towards the development of the Service Agreements. This process allowed greater opportunities for Health Service Providers to give feedback and improve transparency around the B&RA process. Increased engagement is designed to enhance the *Purchaser/Provider* relationships and therefore improve the planning and management of activity allocation.

The activity profiles were weighted using the IHPA 2015-16 Model as per the NEP determination. The distributional effects introduced by the updated model were evaluated, particularly the overall effect on general inpatient allocation due to cost weight model changes for inpatient Mental Health. Matters related to activity profiles raised by Health Service Providers were taken into consideration during this process.

The 2015-16 activity profiles for metropolitan Health Service Providers were constructed using ESRG, URG and Tier 2 clinics for IP, ED and OP services respectively. The 2015-16 IP, ED and OP activity profiles for WACHS regional and integrated hospitals were developed at a hospital level. These initial activity profiles were further refined through each stage of the Service Agreement draft process involving various engagement meetings with each Health Service Provider.

The three-year activity outlook was determined by the 2015-16 targets escalated by the most recent CSF and the Capacity Demand Modelling growth parameters.

For 2015-16, sub-acute activity will be weighted under the sub-acute model when a valid AN-SNAP class is provided; otherwise the calculation of the weight will revert back to the DRG model. Overall, Health Service Provider activity is reconciled to WA State Budget activity profiles.



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



Click here for more information on the [National Efficient Price \(NEP\) Determination 2015-16](#)

CLASSIFICATION SYSTEM ACRONYMS

ESRG	Extended Service Related Group
URG	Urgency Related Group
IP	Inpatient
ED	Emergency Dept.
OP	Outpatient
DRG	Diagnosis Related Groups
AN-SNAP	Australian National Sub-acute and Non-Acute Patient



Handy Tip:

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



National Efficient Price (NEP)

The 2015-16 NEP is \$4,971 per National Weighted Activity Unit (NWAU[15]).

Calculation of the NEP

The 2015-16 NEP is based on the calculated average cost of public hospital activity for the 2012-13 financial year of \$4,549 per NWAU(15), indexed at a rate of 3% p.a. Consistent with the NHRA, Cwlth directly funded programs have been removed prior to determining the underlying cost data of the 2012-13 reference cost. Click here for more info on [Understanding the NEP](#)



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

Click here for more info on [Understanding the NEC](#)

6.1.2 Local WA Modifications to the Independent Hospital Pricing Authority Model

The Department modifications to the IHPA model 2015-16 activity profiles are outlined below:

- ambulatory surgery initiative activity is not in-scope for the NHRA. Activity related to this program is in-scope under the WA ABF model with the IHPA schedules discounted for the medical cost component that is funded under the Medicare Benefits Schedule. The value of the scaling factor used to adjust for the medical costs component is based on National Hospital Cost Data Collection (NHCCD) costing information
- weighted activity related to the contracted satellite dialysis services in the metropolitan area has been scaled to return the real expenditure related to these contracts. This expenditure is less than the normal cost of hospital delivered dialysis. This approach and relevant calculations will be further reviewed and compared with the latest NHCCD data when available.
- service agreements for WACHS include 10 integrated (district) hospitals that, under the current IHPA definition are treated as NEC funded hospitals. This approach will be reviewed as part of the annual NEP and NEC comparative analysis process
- the inpatient mental health activity is consistent with the IHPA 2015-16 model. The exception is Graylands/Selby Hospital activity, which is generally of a long-stay nature. For 2015-16, selected Graylands wards will move to a DRG-based activity allocation. The remaining wards will continue to be weighted using bed-state information as per previous years. This approach is required due to the impact of long stay patients on the Graylands campus. WA is currently participating in the national development of a new Mental Health classification system and it is anticipated that this issue will be addressed in the near future
- the agreements for the provision of public hospital services with private providers are not consistent with the national ABF model. To facilitate performance reporting for the WA Health and reporting to State Government, the agreed activity as specified under these specific contract agreements, is converted to the equivalent IHPA 2015-16 cost weight model activity profiles
- service agreements are developed for a total expenditure profile which includes weighted activity related to private patients in public hospitals. The IHPA model, however, applies a discount for these types of patients in order to offset revenue that States and Territories receive from alternative funding sources. The WA ABF model currently, does not utilise the DRG discount for private patients or the bed day accommodation adjustment.

6.1.3 Pricing Principles for Health Service Provider Allocations

Prices per Weighted Activity Unit (WAU) for 2015-16 are detailed in *Table 12*, below.

The Health Service Allocation Price (HSAP) has been aligned with the updated Price convergence strategy that was approved by the Government as part of the 2015-16 budget process.

TABLE 12: Health Service Allocation Price per WAU in 2015-16

Hospital Type	2014-15	2015-16	Forward Estimates		
			2016-17	2017-18	2018-19
Adult Tertiary Hospitals	5,464	5,562	5,650	5,728	5,798
All other Sites	5,289	5,384	5,469	5,544	5,612

To preserve price stability, the indicative prices for 2015-16 have been updated and derived by indexing the Health Service Allocation Prices for 2014-15 by 1.8 per cent for cost growth. The escalation rates for 2015-16 and the outyears have been reduced from 2.1 per cent to 1.8 per cent to align with the State Government's updated price convergence strategy outlined in the 2015-16 Budget of transitioning the cost of delivering hospital services to the new '2015-16 PAC' by 2020-21.

A convergence of the cost of delivering hospital services to the benchmark 2015-16 PAC by 2020-21 aligns with anticipated timeframes for the completion of a range of reform projects currently being undertaken by WA Health.

6.1.4 Adjustments

It is recognised that there are legitimate and unavoidable variations in the costs of delivering hospital services. Some of these costs have been recognised by the IHPA in the NEP determinations. Other costs specific to WA, are reflected through the application of a CSS in the WA ABF model.

The IHPA is responsible for determining the national adjustments to the NEP. The 2015-16 IHPA model adjustments are outlined in *Table 13*.



What is the Health Service Allocation Price (HSAP)?

The HSAP is the price that Health Service Providers are funded, which includes the CSS (*Community Services Subsidy*).

For a full explanation, go to [6.2.2 Health Service Provider Resource Allocation](#)



What does ABF allocation mean for WA Health Service Providers?

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

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

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

Data Collection Improvements in WA Health

Currently not all 'Activity' is adequately captured, measure and costed in a way that suits the ABF approach. Therefore, WA Health is continually working to improve the way data is captured to better inform funding decisions and achieve efficiency gains while improving access and delivering better health care to patients.



*National ABF Adjustments Table sourced from the [National Price Determination 2015-16](#) Chapter 5 - Adjustments

Visit [IHPA](#) for further information

TABLE 13: National ABF Adjustments 2015-16*

Name	Context - where an ABF activity:	Amount to be applied
Paediatric Adjustment	Is in respect of a person who: <ul style="list-style-type: none"> is aged up to and including 17 years; and is admitted to a Specialised Children's Hospital (Appendix E). 	Refer to column headed 'Paediatric Adjustment' in the tables of Admitted Acute Price Weights Appendix H (refer to the <i>National Price Determination 2015-16</i>).
Specialist Psychiatric Age Adjustment (≤ 17 years, in MDC 19 or 20)	Is in respect of a person who is aged 17 years or less at the time of admission, with a mental health-related primary diagnosis (Major Diagnostic Category [MDC] 19 or 20) and has one or more Total Psychiatric Care Days recorded.	Admitted Acute Patient: 15 per cent (except patients admitted to a Specialised Children's Hospital, who will receive 9 per cent)
Specialist Psychiatric Age Adjustment (≤ 17 years, not in MDC 19 or 20)	Is in respect of a person who is aged 17 years or less at the time of admission, with a primary diagnosis which is not mental health-related (not in MDC 19 or 20) and has one or more Total Psychiatric Care Days recorded.	Admitted Acute Patient: 22 per cent (except patients admitted to a Specialised Children's Hospital, who will receive 41 per cent)
Specialist Psychiatric Age Adjustment (> 17 years, not in MDC 19 or 20)	Is in respect of a person who is aged over 17 at the time of admission, with a primary diagnosis which is not mental health-related (not in MDC 19 or 20) and has one or more Total Psychiatric Care Days recorded.	Admitted Acute Patient: 34 per cent
Outer Regional Adjustment (1)	Is in respect of a person whose residential address is within an area that is classified as being <i>Outer Regional</i> .	Admitted Acute or Admitted Subacute Patient: 8 per cent
Remote Area Adjustment (1)	Is in respect of a person whose residential address is within an area that is classified as being <i>Remote</i> .	Admitted Acute or Admitted Subacute Patient: 16 per cent
Very Remote Area Adjustment (1)	Is in respect of a person whose residential address is within an area that is classified as being <i>Very Remote</i> .	Admitted Acute or Admitted Subacute Patient: 22 per cent

Name	Context - where an ABF activity:	Amount to be applied
Indigenous Adjustment	Is in respect of a person who identifies as being of Aboriginal and/or Torres Strait Islander origin.	Admitted Acute, Admitted Subacute, Emergency or Non-admitted Patient: 4 per cent
Radiotherapy Adjustment	Is in respect of an admitted acute patient with a specified ICD-10-AM 9 th edition radiotherapy procedure code recorded in their medical record (2).	Admitted Acute Patient: 26 per cent
Dialysis Adjustment (2)	Is in respect of an admitted acute patient with a specified ICD-10-AM 9 th edition renal dialysis code who is not assigned to the AR-DRG L61Z Haemodialysis or AR-DRG L68Z Peritoneal Dialysis. ⁽²⁾	Admitted Acute Patient: 25 per cent
Intensive Care Unit (ICU) Adjustment	a. Is not represented by a newborn/neonate AR-DRG identified as 'Bundled ICU' in the tables of Price Weights (Appendix H); but b. Is in respect of a person who has spent time within a Specified ICU (3).	0.0440 NWAU(15)/hour spent by that person within the Specified ICU.
Private Patient Service Adjustment	Is in respect of an Eligible Admitted Private Patient.	Admitted Acute Patient: Refer to column headed 'Private Patient Service Adjustment' in the table of Price Weights at Appendix H . Admitted Subacute Patient: Refer to Appendix F for applicable adjustment (<i>refer to the National Price Determination 2015-16</i>).
Private Patient Accommodation Adjustment	Is in respect of an Eligible Admitted Private Patient.	Admitted Acute or Admitted Subacute Patient: Refer to Appendix F for applicable adjustment (<i>refer to the National Price Determination 2015-16</i>).
Multi-disciplinary Clinic Adjustment	Is in respect of a non-admitted service event where three or more health care providers (each of a different specialty) are present, as identified using the non-admitted 'multiple health care provider indicator'.	Non-admitted Patient: 55 per cent

Table 13 Source:
[National Price Determination 2015-16](#)
Chapter 5 - Adjustments

6.1.5 Block Funded Programs for 2015-16

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

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

IHPA has established a work program to develop a new mental health classification system that would include admitted and non-admitted services data collection. Until IHPA advise how the new classification system will be implemented in the national ABF model, non-admitted mental health services will continue to be block funded under the NHRA.

Under the NHRA, the IHPA is required to implement an activity based TTR funding model by 2017-18. Following development of definitions for TTR for the purposes of national ABF, a national costing study is currently underway for 2015 which will inform the development of a classification system to be implemented for the 2017-18 timeframe. In the interim, TTR continues to be block funded under the NHRA.

The NEC determination for 2015-16 defines the funding model for CSO sites. While the definition for what is considered to be a CSO site may be adjusted, the overall principle of CSO sites under the NHRA will remain. For more information on the NEC determination visit the IHPA website.

Non-Admitted Mental Health

The MHC has determined the allocation and escalated the 2014-15 block funded amount by cost and population growth. The MHC is working with the Department to determine priority areas for targeted purchasing.

Teaching, Training, and Research

The allocation for TTR in 2015-16 will be consistent with the methodology used in 2014-15 where the funding allocation relates to the activity profiles for each site. The Teaching Training and Research percentage allocations will be developed along with the activity profiles consistent with the costing methodology. The allocation available in the State Budget included both cost and activity growth from the 2014-15 allocations.

Community Service Obligation – Small Rural Hospitals

Because of diseconomies of scale and volatile activity, some smaller hospitals do not fare well under the ABF model. IHPA have funded these smaller hospitals under the National Efficient Cost (NEC) model. The NEC determines the Commonwealth contribution to these block funded hospitals. Hospitals are assigned to a size-locality group matrix where different weights apply. These weights are then multiplied by the NEC figure. Generally, a hospital in a remote location should have a higher weight component than a similar sized hospital in a regional area and hence attract larger funding.



National Efficient Cost (NEC) is defined in chapter 3 of the [National Efficient Cost Determination 2015-16](#)



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

Small hospitals in country WA are considered CSO hospitals and therefore receive Commonwealth funds through the NEC model. The Department block funds these hospitals. Most of the Integrated (district) hospitals in rural WA also receive Commonwealth funding through the NEC model, however, the Department have funded these hospitals within the WA ABF framework.

6.1.6 Special Purpose Programs in 2015-16

Special Purpose Programs are the services provided via Health Service Providers that are not included in the ABF activity profile.

The funding allocation for these services is via various sources such as:

- Commonwealth programs
- WA State Government decisions
- election commitments
- services which are not deemed consistent with ABF principles.

Those programs that do not have specific funding for 2015-16 will attract a cost growth escalation based on 2014-15.

The applied indexation is as set out below:

CPI indexation <ul style="list-style-type: none">• 2.25% applied as required for 2015-16• 2.5% across the outyears
Non-Government Human Services Sector (NGHSS) indexation <ul style="list-style-type: none">• 3.1% applied to NGO contracted services for 2015-16• 3.3% for 2016-17• 3.5% for 2017-18 and 2018-19.

6.1.7 Former National Partnership Agreement Funding in 2015-16

While a significant amount of National Partnership Agreement (NPA) funding was ceased by the Commonwealth as part of its 2014-15 Budget, some legacy funding remains.

For 2015-16, the funded activity profiles for each Health Service Provider will be inclusive of any NPA funding. NPA funding not related to activity delivery will be clearly identified.



Visit [IHPA](#) for more info on the [NEC determination](#)



Block Funded Services are cost escalated for 2015-16 as outlined in [Section 6.1.5 Block Funded Programs for 2015-16](#)

6.2 WA Health Resource Allocation

6.2.1 Methodology for Distribution of the WA Health Budget

For 2015-16 the Department will continue to use an ABF methodology to purchase the majority of services from the Health Service Providers. In broad terms, this ABF methodology includes:

- activity based allocations based on the IHPA 2015-16 model with adjustments applied to suit WA Health specific funding requirements
- activity based allocations for 2016-17 onwards are based on the established growth outlined in the CSF and its demand and capacity modelling
- adjustments for circumstances such as budget constraints as well as contracted privately-provided public hospital services, post-CSF arrangements, and/or other relevant factors.

As discussed in section [5.2.1.1 Activity Based Services](#), *Table 9* identified the approved State Price (SP) of \$5,587, which is based on adding the PAC and to the State Community Services Subsidy (CSS), as illustrated in *Figure 12* below.

FIGURE 12: State Approved Price Setting



The ABF budget allocation for WA Health is based on the SP multiplied by Activity to create the global ABF budget allocation for WA Health, as per *Figure 13*.

FIGURE 13: Global ABF Allocation for WA Health Budget



6.2.2 Health Service Provider Resource Allocation

The Department determines a base ABF allocation for Health Services Providers by multiplying the PAC (\$5,122 for 2015-16) with the targeted volume of activity, expressed as WAU to provide the Base Allocation as per *Figure 14*.

FIGURE 14: Base ABF Allocation for Health Service Providers



Health Service Allocation Price (HSAP)

As the base ABF allocation does not take into account the higher costs in delivering services within WA compared to other States, the Department provides an additional price loading to the PAC by way of a CSS to enable Health Service Providers to better manage cost pressures.

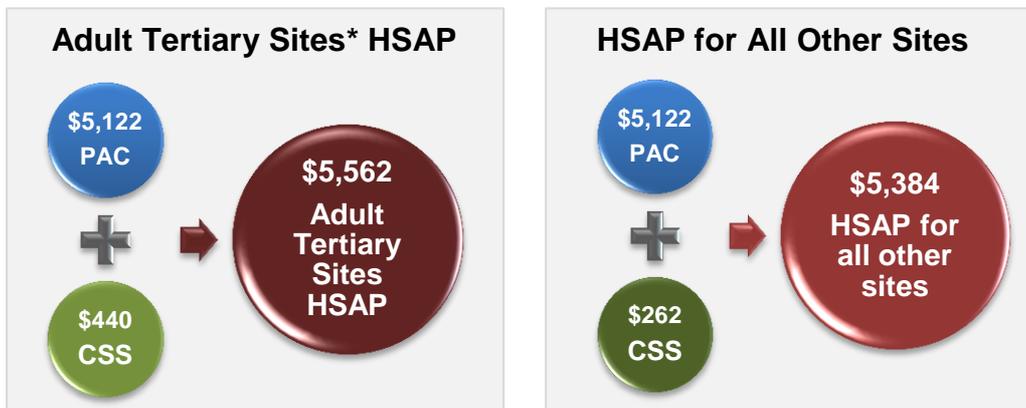
The price loading provided to Adult Tertiary Sites is higher (\$440 per WAU) than for all other sites (\$262 per WAU). The differential loading is in recognition of the additional costs associated with complexity, specialisation and case severity of services delivered at Adult Tertiary Sites compared to other sites.

Princess Margaret Hospital (PMH) is funded for specific additional costs incurred in paediatric service delivery via a loading embedded within the paediatric activity cost weights. This specific cost weight loading is derived from a national benchmark process involving paediatric hospitals across Australia and is estimated at 10 per cent when compared against non-paediatric hospitals.

The derived new price is called a Health Service Allocation Price (HSAP) which is categorised into two prices for 2015-16, as illustrated by *Figure 15*:

1. Adult Tertiary Sites HSAP \$5,562
2. HSAP for All Other Sites \$5,384

FIGURE 15: Adult Tertiary Sites HSAP and HSAP for All Other Sites



The final ABF allocation for Health Service Providers is identified in the individual Service Agreements and is calculated as per *Figure 16* below.

FIGURE 16: Final ABF Allocation for Health Service Providers



The HSAP has been developed to provide equity, stability, and sustainability in managing ABF funding allocation for WA Health Service Providers.



What is the Health Service Allocation Price (HSAP)?

The HSAP is the price that Health Service Providers are funded, which includes a CSS (Community Services Subsidy).



Which WA Hospitals are considered Adult Tertiary Sites?

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

As per the 2015-16 Budget, the State's public hospitals are expected to converge to the PAC within the reconfiguration timeframe of 2020-21. In effect the 'CSS component' will continue to decrease until being phased out completely in 2020-21.

6.2.3 Department of Health

The Department comprises of the Office of the Director General; Office of the Deputy Director General Reform Division; Office of the Chief Psychiatrist; Public Health Division; Clinical Services and Research Division; System Policy and Planning Division; Purchasing and System Performance Division; and the System and Corporate Governance Division.

For 2015-16, the Department will continue to use a budget-to-budget methodology for Departmental divisions. This method considers new initiatives, organisational re-alignments, or the cessation of activities that were previously undertaken.

6.2.4 State-wide Support Service Providers

The state-wide Support Service Providers involve the following entities:

- PathWest
- Dental Health Services
- Health Corporate Network
- Health Information Network
- Queen Elizabeth II Medical Centre Trust
- Quadriplegic Centre.

For 2015-16, the Support Service Providers are funded on a budget-to-budget methodology. Cost growth of 2.25 per cent was flowed through to all Support Service Providers budget holders. Budget holders are funded for financial products including RiskCover premium payments for 2015-16.

6.2.5 Mental Health Services

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

Annual Service Agreements between the MHC the Department are developed for the purchase of four funding categories of mental health services, namely inpatient services, non-admitted services, teaching training and research and other miscellaneous services from the State's public Health Service Providers.

The Department, Office of Mental Health, and MHC work 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 Provider level in 2015-16 and subsequent financial years.

As outlined in [Section 3.2 Purchaser Policy](#), a *Western Australia Mental Health and Alcohol and Other Drug Services Plan 2015-2025* (the Plan) was released for consultation in late 2014. The Plan outlines the strategic direction for the State's public mental health services and key areas for future reform.

A revised version of the Plan is expected to be endorsed by Cabinet by June 2015. Starting in 2015-16, the MHC intends to undertake targeted purchasing services from the Department, in accordance to the Plan directives.

A significant change for 2015-16 is the introduction of WA's new *Mental Health Act 2014*. The new legislation is a key element in the Government's mental health reform agenda and places individuals and families at the centre of mental health treatment and care.

6.2.6 Public Hospital Funding Flows

The *National Health Funding Pool Act 2012* gives effect to the State's commitments under the NHRA. This 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* and the *Lotteries Commission Act 1990*.

Figures 17 and 18 on the following page show the State and Commonwealth public hospital funding flows for both ABF and non-ABF public hospital services.



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

FIGURE 17: State and Commonwealth ABF Funding Flows for Public Hospital Services

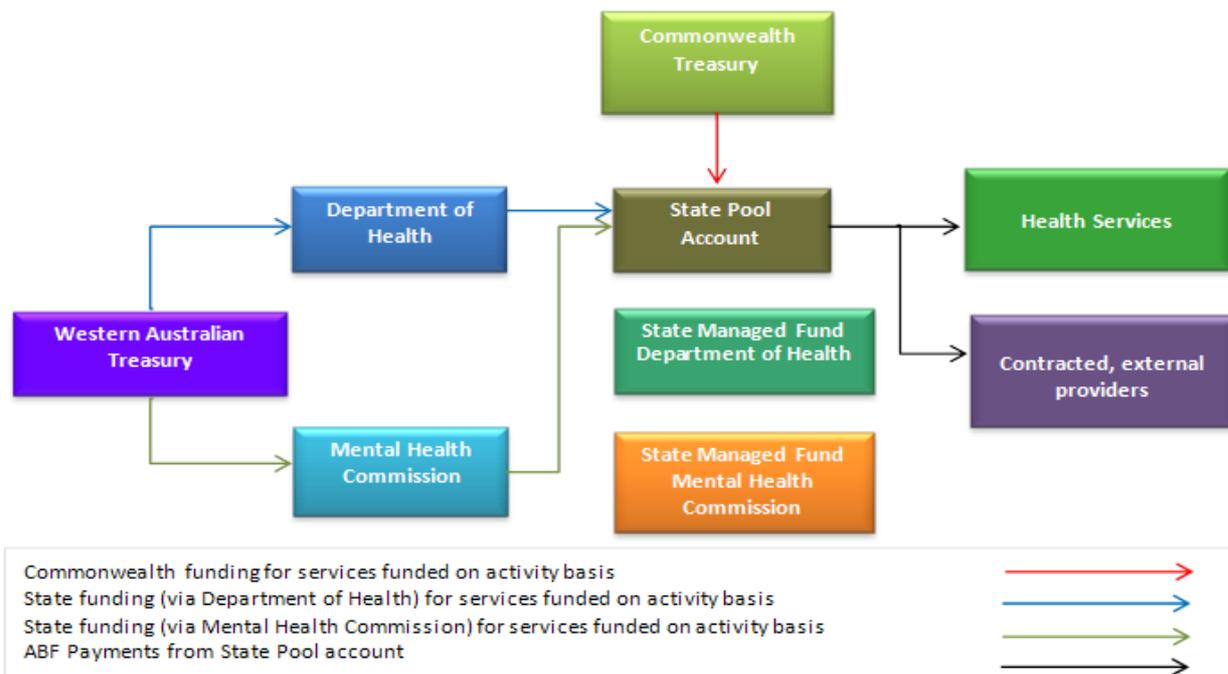
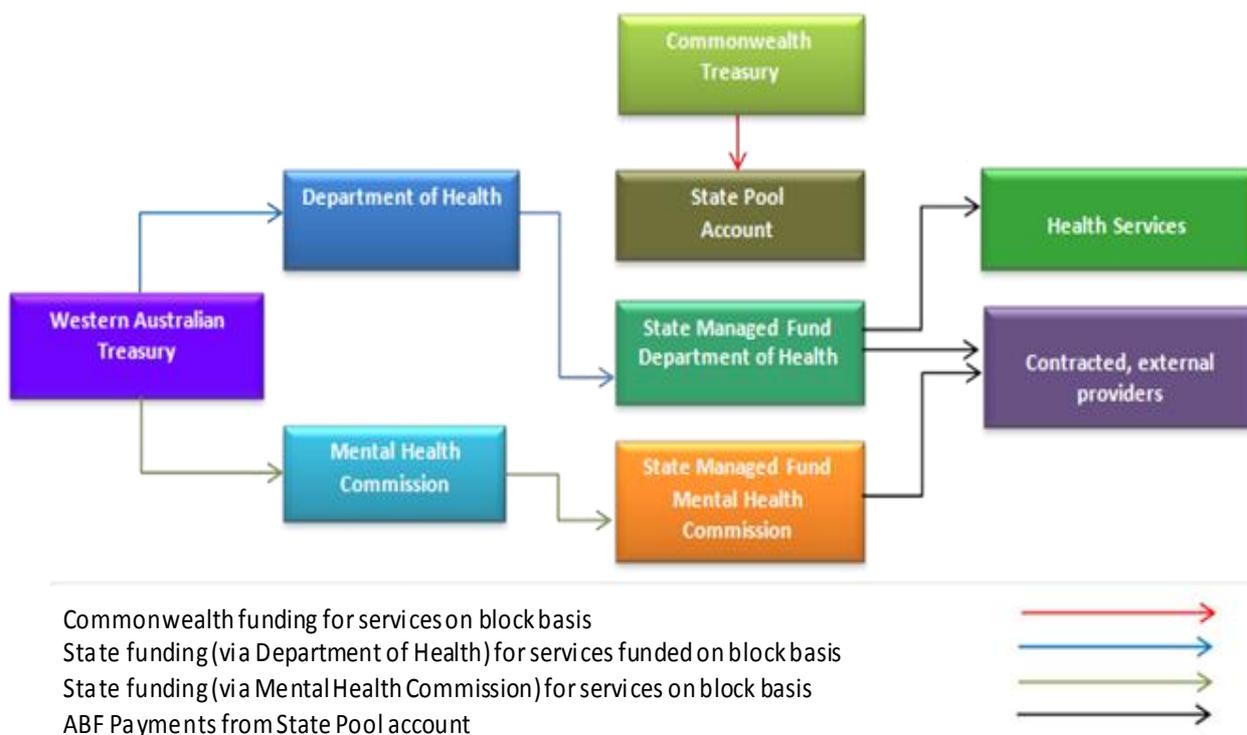


FIGURE 18: State and Commonwealth Block Funding Flows for Public Hospital Services



A breakdown of the Health Service Providers budget allocations and, the non-health services budget allocations are provided in **Appendices B and C** respectively.

6.2.7 Key Financial Considerations

Own Source Revenue (OSR) Targets - Revenue Reform

The Department will set targets for Total OSR for 2015-16. Specifically, Private Patient Revenue targets will be set with the requirement that Health Service Providers achieve their revenue targets by improving the efficiency and capability of internal revenue generation systems. It is a requirement that this revenue target is generated in compliance with standard WA Health policy, legislation and Commonwealth agreements.

To achieve this goal, *Own Source Revenue* (OSR) targets have been set and focused specifically on increasing the number of private patient separations as well as increasing the efficiency of private patient billing. Performance indicators and monitoring processes will be implemented to ensure transparency in achieving revenue targets.

The Department has established the WA Health Revenue Reform project to implement the Government recommendations for increased revenue relating to user fees and charges, the setting of annual revenue targets and implementing robust monitoring and reporting process.

Project implementation will focus on establishing legislation and governance, developing policy and accountabilities. The improved performance of private practice arrangements, business systems and processes, in addition to developing an employee learning framework is designed to improve WA Health's performance in achieving revenue targets.

27th Pay

Every eleven years there are 27 fortnights in a financial year, and as a result employers are required to make a 27th pay to their employees. The next 27th pay falls on 30 June 2016 and WA Health will be required to fund an additional pay for all staff within the agency in the 2015-16 financial year. Part of the annual government appropriation to WA Health includes a component for the 27th pay. Funds are deposited by the Department into an investment account held by the WA Treasury, and the annual provisioning for the 27th pay is an ongoing funding requirement.

The resource allocation process includes the withdrawal of cash and expenditure limit from budget holders to accommodate the 27th Pay commitment. This will be re-distributed to budget holders in June when the 27th Pay falls due. This strategy is to ensure that WA Health does not commit expenditure to the fully approved expenditure limit and therefore over-commit WA Health's operating cash position for 2015-16.

The 27th Pay commitment is based on two requirements:

- (a) prior year adjustment
- (b) the 2015-16 component.



Contact the **Financial Reform Project Team** on phone (08) 9222 2414



Own Source Revenue (OSR) is best described as revenue derived from operating activities excluding revenue from State Government

RiskCover Premium

On an annual basis, RiskCover issues an invoice to WA Health detailing the charges for various insurance types by site. In prior periods, the insurance premium was not separately detailed in the annual service plan, however, the funding for this expense was provided in the price to deliver activity.

In 2015-16, the RiskCover Premium will be separately identified in each Health Service Provider's Service Agreement or non-health services budget notification. Approved funding for 2015-16 allows for performance adjustments related to actual insurance outcomes from previous periods. WA Health will consider developing further processes around RiskCover adjustments for performance to include an incentive element.

Bad Debts

A bad debt appears as an expense in the income statement reflecting the situation where accounts receivable are uncollectable and will be written off. The accounts receivable in question relate to Private Patient Fees. The allocation of 'Bad Debts' is allocated to Health Services based on the 2013-14 Actual Receipts for Private Single Rooms escalated to 2015-16 values. For the 2015-16 budget process this is reflected in the Service Agreements and accompanying Revenue Plans as a financial product. This 'budget' does not provide additional expenditure limit for the Health Service Providers to utilise for alternative purposes.

Accrued Salaries

Accrued salaries represent salary expenditure which is incurred but for which no cash payment is made during an accounting period. These accruals are shown in the Statement of Financial Position as a liability. Given the size of WA Health's workforce, and the 24 hour a day/7 day a week nature of health service delivery, the size of WA Health's accrued salaries fluctuates. The negative accrued salaries figure in the 2015-16 Revenue Plan illustrates that salaries operating payments made via the Statement of Cashflow in 2015-16 will exceed salaries expenditure recorded in the Statement of Income.

This outcome is reflective of 27 fortnightly cash payments for the financial year, while the Statement of Income will continue to reflect only 26 weeks of incurred salaries expenditure. In the budgeting module of general ledger, the negative amount should be included in the salaries component but only in the Statement of Income and not the Statement of Cashflow.

Savings and Corrective Measures

- Efficiency Dividend - A one per cent efficiency dividend has been applied from 1 October 2014 based on the cash service appropriation for WA Health.

- Procurement Savings - This provides for a 15 per cent reduction in non-essential procurement, targeting expenditure on administration, communication, consultants, consumables, equipment repair and maintenance, staff travel and 'other' expenses.
- Targeted Separation Scheme (TSS) - Cabinet has approved a TSS for 1,500 public sector employees, of which 419 separations have been found within WA Health.
- Workforce Renewal Policy (WRP) - The Public Sector WRP applies from 1 January 2015 over the forward estimates. It is a corrective measure targeted at reducing the cost of services primarily through making adjustments to the public sector workforce. WA Health's existing reform and price convergence strategies have been accepted as significant contributions to reducing the cost of services and have been taken into account in negotiating the WRP parameters. A policy to operationalise the reduction in funding is yet to be determined, and a range of options will be considered by the State Health Executive Forum in the 2015-16 financial year.

Paediatric Reconfiguration

Previously known as the PIP, the reconfiguration refers to the safe transition of secondary paediatric activity and services from the State's tertiary paediatric hospital, PMH, to the appropriate metropolitan hospital with a paediatric role designated and corresponding infrastructure.

The aim of reconfiguration is to develop sustainable paediatric service units at all hospital sites where paediatric activity is specified in the CSF, addressing two key reform principles: care closer to home and economic service efficiency. Paediatric reconfiguration will ensure the future activity for PCH will be tertiary and quaternary care and only local catchment secondary care.

The reconfiguration has been incorporated into the 2015-16 Preliminary Activity Profiles. As a first step, a site-based bed profile of paediatric activity (unweighted) is provided in each Health Service Provider Agreement. During 2015-16, as System Manager, the Department intends to monitor actual paediatric activity (across all service categories) and examine the progress of the paediatric reconfiguration across each Health Service.

Support Services Charging Model

As the Department moves toward the System Manager role and the implementation of ABF continues it is conducting an independent review of pricing and costing structures. This will result in the provision of an independent proposal for the new service charging model with reference to ABM and ABF requirements.

Service Agreements will be developed between Support Services and each Health Service Provider and the Department that will set out:

- services to be provided
- price to be paid
- key performance indicators to be measured.



Click here to find out more information on [Targeted Separation Scheme](#)



The **Service Activity Amendment** policy and framework will become effective from 1 July 2015.

Once released click here to access the [Service Activity Amendment Framework](#)

6.2.8 Service Activity Amendment Framework

The Department has investigated options to address activity 'change requests' for 2015-16 in a standardised method. This has led to the development of a state-wide policy to process service activity amendments between the Department and Health Service Providers through the financial year. This will include amendments related to mental health service activity between the Department, MHC and Health Service Providers.

Activity amendments may occur:

- within a Health Service Provider (e.g. transfer of activity from one site to another within that Health Service), or
- across different Health Service Providers (e.g. transfer of activity from one site to another between different Health Services).



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Performance Monitoring

7.0 Performance Monitoring

7.1 Framework

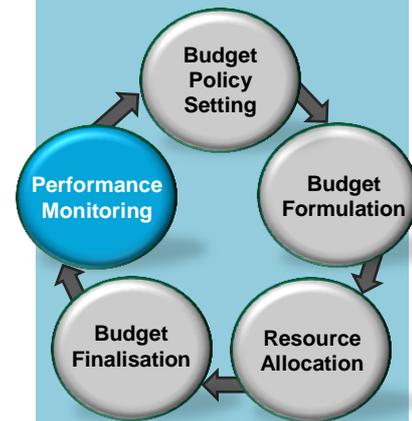
The Performance Management Framework (PMF) was introduced in 2010-11 for ABF hospitals in WA to consolidate performance reporting, monitoring, evaluation, management and intervention. Governance for WA Health comprises of several key components of which Performance is a vital element in line with the System Manager role for the Department.

An independent review of the performance reporting within the PMF has been commissioned as a part of the Health Reform Program. The Performance Projects Board (PPB) will review the findings from the independent review and endorsed recommendations will be implemented in 2015-16. The PMF aims to support WA Health's vision to *deliver a safe, high quality, sustainable health system for all Western Australians*.

Currently, the PMF informs the Health Service Provider Service Agreements between the Director General of Health as the delegated 'Board' and the Health Service Providers. The Service Agreements, in turn, form the basis of the Personal Performance Agreements between the Director General of Health, Health Service Provider Chief Executives (CEs) and Executive Directors who have a direct accountability for delivery of health services.

Health Service Providers operate in an environment of delivering the services set out in the Service Agreements. The Service Agreements are informed by the WA Health CSF 2014-2024¹³, specifying the scope of services and target levels of activity for a facility. The Service Agreements, in conjunction with the Guidelines ensure that the Governments' policy objectives on service delivery are clearly set out and provide the basis for both payment and evaluation of performance.

The PMF provides the health care system with a common set of performance objectives and targets across WA Health. There is considerable pressure on health systems world-wide to contain costs, improve performance and maximise value for money.¹⁴ The PMF enables Service Providers within WA Health to address these challenges by identifying performance improvement opportunities.



For more information on the **PMF** click here
[Annual Performance Management Framework](#)



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

¹³ Department of Health. (2015). *WA Health Clinical Services Framework 2014- 2024*, Innovation and Health System Reform Division, Department of Health, Perth. Available from: www.health.wa.gov.au.

¹⁴ Department of Health. (2014). *ABF/M Performance Management Strategic Directions 2014-15 and Beyond Consultation Framework*, Resourcing and Performance Division, Department of Health, Perth.

Additionally, the PMF facilitates a cultural transformation within the health system that empowers not only the WA Health leadership but every member of staff to collaboratively work towards achieving better value health care.

The PMF is a policy document and is to be read in conjunction with other Department of Health documents and publications including:

- [WA Strategic Plan for Safety and Quality in Health Care 2013-2017](#)
- [ABF/M Performance Management Report Performance Indicator Definitions Manuals](#)
- [ABF/M Performance Management Strategic Directions 2014-15 and Beyond Consultation Framework](#)
- [Performance Reporting and Data Quality within the Performance Management Framework.](#)

7.1.1. Performance Reporting, Monitoring, Evaluating and Management

The PMF is monitored through the monthly Health Service Performance Report (HSPR).

Performance Reporting has been the subject of a recent independent review to ensure continued effectiveness in managing health system performance. Outcomes from this review and subsequent endorsement of recommendations by the Performance Projects Board (PPB) ¹⁵ may result in changes to the performance reporting mechanisms.

The HSPR provides targeted and timely information and analysis to assist in managing performance. Focusing expectations around a core set of performance indicators covering:

- safety and quality
- finance
- activity
- access.

These performance indicators are critical in underpinning an effective Purchaser Provider relationship and are discussed in detail in [Sections 7.2 - 7.5](#). In consultation with key stakeholders, the suite of Key Performance Indicators (KPIs), in the HSPR will be endorsed by the PPB.

¹⁵ The Performance Projects Board (PPB) has replaced the Finance, Purchasing, and Performance Group (FPPG)

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

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

The *performance targets* and thresholds have been set for each KPI following rigorous stress testing and consultation with data stakeholders. The purpose of the stress testing process is to ensure that the proposed performance indicators are meaningful and reliable in order to drive performance improvement.

Performance thresholds establish the levels of performance that forms the criterion whether any action needs to be taken in relation to identifying and resolving poor performance, or acknowledging excellent performance.

Standard Monitoring and Evaluation

The performance of Service Providers is monitored regularly against the KPIs, targets and thresholds specified in the HSPR. Performance review meetings are held monthly between the Department, as the System Manager, and each Health Service Provider. The performance review meeting is held as part of the monthly Board meetings.

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

The performance evaluation in the HSPR involves an assessment for each of the KPIs at four levels of performance:

Highly Performing	
Performing	
Under-Performing	
Not Performing.	

7.2 Safety and Quality

The release of the Mid Staffordshire UK NHS Foundation Trust Public Inquiry¹⁴ report highlights the appalling and unnecessary suffering when cost control is put ahead of patients and their safety. WA Health has a strong commitment to safety and quality in order to achieve better health system outcomes.

WA Health's performance reporting reflects this commitment, with the inclusion of a number of safety and quality indicators, such as infection rates, death in low-mortality DRGs, and rates of community follow-up of¹⁶ mental health patients in seven days from discharge. Safety and quality indicators are selected to ensure the effectiveness of patient safety and quality practices that are in place as well as provide a measure of Service Providers' performance. This focus aims to ensure that patient safety and quality is not compromised as efficiency measures are implemented across the health system.

7.3 Finance

Due to continuing significant pressure on the State's major sources of revenue, there is limited scope for consideration of new initiatives with agencies required to manage within the State's current financial parameters.

The Commonwealth Government's 2014-15 Budget detailed the cessation of the funding guarantees under the National Health Reform Agreement 2011 and the revision of Commonwealth Public Hospital funding arrangements from 1 July 2017. The indexation of the Commonwealth Government's contribution to hospital funding from 2017-18 will be based on the Consumer Price Index and population growth.

These budget pressures highlight the importance of achieving performance targets to unlock better value health care outcomes and ensure health system sustainability.

7.4 Activity

WA Health has adopted an ABF model where budgets are linked to the provision of a defined level of activity based on an allocated price. The monitoring of activity enables the assessment of Service Provider performance against budget allocations.

The HSPR monitors inpatient, ED and non-admitted activity at a facility level. It is important for activity to be monitored to minimise the risk of budget variances as a result of activity levels above or below set targets.

¹⁶ The Mid Staffordshire NHS Foundation Trust. (2013). Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, The Mid Staffordshire NHS Foundation Trust, United Kingdom. Available from www.midstaffpublicinquiry.com/report.



Click here for more information on the [National Health Reform Agreement](#)

7.5 Access

Access continues to be a key priority area for WA Health. The Four Hour Rule Program commenced in WA in 2009. The aim of the Program was to improve the patient experience and quality of care provided to the patient by reducing delays in the ED and streamlining processes for admission and discharge across the hospital.

The Four Hour Rule Program was subsequently transitioned to align to the National Emergency Access Target (NEAT) in the National Partnership Agreement (NPA) on Improving Public Hospital Services¹⁷ which commenced in 2011.

Similarly, improvement of elective surgery access has also remained a key priority for WA Health for many years. Like the Four Hour Rule Program, elective surgery initiatives were transitioned to align to the National Elective Surgery Target (NEST) and the NPA on Improving Public Hospital Services.

With the inception of the PMF in 2010-11, both elective surgery and ED access were established as KPIs. The HSPR strengthens this commitment by maintaining a suite of access indicators such as emergency department patients not seen within recommended times and over-boundary elective surgery patients. These indicators drive better clinical outcomes and aim to monitor improvements in the efficiency and effectiveness of health care delivery.



Click here for more information on the [Performance Management Framework \(PMF\)](#)

Section 1 Introduction	Section 2 Roles & Responsibilities	Section 3 Key Policy Settings	Section 4 Budget Policy Setting	Section 5 Budget Formulation	Section 6 Resource Allocation	Section 7 Performance Monitoring
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¹⁷ The Commonwealth Government has ceased a significant amount of funding for National Partnership Agreements as part of its 2014-15 Budget, some legacy funding remains.

List of Commonly Used Acronyms and Abbreviations

Acronym	Description
ABF	Activity Based Funding
ABM	Activity Based Management
ARDT	Admission, Readmission, Discharge and Transfer Policy
AWPGR	Age-Weighted Population Growth Rate
BSC	Budget Steering Committee
B&RA Process	Budget & Resource Allocation Process
CAHS	Child and Adolescent Health Service
COAG	Council of Australian Governments
CPI	Consumer Price Index
CSF	Clinical Services Framework
CSO	Community Service Obligation
CSS	Community Service Subsidy
Cwlth	Commonwealth
DG	Director General
the Department	Department of Health
DVA	Department of Veterans' Affairs
ED	Emergency Department
EERC	Economic and Expenditure Reform Committee
EOT	Estimated Out-turn
FPPG	Finance, Purchasing, and Performance Group (<i>Note: Replaced by the PPB</i>)
FSH	Fiona Stanley Hospital
FTBH	Footprints to Better Health Strategy (Aboriginal Health)
HSAP	Health Service Allocation Price
HSPR	Health Service Performance Report
Health Service Providers	WA's four Health Services: CAHS, NMHS, SMHS and WACHS
HSM	Health Service Measure
ICT	Information and Communications Technology
IHPA	Independent Hospital Pricing Authority
KPI	Key Performance Indicator
LHN	Local Hospital Network
MBS	Medicare Benefit Schedule
MHC	Mental Health Commission

Acronym	Description
Management Report	Health Service Management Report
MYR	Mid-Year Review
NEAT	National Emergency Access Target
NEC	National Efficient Cost
NEP	National Efficient Price
NGHSS	Non-Government Human Services Sector
NGO	Non-Government Organisation
NHCA	National Health care Agreement 2012
NHCDC	National Hospital Cost Data Collection
NHFB	National Health Funding Body
NHRA	National Health Reform Agreement 2011
NMHS	North Metropolitan Health Service
NPA	National Partnership Agreement
nWAU	National Weighted Activity Unit
OSR	Own Source Revenue
PAC	Projected Average Cost (also known as National Average Cost)
PCH	Perth Children's Hospital
PIP	Paediatric Implementation Plan
PMF	Performance Management Framework
PPB	Performance Projects Board (<i>Note: Replaces the FPPG</i>)
PMH	Princess Margaret Hospital
RfR	Royalties for Regions
SHEF	State Health Executive Forum
SMHS	South Metropolitan Health Service
SP	State Price
State Government	Government of Western Australia
TTR	Teaching, Training, and Research
WA Treasury	WA Department of Treasury
WA	Western Australia
WACHS	WA Country Health Service
WAU	Weighted Activity Units

Appendix A – State and WA Health Budget Framework

The WA State Government Fiscal Governance Program

The WA Health Budget Framework is influenced by the State Government’s Fiscal Governance program that aims to ensure that public resources are used efficiently, effectively, and accountably to benefit those who need them most. WA’s fiscal governance framework includes rules, regulations and procedures that influence how budgetary policy is planned, approved, carried out and monitored, including:

- Financial Management Act 2006
- Financial Management Regulations 2007
- Government Financial Responsibility Act 2000
- Government Financial Regulations 2006
- Treasurer's Instructions.

The key steps within the WA State Government’s fiscal governance program that impact on the development of WA Health annual budget see *Figure 19*:

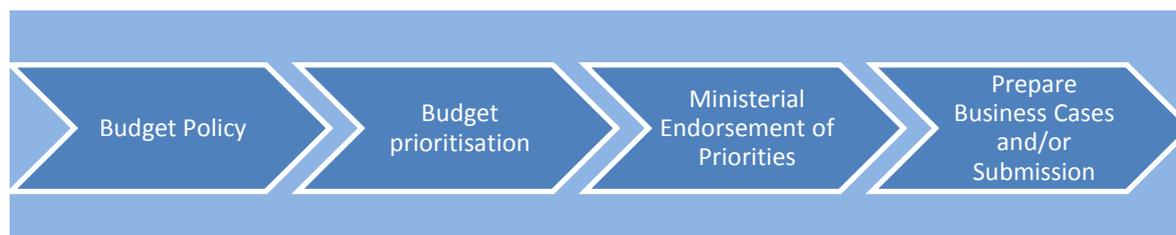
FIGURE 19: Key Steps within the WA State Government Fiscal Governance Program



WA Health’s Budget Formulation

WA Health’s 2015-16 Budget has been formulated against the Budget Policy Settings discussed under [Section 4 Budget Policy Setting](#) and an internal prioritisation process to seek Ministerial endorsement for key budget initiatives.

FIGURE 20: WA Health Budget Formulation Process



Appendix A - Continued

WA Health's Budget Approval

Budget settings for WA Health are primarily agreed to over the period from September to April, with the State Government. This process includes extensive engagement and consultation with the WA Treasury, in the role as the key advisor to Government provide advice to the EERC (Government's financial committee).

During the period from September to April the following two key Government processes are critical:

- Annual MYR Process
- Annual Budget Process.

Annual MYR Submission

The primary objective of the annual MYR process is to agree on a baseline budget position and to track budget process with the State Government prior to the beginning of each new budget cycle. WA Health's MYR Submission¹⁸ seeks to ensure that WA Health's budget settings are reflective of:

- all State Government funding decisions since the previous State Budget
- latest wage and Consumer Price Index (CPI) parameters
- all accounting adjustments emanating from the finalisation of end of financial year reports and other reviews.

The MYR process can also be a forum for addressing cost and demand policy pressures that are unable to be postponed until the Budget process.

Annual Budget Submission

WA Health's annual Budget Submission generally includes the following:

- overall budget priority and policy setting for the health system
- adjustments to the base funding to take into consideration the latest demand and cost parameters
- funding for new priority initiatives underpinned by an evidenced based business care framework
- specific purpose funding initiatives such as the Royalties for Regions initiatives, Commonwealth programs and Election Commitments
- financing and accounting adjustments due leave liability estimates, depreciation costs, etc.

Other Funding Requests to Government

Some funding decisions may be made by the State Government outside of annual Budget and MYR processes. These include specific urgent policy issues or cost and demand pressures issues such as Enterprise Bargaining Agreement wage re-negotiations.

¹⁸ Submitted in October annually ahead of the Government's publishing of its Mid-Year Review in December each year.

Appendix A - Continued

Format of Funding Requests to Government

Proposals to Government can take the form of a:

- MYR Submission
- Budget Submission
- EERC Submission
- Cabinet Submission.

All funding decisions require final Cabinet endorsement in order to be reflected in WA Health's budget settings.

Outcomes of the 2015-16 State Budget

WA Health's 2015-16 Budget builds on the Budget Policy set out under [Section 4 Budget Policy Setting](#). The 2015-16 Budget Policy sets the importance of maintaining current Health budget settings to provide predictability and stability to the Health system to plan with confidence over the forward estimates period. WA Health system budget stability is considered critical towards health system workforce engagement for the seamless and safe transition of health services to new infrastructure facilities.



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