Activity Based Funding
National Framework
and
Implementation Plan

National Partnership Agreement on Hospital and Health Workforce Reform

This document has been endorsed by the following jurisdictions:

The Commonwealth of Australia

New South Wales

Victoria

Queensland

Western Australia

South Australia

Tasmania

Northern Territory

Australian Capital Territory

Contents

Acronyms

ABF	Activity Based Funding
ABC	Activity Based Costing
AR-DRG Groups	Australian Refined Diagnosis Related Groups
COAG	Council of Australian Governments
ICD-10-AM	International Classification of Disease 10th edition Australian Modification
MH-CASC	Mental Health Classification and Service Costs
NHCDC	National Hospital Cost Data Collection
NPA	National Partnership Agreement
SNAP	Sub-Acute and Non-Acute Patient

1. Introduction

1.1 The commitment to activity based funding

Through the National Partnership Agreement on Hospital and Health Workforce Reform (the National Partnership Agreement) the Commonwealth and the States and Territories will implement a 26 March 2008 COAG commitment to:

> move to a more nationally consistent approach to activity based funding for public hospitals – but one which also reflects the Community Services obligations required for the maintenance of small and regional hospital services.

The agreement is reflected in the COAG communiqué of 29 November 2008, Attachment A, which states that:

> the Commonwealth and the States have […] agreed to provide a basis for more efficient use of taxpayer funding of hospitals, and for increased transparency in the use of those funds through the introduction of Activity Based Funding. It will also allow comparisons of efficiency across public hospitals.

The Commonwealth has committed $153.58 million for this initiative, of which $133.41 million is to be paid to the States and Territories in three separate tranches. Of the $133.41 million, $36.49 million is scheduled for payment before the end of the 2008-09 financial year.

$m	2008/09	2009/10	2010/11	2011/12	2012/13	Total
Total	36.49	5.20	5.20	47.54	59.2	153.58
States	36.49			41.40	55.52	133.41
Commonwealth		5.20	5.20	6.14	3.63	20.17

1.2 Intent of this document

This document is intended to guide the implementation of this complex and important reform. It is an Interim Report that contains the results of work to this point on the development of a National Framework and Implementation Plan for the nationally consistent approach to Activity Based Funding as outlined in the National Partnership Agreement.

This Interim Report contains the penultimate draft of the National Framework.

- The National Framework describes the activity based funding infrastructure that will be collaboratively developed by the Commonwealth and the States and Territories over the period of the National Partnership Agreement. It is designed to identify the key elements of a fully operational, nationally consistent activity based funding regime, addressing patient typology, classification, costing and funding in public hospitals. It also addresses activities such as research and training which are not directly related to the treatments provided to individual patients and to Community Service Obligations for small and rural hospitals for which an activity based funding approach may not be appropriate.

States and Territories have undertaken to develop detailed implementation plans by August 2009 and to provide these to the Commonwealth Minister for Health and Ageing. This Interim Report includes a **preliminary** analysis of the actions needed to be undertaken by all jurisdictions to develop and implement activity based funding. That preliminary analysis is set out in the Implementation Plan in this document. It identifies domains in which development activity is required, the products of those activities, milestones that align with those in the National Partnership Agreement, and provides indicative allocations of resources.

- The purpose of the outline Implementation Plan is to provide sufficient detail about jurisdictions' implementation intentions to enable the Commonwealth Minister for Health and Ageing to make an informed decision on the release of 2008-09 funding to States and Territories to support implementation of the Activity Based Funding initiative.

The Interim Report will be followed by a Final Report, which will contain the final National Framework, a gap analysis and a more detailed Implementation Plan.

2. Methodology

2.1.1 Consultations

This National Framework and Implementation Plan for activity based funding reflects extensive consultations with key policy makers, patient classification and costing officers and finance officers in the Commonwealth Department of Health and Ageing and in all state and territory health departments. Consultations were structured around a set of interview questions that covered the key areas of typology, classification, costing and funding and sought to describe current and proposed practice in these areas. A number of face to face workshops involving all jurisdictions were also held.

The Commonwealth engaged the services of a consortium comprising Ernst and Young and Health Outcomes International to assist in this work.

The National Partnership Agreement on Hospital and Health Workforce Reform Implementation Steering Committee (the Steering Committee) provided oversight of the consultancy.

The Steering Committee, whose membership comprises senior Commonwealth and state health officials, thanks Ernst and Young / Health Outcomes International for their invaluable assistance.

3. National Framework

3.1 Introduction

On 29 November 2008, the Council of Australian Governments (COAG) agreed to a National Partnership Agreement on Hospital and Health Workforce Reform[1] (the National Partnership Agreement) involving $1.383 billion in Commonwealth payments to states and territories to improve efficiency and capacity in public hospitals through four key reform components, one of which is the development of a nationally consistent approach to Activity Based Funding. The Activity Based Funding component of the National Partnership Agreement formalises the 26 March 2008 COAG commitment "for jurisdictions, as appropriate, to move to a more nationally-consistent approach to activity-based funding for services provided in public hospitals – but one which also reflects the Community Service Obligations required for the maintenance of small and regional hospital services" and is the instrument by which the commitment will be put into effect.

Under the National Partnership Agreement, all jurisdictions are committed to:

- the development and implementation of patient classification and costing methodologies to enable activity based costing of public hospital services,
- the development and implementation of funding strategies for training, research and development and other activities not directly related to the treatment of individual patients, and the establishment of a common public and private funding framework for teaching and research; and
- the development of an activity based funding methodology, including for setting price, incentives and transition arrangements, and to the implementation of these methodologies, should COAG agree to their implementation.

This National Framework below outlines the basic components of a fully operating, nationally consistent approach to activity based funding of public hospital services, noting that the National Partnership Agreement requires the development of such an approach prior to COAG's decision on whether it should be implemented.

The discussion begins with an examination of the service delivery and policy context. The intention is to identify drivers of change and reform that are particularly relevant to this activity based funding initiative.

The discussion then identifies the basic building blocks of an approach to activity based funding that meets the requirements of the National Partnership Agreement. These building blocks are discussed in terms of the principles governing their development and the actions required for successful development and implementation.

One of the features of the National Framework is its capacity to be applied across different setting and service types. The National Framework describes an activity based costing model that costs activity at the patient level in a way that allows for changes in the settings and care types in which the activities occur to be reflected in the data. The model is thus responsive to innovations driven by emerging evidence, new technologies and patterns of care. The model encompasses non-treatment related activities, such as training and research, and recognises the need to consider requirements for a Community Service Obligation approach to small and rural hospitals to which an activity based funding approach may not apply.

3.2 Context

3.2.1 Changing Models of Care

Health is a dynamic environment in which change is driven by a range of factors including shifts in patterns of demand, increasing cost pressure, advances in medical technology and innovation in care practices and care models.

Within the hospital sector, emerging models of care focus on improving outcomes for high end health service users, generally those with chronic and complex conditions and on treating ambulatory sensitive acute conditions in out of hospital settings[2]. There are common elements to many new models of care, including:

- a focus on the patient at the centre of the care system;

[1] National Partnership Agreement on Hospital and Health Workforce Reform, 2008
[2] Australian Resource Centre of Healthcare Innovations, http://www.archi.net.au/

- ► increased integration between hospital and community care settings;
- ► greater co-ordination of care across professions and across agencies; and
- ► a shift from hospital to community care or primary care settings, the use of technology for remote monitoring/maintenance and shared clinical information.

Accordingly, the cost and benefits of new models of care and changed service delivery settings must be accurately assessed as part of their evaluation and future planning for additional system and service delivery reform.[3]

3.2.2 Policy directions

There is significant reform occurring across Australia in response to the common drivers of increasing demand for and increasing cost of health care delivery. In the main, these reforms centre around creating system level capacity to promote wellness and illness prevention at the population level, combined with specific clinical reforms designed to improve individual patient care. Underpinning reform is the need to deliver cost-effective health care, often through shifting care from hospital to the community and increasing early intervention into complex conditions.

An examination of the Intergovernmental Agreement on Federal Financial Arrangements, the National Healthcare Agreement and associated national policy documents has enabled the identification of a wide range of policy drivers of particular relevance to the design of activity based funding. These include the need for:

1. more integrated and responsive services for individuals and families,
2. the delivery of appropriate high quality and affordable hospital and hospital related care within a sustainable health system;
3. increased transparency in the use of taxpayer funds for public hospitals, coupled with enhanced accountability to the community;
4. the capture of consistent and detailed information on hospital sector activity and accurate measurement of the costs of delivery; with an explicit relationship between funds allocated and services provided;
5. increased accountability for the performance of all of our healthcare system;
6. improved capacity to make comparisons of efficiency across public hospitals and improved capacity to compare the performance of public and private hospitals at the sector and facility levels;

[3] Caplan G, Hospital in the Home: a concept under question, Medical Journal of Australia, 2006, 184, (12) , pp 599 – 600

7. strengthened management focus on outputs, outcomes and quality and local identification and management of variations in costs and practices by clinicians and managers;

8. development of new, cost-effective approaches and improved planning for future healthcare needs; and

9. use of the best available information, to foster innovation and sharing of practices shown to be effective with mechanisms to reward good practice and support quality initiatives.

3.2.3 National Partnership Agreement

The National Partnership Agreement provides specific guidance as to the required performance of activity based funding of public hospital services. The Agreement describes activity based funding as:

> "a management tool that has the potential to enhance public accountability and drive technical efficiency in the delivery of health services by:
>
> a) Capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery;
>
> b) Creating an explicit relationship between funds allocated and services provided;
>
> c) Strengthening management's focus on outputs, outcomes and quality;
>
> d) Encouraging clinicians and managers to identify variations in costs and practices so these can be managed at a local level in the context of improving efficiency and effectiveness; and
>
> e) Providing mechanisms to reward good practice and support quality initiatives."

In addition, the Agreement states that the above will be achieved through:

> "the development and implementation of:
>
> a) activity based funding for public hospital services;
>
> b) nationally consistent classifications and data collections for hospital provided care including admitted care, sub-acute care, emergency departments, outpatient, sub-acute and hospital-auspiced community health services ; and
>
> c) a nationally consistent costing model and, if COAG agrees, a nationally consistent funding model for hospital provided treatment (in admitted care, sub-acute care, non-admitted care emergency departments and hospital-auspiced community health services) as well as non-clinical hospital services including teaching and research.
>
> d) The costing model will build on the National Hospital Cost Data Collection (NHCDC)."

3.2.4 Application of the National Framework

Taking the above considerations into account, it is intended that the National Framework will be able to be used to:

1. support a costing model which defines the patient as the basic unit, with as many costs as possible allocated at the patient level;

2. support the achievement of a national Activity Based Funding model for those components of the health system covered by the National Partnership Agreement – that is, services provided by public hospitals;

3. ensure national consistency in the application of the infrastructure and model across Australia;

4. lead to an implementation plan which will be achievable within the 4 year time frame of the National Partnership Agreement and align to the milestones of the Agreement;

5. identify a work program that considers and maximises the use of existing data sets and classification systems where these are consistent with the objectives of the activity based funding initiative;

6. incorporate a level of flexibility that will support its relevance in the face of inevitable changes in health service delivery models and systems;

7. enable the generation of management information that can be aggregated or disaggregated to meet hospital management needs in jurisdictions; and

8. recognise the differences that exist between the jurisdictions and incorporate evidence-based practices from Australia and overseas.

3.3 Building blocks of activity based funding

3.3.1 Key elements of activity based funding

Activity based funding is a generic management tool that can be applied to a wide range of organisations and service sectors. A national approach to activity based funding is likely to comprise the following elements.

- Product Identification and classification
- Counting
- Costing
- National Data Management, Analysis and Reporting
- Funding
- Governance & Management.

It should be noted that national data management, analysis and reporting is a supporting element for other elements and for a range of activities which facilitate standardised national reporting, data consistency, benchmarking and quality assurance whilst supporting flexible local reporting requirements. In the hospital context, these elements can be defined as follows:

1.	Product Identification and Classification	A system of taxonomies that adequately classifies care across different care types and settings and to a level that allows for variation in complexity and care needs.
2.	Counting	A system that supports accurate, electronic counting of all patient related services, linking clinical and accounting feeder systems.
3.	Costing	Product level costing with as close to full cost absorption as possible yielding a nationally recognised unit cost per product type.
4.	National Data Management, Analysis & Reporting	National data management, analysis and reporting is a supporting element for counting, costing, benchmarking and (when and if required)funding and for-a range of activities which facilitate standardised national reporting, data consistency and quality assurance whilst supporting flexible local reporting requirements.
5.	Funding	A system of activity based funding based on a sound and nationally accepted activity based costs and classification of products.
6.	Governance & Management	A model of clinical and corporate governance at national, jurisdictional and regional/local level. It includes business processes and systems to support national activity based costing and funding.

3.3.2 Domains of application and workstreams

The following is a list of the domains within the public hospital sector to which each of the above elements will need to be applied to achieve the objectives of the National Partnership Agreement.

- Admitted Acute: Patients can be admitted into an acute care "ward" in hospital and in out-of-hospital settings. For example, community acute care services and hospital in the home provide acute care in the home or alternate residential settings for conditions such as deep vein thrombosis (DVT), cellulitis,

community-acquired pneumonia and acute exacerbations of chronic obstructive pulmonary disease (COPD)4,5. The AR-DRG is the nationally accepted basic grouping in use for acute inpatient care in Australia.

- Emergency Care: Emergency care is generally provided in designated Emergency Departments in hospitals. Emergency presentations, however, have a number of defining characteristics and associated costs. Most, but not all Australian states and territories use a triage system for initial classification of emergency presentations, and a range of clinical management tools are in use, but there are no common systems. There is currently no national patient level activity based costing system in place for emergency care.

- Sub-acute care: Subacute care is defined in the National Partnership Agreement as "rehabilitation, palliative care, geriatric evaluation management, and psychogeriatric care as defined in the National Health Data Dictionary 14th ed. Australian Institute of Health and Welfare, 2008". Sub-acute care is provided across a range of settings, and potentially in more than one setting during the period of an episode of care. There is a classification for sub-acute care - AN-SNAP, which is not implemented nationally.

- Mental health: The existing mental health service system is planned, structured and evaluated as an integrated service, which delivers care in the most appropriate setting dependent on patient care needs and service availability. An episode of mental illness tends to be long term and is closer in nature and treatment needs to a complex chronic condition than it is to an acute illness. The existing classification system for mental heath care is MH-CASC, which covers the integrated care of mental health patients through community-based and inpatient care, acute and sub-acute care and ongoing maintenance. All states are collecting the data required for MH-CASC and pooling this nationally. However, it is not nationally adopted as a classification tool for funding purposes.

- Outpatient care: Outpatient care covers care provided in clinics and procedures provided in an outpatient setting (such as chemotherapy and renal dialysis in some states).

- Hospital auspiced community health services: The term hospital auspiced community services describes those services funded by hospitals but provided in the context of community health centres or home-based services delivered from a community health service. This varies from jurisdiction to jurisdiction and within jurisdictions.

- Community Service Obligations (or minimum volume hospitals): This describes those services, which by their location or specialisation do not meet the critical mass of activity required to make activity based costing and funding viable. The most common example is small rural hospitals, which exist in all states and territories other than the ACT. They generally provide sub-acute inpatient and residential aged care, rehabilitation, palliation, some level of outreach such as domiciliary nursing and child health services, and varying levels of first aid or frontline emergency care. These services are central to the economic and social future of small rural communities but can not be adequately funded using a pure casemix formula, due to the small numbers of admissions and the low level of acuity. Most of the costs associated with running these services are constant and independent of admissions, particularly those that are run on minimum staffing levels. A funding model for these services should provide an incentive to provide efficient, appropriate and safe care. Block funding alone may not achieve this goal, if there are no incentives or performance measures attached to the funding.

- Teaching, training and research: Teaching, training and research has historically been the province of large teaching hospitals. With the development of rural hubs for universities, the development of clinical schools attached to hospitals in rural centres, increased focus on rural medical placements and GP procedural training, it is now accepted that teaching, training and research occurs in more settings than teaching hospitals. Teaching, training and research often comprise activities that can be apportioned at the patient level and activities that cannot. There is no nationally standardised methodology for classifying, counting and allocating costs to teaching, training and research.

It should be noted that state-wide, supra-state and specialty services are in place in most jurisdictions and that these will require special consideration. It will be necessary that services such as these that may not be readily

[4] Richards D, Toop L, Epton M, McGeogh G, Town G, Wynn-Thomas S, Dawson R, Hlavac M, Warno A, Abernethy P, Home Management of Mild to Moderately Severe Community-Acquired Pneumonia: a randomized controlled trial, Medical Journal of Australia, 2005, Vol 5, pp 235 – 238

[5] Wilson A & Parker S, Hospital in the Home: what next?, Medical Journal of Australia, 2005, Vol 5, pp228 – 229.

located in one of the workstreams be identified prior to the commencement of the business case process, so that if necessary, a brief business case on the proposed treatment of such exceptions can be prepared. A nationally consistent approach to these exceptions will need to be developed during the life of the National Implementation Plan.

The diagram below shows the intersections of the six ABF elements defined above and the 8 hospital activity domains.

Each intersection represents a discrete area of developmental work for this initiative. For example, developmental work will be required to improve systems and processes for the counting of treatment events in Emergency Departments (A); and in the development of data management infrastructure (manuals, definitions) for outpatients (B). In what follows, these 8 domains are described as workstreams.

		WORKSTREAMS							
ABF Elements		Admitted acute	Emergency	Subacute	Outpatient	Mental health	Community	Teaching and research	Community service obligations
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Product identification and classification	**1**								
Counting	**2**		**A**						
Costing	**3**								
National data management	**4**				**B**				
Funding	**5**								
Governance and management	**6**								

It is important to note that the successful implementation of the commitment to activity based funding in public hospitals will require development at every intersection shown in the diagram, noting that some areas require more work than others and that consistency of approach across workstreams is clearly desirable.

The remainder of this National Framework focuses on analysis the ABF elements as they are to be applied in this initiative. The Implementation Plan will be structured around the application of the elements to the eight workstreams.

3.4 Element 1: Product identification and classification

3.4.1 Definition

Product identification and classification relates to a system of taxonomies that adequately classifies care across different care types and settings and to a level that allows for variation in complexity and care needs.

3.4.2 Principles

Governing principles for this element of the National Framework encompass:

- Products should be defined at the patient level wherever possible. Exceptions to this are in the areas of:
  - Teaching, training and research
  - Community service obligations (i.e. minimum volume hospitals)
  - Health promotion/prevention and community development work, where these are hospital auspiced activities.
- The list of exceptions should be kept to a minimum wherever possible.
- It should be possible to track patients across settings increasing the flexibility of funding, bundling episodes of care and facilitating integrated health care service costing.
- Characteristics other than diagnostic or procedural that describe variations in patients, such as complexity, treatment regime, setting etc. or resource utilisation, should be taken into account in the identification of products and developing appropriate classification systems.
- Product identification and classification should be based on information routinely collected and on existing systems wherever possible.
- There should be maximum capacity to modify and update the classification system in a cost efficient manner and to ensure free access and use of the funding model by jurisdictions.
- Jursidictions should at a minimum adopt commensurable versions of respective classification systems, and at the optimum adopt the most recent version wherever possible.

3.4.3 Possible methods or processes

Possible methods of implementing some of the principles listed above include but are not limited to:

- ICD-10-AM being identified as the default clinical taxonomy for patients in all settings.
- A unique/common patient identifier being used to track patients across settings.
- Additional patient characteristics being defined for different product types via data sets which could be appended to the patient record
- The Commonwealth of Australia owning the intellectual property of any patient classification systems developed and implemented. Vested IP has the potential to recover some costs (through overseas sales) of development.

3.4.4 Minimum Set of Activities

The table below outlines broadly the minimum set of activities that would need to be pursued to successfully put in place nationally consistent coding and classification systems across health services. This template has been used in defining the specific work program for hospital auspiced services which is presented in further detail in the accompanying Implementation Plan.

Element	SEQUENTIAL STEPS
Product Identification & Classification	1. Identify and develop a list of candidate data items that enhance product identification and definition. These typically relate to data items that predict product homogeneity, resource consumption or add further depth to describing and distinguishing the product. Examples may include outcomes measures such as HONOS, functional indicators such as FIMs or Bartels, disease staging, disposition codes, etc. Both candidate and final data item sets will need to be identified and developed through this stage.. 2. Harvest information plus review information required. 3. Develop classification 4. Pilot 5. Evaluate pilot 6. Modify Classification Grouper software – develop/build/resource/implement/train – (IP issues to be resolved) 7. Develop IT strategy specific to ABC (include processes for linking existing feeder systems and new systems) 8. Modify/acquire suitable management systems 9. Manuals 10. Training of relevant professionals 11. System support 12. Implement 13. Monitor (use quality circle) 14. Refine

3.5 Element 2: Counting

3.5.1 Definition

Counting encompasses systems that support accurate, electronic counting of all patient related services, linking clinical and accounting feeder systems.

3.5.2 Principles

Governing principles for this element of the National Framework encompass:

- There should be national consistency and confidence in how similar products are defined, counted and reported across jurisdictions.
- Counting systems should be a natural by-product of health information systems and not require secondary or one off data collections.
- Counting rules and systems should not create any undue burden on clinicians nor should it reduce their capacity to undertake clinical activities.
- Counting rules should be introduced only if found to be cost effective and of benefit to the health system.
- Counting rules should support service integration and co-ordination.

3.5.3 Possible methods or processes

Possible methods of implementing some of the principles listed above include but are not limited to:

- The establishment of nationally consistent rules to ensure similar products are defined, counted and reported in the same way across jurisdictions.
- Routine audits undertaken to ensure that counting of products is undertaken in a consistent and systematic manner across all jurisdictions.
- The development of counting rules that are based on the patient/product and setting independent wherever possible

3.5.4 Minimum Set of Activities

The table below outlines broadly the minimum set of activities that would need to be pursued to successfully put in place nationally consistent counting rules across health services. This template has been used in defining the specific work program for hospital auspiced services which is presented in further detail in the accompanying Implementation Plan.

Element	SEQUENTIAL STEPS
Counting	1. Define counting rules 2. Develop Minimum Data Sets 3. Acquire or modify information systems 4. Develop manuals 5. Training of relevant professionals 6. Implement (Required date) 7. Monitor/Audit 8. Refine 9. Report

3.6 Element 3: Costing

3.6.1 Definition

Costing encompasses product level costing with as close to full cost absorption as possible yielding a nationally recognised unit cost per product type.

3.6.2 Principles

Governing principles for this element of the National Framework encompass:

- Wherever possible the patient should be the basic unit of costing.
- Where possible actual costs of patient care should collected and calculated through inputs from feeder systems.
- Costing based on utilisation or consumption patterns should be supported and replace cost modelling processes.
- Processes should be in place that support nationally standardised methodologies to ensure national consistency and maintain user confidence in the outputs of activity based costing.
- Focus on improving costing methods should be given to areas with highest explanatory power for cost variations. This is likely to occur in improved intermediate cost allocation processes rather than overhead distributions.
- Product costing should be undertaken as a by-product of available information. Any costing that requires ongoing secondary data collection should require a cost benefit analysis to be undertaken prior to committing to ongoing data collections.
- Costing should be comprehensive and transparent, aiming to be as close to full absorption costing as possible.
- Capital and depreciation standards should be adopted and incorporated into any activity based costing processes.

3.6.3 Possible Methods or Processes

Possible methods of implementing some of the principles listed above include but are not limited to:

- Strategies are required to be developed for the implementation of clinical information systems which will provide the mechanism for identification of activity and costs at the patient level.
- Strategies should be developed to meet the need to maintain (and periodically upgrade) costing systems
- Conduct annual review of products with significant cost variation to understand the underpinning rationale for such variation.
- Conduct regular reviews of the service utilisation and costing allocation methods used in deriving the activity based costs.
- Policy needs to be developed for the costing methods to be deployed for services deemed to be “community service obligations”.
- Appropriate training plans and programs need to be developed and implemented to support activity based costing.
- A nationally standardised process for correlating charts of accounts, cost centre definitions and allocative processes should be in place.
- A standard costing methodology should be developed to facilitate activity based costing and engender a high degree of confidence in the resultant outputs.

- Regular audits of focussing on compliance against allocative processes and quality of data should be undertaken.

3.6.4 Minimum Set of Activities

The table below outlines broadly the minimum set of activities that would need to be pursued to successfully put in place nationally consistent costing methods and systems across health services. This template has been used in defining the specific work program for hospital auspiced services which is presented in further detail in the accompanying Implementation Plan.

Element	SEQUENTIAL STEPS
Costing	1. Develop costing standards and methodology 2. Collect data and activity 3. Identify costs 4. Routine collection of costs 5. Implement 6. Develop manuals 7. Training of relevant professionals 8. Monitor 9. Refine

3.7 Element 4: National data management, analysis and reporting

3.7.1 Definition

National data management, analysis and reporting is a supporting element for counting, costing, benchmarking and (when and if required) funding and for a range of activities which facilitate standardised national reporting, data consistency, and quality assurance whilst supporting flexible local reporting requirements

3.7.2 Principles

Governing principles for this element of the National Framework encompass:

- National data management, analysis and reporting should support easy access to activity based costing information subject to appropriate security provisions.
- There should be national accessibility, consistency and high quality in data collected through activity based costing processes.
- There should be flexibility for jurisdictions to review and resubmit data as part of activity based costing and funding processes.
- The by-products of implementing the National Framework should support policy decision making processes, quality assurance activities and foster greater understanding of health service delivery.
- Data management should support appropriate and relevant peer groupings of health services, relevant to the data being benchmarked.
- Data required and produced should be relevant and of value to the system.

3.7.3 Possible Methods or Processes

Possible methods of implementing some of the principles listed above include but are not limited to:

- A national data warehouse for national activity based health care data could be established, along with a single data set of national activity based cost data.
- Reporting frameworks could be routinely reviewed to determine the utility of the resultant data and value to the system. For example the NHCDC reporting framework should be reviewed to identify areas for improvement and consistency.
- Establishment of Round Tables for specific interest areas could be established utilising the data generated through the implementation of the National Framework.
- Nationally consistent data edits, integrity checks and trimming algorithms should be agreed to.

3.7.4 Minimum Set of Activities

The table below outlines broadly the minimum set of activities that would need to be pursued to successfully put in place nationally consistent national data management, analysis and reporting across health services. This template has been used in defining the specific work program for hospital auspiced services which is presented in further detail in the accompanying Implementation Plan.

Element	SEQUENTIAL STEPS
Reporting	1. Develop appropriate reporting frameworks 2. Routine collection of data 3. Undertake relevant quality assurance assessment of data 4. Submit data to central co-ordinating body 5. Generate relevant data for specified purposes 6. Monitor utility of data 7. Refine reporting frameworks

3.8 Element 5: Funding

3.8.1 Definition

Funding within the context of this National Framework refers to a system of activity based funding based on sound and nationally accepted activity based costs and classification of products.

There are two stages within the National Partnership specifying required outcomes with regards to funding[6].

Stage 2 of the National Partnership Agreement requires:

Complete development of a common approach to costing of small or regional hospitals with community service obligations that will not be adequately funded using activity-based funding, in order to inform funding strategies. Implement funding strategies for training, research and development and other activities not directly related to treatment of individual patients. This work should establish a common public and private funding framework for teaching and research.

Stage 4 of the National Partnership Agreement requires:

Complete development of an activity-based funding methodology, including methodology for setting price, incentives, and transition arrangements. Subject to COAG decision – Use of an activity-based funding model would begin from 2014-15, with an evaluation undertaken after the first year of operation.

This section relates to the development of an activity based funding methodology and the required actions to implement should COAG agree. It should be noted that within the context of the National Implementation Plan the development of funding strategies should also make provision for agencies providing community service obligations and for teaching and research and other non patient related activities.

3.8.2 Principles

Governing principles for this element of the National Framework encompass:

- The activity based funding framework should be underpinned by activity based costing models.
- An activity based funding framework should:
    - Support principles of equity of access, service integration and co-ordination
    - Take account of specific services that are provided to a target population including the safeguarding of funding of selected speciality services that benefit the entire health system, are provided in limited locations, etc.
    - Support methods of estimating relative needs for the target population
    - Take account of cross border flows
    - Be flexible enough to cope with changes to service type, care type, boundaries or service delivery methods
    - Ensure the resource allocation process is efficiently administered, transparent and easily understood by all stakeholders
    - Be capable of reporting and acquitting against agreed frameworks of outcomes and outputs
    - Support technical and allocative efficiency of service delivery
    - Be designed utilising the best available information with information gaps to be systematically addressed; and

[6] National Partnership Agreement on Hospital and Health Workforce Reform, 2009.

- Be responsive to changes in policy direction and service provision.

- Activity based funding models should be capable of providing meaningful data to inform policy development.
- Activity based funding models should support and enhance innovative approaches to health service delivery.
- Funding models for small rural hospitals with community service obligations should support efficiency and quality of care, even if not based on activity.
- Funding models for teaching and research should support research and teaching across the entire system, including in rural and regional hospitals.
- Funding models for teaching and research should enable transparent counting and costing of teaching and research activities, even if funding at the patient level is found not to be appropriate.

3.8.3 Possible Methods or Processes

Possible methods of implementing some of the principles listed above include but are not limited to:

- The establishment of an ongoing research and development plan to address identified information gaps.
- The development of a methodology for funding small hospitals that includes incentives for efficiency and quality of care.
- The development of funding models that take account of population health needs and activity based funding to provide incentives for the provision of efficient, high quality health services that meet population needs.

Outcomes for some of the principles listed above will require further development should COAG agree to the implementation of activity based funding.

3.8.4 Minimum Set of Activities

The table below outlines broadly the minimum set of activities that would need to be pursued to successfully put in place nationally consistent activity based funding across health services. This template has been used in defining the specific work program for hospital auspiced services which is presented in further detail in the accompanying Implementation Plan.

Element	SEQUENTIAL STEPS
Funding	1. Develop funding model framework 2. Develop model 3. Sensitivity analysis 4. Final model 5. Price setting 6. Develop guidelines 7. Training of relevant health professionals 8. Implement (for Community Service Obligations and training and research 2010–11 and, if COAG agrees, for ABF 2014-15) 9. Communicate

3.9 Element 6: Governance and management

3.9.1 Definition

Governance and Management encompass models of clinical and corporate governance at national, jurisdictional and regional/local level. It includes governance of business processes and systems to support national activity based costing and funding.

3.9.2 Principles

Governing principles for this component of the National ABF Framework encompass:

- Governance and management arrangements should be built upon existing infrastructure.
- Governance should be linked throughout the system from national to local levels.
- Governance and management should enable the Commonwealth and States and Territories to work in a partnership, with involvement, as appropriate, of key stakeholder groups.
- Governance and management arrangements should encourage processes to support parallel developments and collaborative learning across jurisdictions.
- Wherever possible the private health sector and, in particular, private hospitals should be included within work programs extending from the adoption of the National Framework.

3.9.3 Possible Methods or Processes

Possible methods of implementing some of the principles listed above include but are not limited to:

- For the monitoring and accountability of the National Framework for hospital auspiced services, existing governance arrangements in place should be utilised. These include:
    - The relevant Australian Health Ministers Advisory Council committees such as the Health Policy Priority Principle Committee for broad policy oversight of the initiative, and the National Health Information Standards and Statistics Committee for endorsement of national data developed for collection;
    - The National Partnership Agreement for Hospital and Health Workforce Reform Steering Committee for national management and coordination of implementation; and
    - The National Health Information Agreement (NHIA), as a vehicle for the articulation of health information data development priorities and processes, noting that it has been agreed that the NHIA will be reviewed to better align it with current intergovernmental policy priorities.
- National governance arrangements should be linked to the jurisdictional governance arrangements, which should link to local or regional governance arrangements.
- The application of a partnership governance model for the National Framework that enables the Commonwealth and States and Territories to work with key stakeholder groups such as:
    - clinicians;
    - technical specialists in patient classification, and public sector costing and funding as they apply to hospitals; and
    - the private sector, and in particular, private hospitals.

3.9.4 Minimum Set of Activities

The table below outlines broadly the minimum set of activities that would need to be pursued to successfully put in place nationally consistent governance and management systems across health services. This template has

been used in defining the specific work program for hospital auspiced services which is presented in further detail in the accompanying Implementation Plan.

Element	SEQUENTIAL STEPS
Governance	1. Define the national governance model. 2. Establish roles and accountability with existing governance committees. 3. Identify additional committees or work groups (if required). 4. Develop jurisdictional and regional governance models. 5. Establish roles and accountability with existing governance committees 6. Identify additional committees or work groups (if required). 7. Review existing compliance processes 8. Develop ongoing monitoring and compliance processes.

3.10 Considerations impacting upon the implementation and take-up of the National Framework

A number of common issues have been identified during the development of the National Framework and Implementation Plan and are outlined below.

3.10.1 Patient Level Costing

There is strong support for the concept of the patient level unit as being the basic unit for costing, capable of aggregation to meet the reporting requirements of the Commonwealth and States/Territories. It is considered that this will support emerging models of care and increased community based models of care, and ensure the ABF model is designed to accommodate future reforms in patient-centred service delivery.

3.10.2 Nationally standardised definitions

Generally there is agreement on the need for a nationally standardised approach to definition, classification, counting and costing for outpatient care (including procedures that were previously inpatient), sub-acute care and emergency care. In the main, there is agreement on the need for a nationally standardised approach to the definition, classification, counting and costing for teaching, education and research. There is common interest in the development of nationally agreed definitions that reduce the ambiguity in service boundaries, particularly between emergency, inpatient, outpatient and hospital based community services.

3.10.3 IT Infrastructure

To varying degrees, all jurisdictions are expressing concern regarding the development and implementation of adequate IT infrastructures and feeder systems to ensure capture of relevant patient level costing data that is as near to complete as possible.

The capacity to collect relevant data to support product identification, classification and costing is heavily Information and Communication Technology dependent and requires significant investment and lead time to roll out. This needs to be factored into any business case undertaken defining the work programs to be pursued as a result of rolling out the ABF Framework.

3.10.4 Workforce and training

There are resourcing as well as skill set issues that need to be addressed. Sufficient resources need to be available at local service delivery, jurisdictional and national levels to ensure that relevant activities embodied in the framework are achieved. For example coding staff, analysts, finance officers, etc. will need to be available to implement the work embodied within the framework. In a climate where health services at all levels are facing difficulties in recruiting staff and are often contracting the staffing establishment numbers, having access to sufficient resources may prove to be problematic. Within this context, having sufficiently experienced staff to undertake relevant tasks embodied by the framework may also create barriers to the timely implementation of the framework and accordingly appropriate training strategies will need to be embodied in any resultant implementation plan.

Training needs to be identified in all elements of the Implementation Plan and on an ongoing and routine basis to ensure that appropriate skill sets and expertise is achieved and maintained across the health sector.

3.10.5 Timeframes

It should be recognised that the timeframes for this initiative are challenging and that successful completion requires a shared, detailed understanding of implementation processes, deliverables and timing; and strong commitment of the parties to meeting the project objectives through collaboration, effective coordination and regular communication.

4. National Implementation Plan – Initial Plan May 2009

4.1 Introduction

The core of this Implementation Plan is in the schedules included section 4.8 below.

The schedules are structured around the 8 workstreams and the 6 ABF elements described in the National Framework and are linked to the timeframes set out in the National Partnership (see 4.2 below). The schedules also include information on performance measurement, indicative resource allocation and jurisdictions' responsibilities.

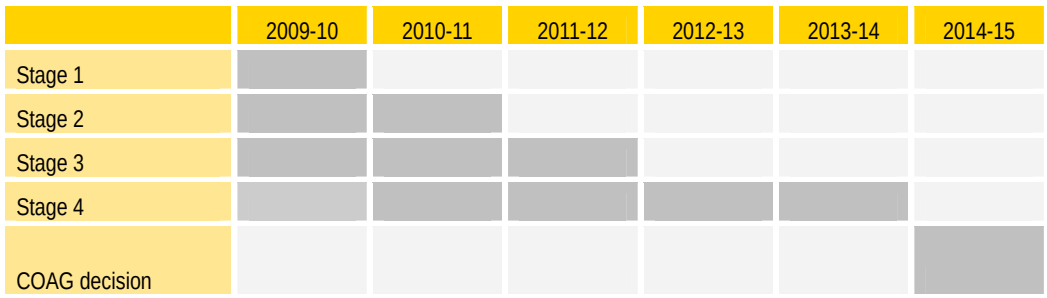
It is important to note that this Implementation Plan is a work in progress, which will shape, and be shaped by, the jurisdictional implementation plans which are to be completed in August 2009. Interim commitments made against this plan may be altered following the additional work undertaken to develop the jurisdictional plans. This National Implementation Plan – Initial Plan May 2009 is an active document and will be subject to regular revision and updates within the current scope of the National Partnership Agreement.

Jurisdictions are committed to development and implementation with the timeframes of the National Partnership Agreement but to address changes that might occur in the life of the National Partnership, the elements that are implemented will be subject to a continuous improvement cycle.

The successful implementation of this plan is dependent on the mitigation or management of identified risks (see below).

4.2 Implementation Stages

The National Partnership Agreement outlines four implementation stages, as shown in the following table. The Stages are not consecutive. The staggering of the end dates reflect the relative complexity of tasks involves in the stages. The Implementation Plan schedules that follow assume that Stages 2, 3 and 4 will commence early in 2009-10.



Stage 1: Acute inpatient services. Complete developmental work on an agreed patient classification system and refined casemix costing methodology.

Stage 2: Costing small and regional hospitals. Complete development of a common approach to costing of small or regional hospitals with community services obligations that will not be adequately funded using activity based funding, in order to inform funding strategies.

Stage 2: Funding strategies. Implement funding strategies for training, research and development and other activities not directly related to treatment of individual patients. This work should establish a common public and private funding framework for teaching and research.

Stage 3: Common classification and costing methodology. Complete developmental work related to the achievement of a common casemix classification and costing methodology for emergency department services, sub-acute care and outpatient services and hospital- auspiced community health services, including mental health, undertaken in several stages.

Stage 4: Activity-based funding methodology. Complete development of an activity-based funding methodology, including methodology for setting price, incentives, and transition arrangements. Subject to COAG decision—use of an activity based funding model would begin from 2014-15, with an evaluation undertaken in the first year.

4.3 Measuring progress

4.3.1 Performance measures

The States and Territories have agreed to report progress in the implementation of the activity based funding initiative against the following performance indicators

From the beginning of 2009-10 (baseline 1 July 2010, annual reporting):

- uptake of nationally consistent admitted patient costing methodology (percentage of public hospitals by state); and
- uptake of agreed national admitted patient classification system (percentage of public hospitals by state).

From the beginning of 2010-11 (baseline 1 July 2011, annual reporting):

- uptake of a nationally consistent model for costing small or regional hospitals (percentage of small and regional public hospitals participating in new costing model, by state); and
- uptake of a nationally consistent approach to funding activities not related to treatment of individual patients (percentage of relevant participating public hospitals, by state).

From the beginning of 2013-14 (baseline 1 July 2014, annual reporting):

- uptake of common casemix classification and costing methodology for emergency department services, sub-acute, outpatient services and hospital-auspiced community health services (percentage of public hospitals, by state).

From the beginning of 2014-15 (baseline 1 July 2015, annual reporting):

- if agreed by COAG, uptake of activity based funding methodology, including methodology for setting price and incentives (percentage of public hospitals, by state).

4.3.2 Targets

The following performance targets are set out in the National Partnership Agreement:

- By 30 June 2011, 100 per cent of admitted episodes classified and costed using the nationally consistent model.

- By 30 June 2015, 100 per cent of emergency department services, sub-acute, outpatient services and hospital-auspiced community health services classified and costed using the nationally consistent model.

- If agreed by COAG, by 30 June 2016, 100 per cent of admitted episodes, emergency department, sub-acute outpatient services and hospital-auspiced community health services funded through a nationally consistent activity based funding model, including 100 per cent application of a nationally consistent approach to funding of small and regional hospitals with community service obligations.

4.4 Risks

A number of risks have been identified, which if not managed may impact on the capacity of the parties to deliver on the commitments in the National Partnership Agreement.

4.4.1 Jurisdictional capability

In order to undertake the necessary work required to achieve the outcomes of the National Partnership Agreement, jurisdictions will need to identify and allocate ongoing resources and staff. Where there are staffing restrictions applied at jurisdictional level or other resourcing limitations that will impact on the capacity to plan and implement required elements of the Implementation Plan, this will represent a risk to its successful completion.

4.4.2 Information infrastructure

The successful implementation of activity based costing at patient level relies on significant investment in clinical information systems and other feeder systems for products such as pharmacy, radiology, pathology etc. This is an investment in time and resources, which applies to IT infrastructure, hardware and software as well as knowledge management systems and processes. There is a risk that jurisdictions will not have adequate time and resources available to fully implement “gold standard” systems and processes within the required timeframes.

4.4.3 Workforce

There is a national shortage of health information staff, including qualified Health Information Managers and coders. Some jurisdictions have advised of ongoing shortfalls at the local level in the skills required to adequately classify, code and count patients. It takes time to adequately train staff in the more complex tasks associated with activity based costing – 2-3 years is an estimated average. There is a risk that there will be inadequate skilled staff available at jurisdictional and local level to effectively introduce and maintain activity based costing.

4.4.4 Clinician engagement

Clinicians are central to the success of an activity based costing and funding strategy. They are responsible for initial diagnosis and follow up extensions or amendments to diagnosis as well as clinical care models. There is a risk that clinicians will not support activity based costing if:

- systems and processes are introduced that do not match evidence based practices;

- they feel excluded or disadvantaged by activity based costing and funding;

- they are not engaged early and become part of the design of the system; or

- they lack the necessary skills and motivation to work within an activity based costing system.

4.4.5 Ongoing Process for Quality Review

The flow on effects of some of the activities embraced within the ABF Framework and Implementation Plan may take time until they are fully realised. This may be due to the lack of available skilled resources, or time necessary to move from research to operational/full implementation. Accordingly it is critical that appropriate ongoing quality review mechanisms are established throughout and beyond the life cycle of the National Partnership to monitor the outcomes, impacts and benefits of implementing the ABF Framework.

4.5 Interdependencies and cross cutting issues

4.5.1 E-Health

This plan intersects with the work being undertaken by NEHTA in developing a national e-health strategy and supporting infrastructure. The NEHTA initiative to develop a unique patient identifier for all Australians is particularly important to linking cross setting episodes of care related to a single patient condition.

4.5.2 Workforce

Current national commitments and work being undertaken at the national level on health workforce reform include strategies to address existing and predicted health workforce shortages. This plan will need to link to and inform existing national initiatives to review and plan for current and future health workforce. Workforce shortages, particularly in the areas of health information management, coding and data analysis, are likely to impact on planning for a number of workstreams in this plan and this will need to be considered in the business planning and implementation strategies for each workstream..

4.5.3 State-wide services

In most jurisdictions there are services provided out of particular hospitals that are state-wide or intra-state services. These include "statewide" services provided through a single hospital like a Drug Information Service (phone help-line for poisonings), TB Statewide Service and a Retrieval Service. Other types of services or products are thought to be very high cost items that would not appropriately be allocated through inpatient or non-inpatient classifications and weights, like highly specialised drugs; and home based services auspiced through hospitals like home dialysis and home oxygen. Such services may not easily fit into any of the defined workstreams and may apply across more than one workstream. Business cases for workstreams will need to consider these cross-cutting or supra services, in terms of definition, classifying, counting and costing models.

4.5.4 Information Technology Infrastructure

The capacity to undertake projects within given workstreams will in part be dependent upon the level of existing infrastructure in supporting information technology. The development of appropriate business cases may need to factor in IT support and capacity requirements at an early stage.

4.5.5 Other components of the National Partnership

In constructing the Implementation Plan recognition was given to the overlap between the ABF and other elements of the National Partnership, specifically the Emergency Department and Sub-acute components. Every effort has been made to ensure that the proposed work program embodied in this Implementation Plan complements the work proposed to be undertaken through these other elements of the National Partnership.

4.6 Business cases

It has been agreed that a business case will be prepared to initiate each workstream. Since each workstream is essential to successful implementation, the purpose of a business case will not be to determine whether or not to proceed with the workstream to which it relates. Rather, it will be to identify options for progressing the workstream and the optimal approach, based on a consideration of relative merits or the options. A number of the business cases will need to deal with matters of scope within the parameters of the National Agreement.

Business cases will vary in their complexity. In some cases a business analysis rather than a full blown business case will be adequate to address the key issues of product identification, classification, counting, costing and data management that need to be considered. Business analyses need to review proposed actions against the particular strategy and consider cost versus benefit plus return on investment for the workstream being

considered. The aim of the analysis is to assess the value of the resources required (human and financial) to develop an activity based costing model against the benefits and outcomes. The business analysis should therefore consider a range of options for product identification, classification, counting, costing and data management, which may include empirical estimate or averaged costing where specific ABC methodologies at patient level will have a high resource cost and create an impost on the system that is not justified in terms of return.

Business cases will need to consider interdependencies and cross-cutting issues, particularly those related to state-wide and intra-state services, specialty services, health workforce and IT infrastructure.

As the business cases will inform threshold decisions, it is essential that their preparation commences immediately. The National Partnership Agreement Implementation Steering Committee will be responsible for the preparation of business cases, and will establish a working group to progress them without delay.

4.6.1 Outline of Business Case Considerations to be identified by Workstream

The following list identifies key issues that need to be addressed in the development of a business case under any of the workstreams listed in the ABF Framework. Each business case is tailored to meet the specific work program or activities under consideration but should cover each of the following points:

- A brief, compelling, service-oriented problem statement
- A mission statement or vision of the future that addresses the problem
- A description of the specific objectives to be achieved
- A description and rationale for the individual approaches
- Consideration of cross-cutting issues such as workforce, IT infrastructure and information systems and how these are linked across workstreams.
- Identification of a preferred approach and the rationale for this preference
- A statement of the benefits that address the concerns of all relevant stakeholders
- An assessment of the impost on relevant stakeholders of the respective approaches
- Measures for gauging improved performance or progress toward each objective
- A statement of the likely risks of the approach and how they will addressed
- A basic plan of work with a timeline and key milestones
- A project management plan and names and roles of key managers
- Alternatives considered and how they would or would not work
- Cost estimates and potential sources of funding
- Opposing arguments and responses to them

4.7 Lead agencies

Implementation will involve research into, for example, classification development, cost drivers and cost models for several non-admitted care types. Piloting of prototypes will also be required.

Jurisdictions should self nominate where they consider they are best placed to act as lead agency for these activities. The role of the lead agency is not to promote jurisdictional interests but rather to progress the

advancement of the National Framework such that it achieves national consistency, acceptance and on-time delivery as agreed by all.

Decisions concerning the lead agency role for the various research and piloting projects should be made immediately following consideration of the relevant business case.

4.8 ABF Work Program

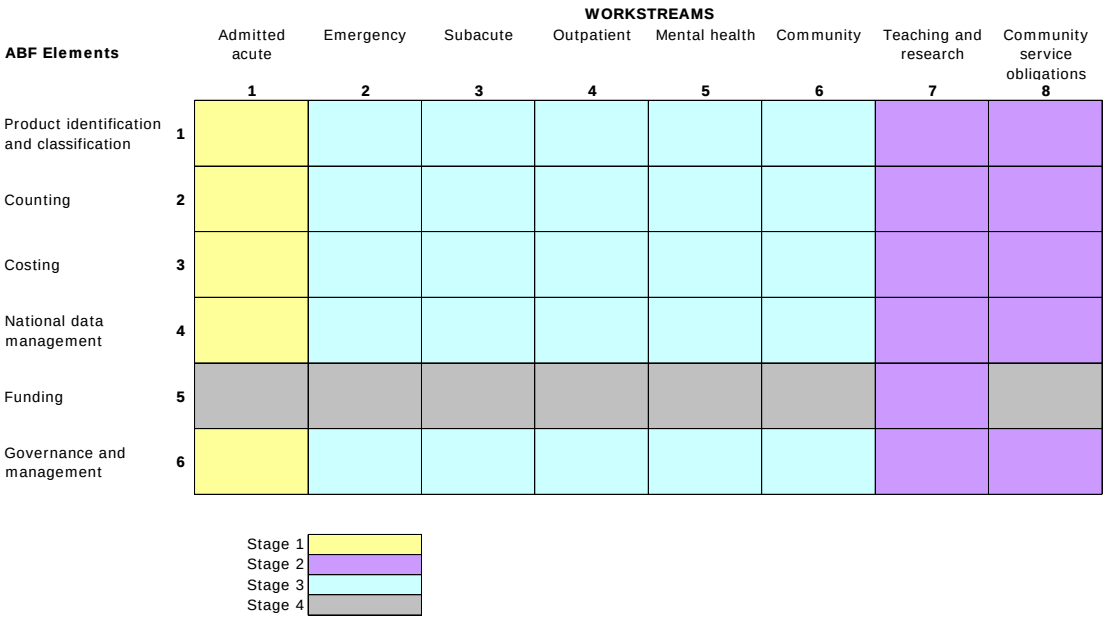
4.8.1 Relationship between NPA Stages, Workstreams and ABF Elements

The matrix below shows the relationship between ABF elements, workstreams and the National Partnership Agreement Stages and builds upon the diagram in Section 3.4.4 above.

Each work schedule focuses on one of the eight workstreams and is divided into six segments each representing each of the key ABF elements.

The colouring links the schedules to the National Partnership timeframes.

Relationship between ABF elements, Workstreams and National Partnership Agreement Stages



4.8.2 Workstream schedules

Workstream 1: Admitted Acute

Admitted Acute - Expenditure comparison between jurisdictions and Commonwealth					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Commonwealth	0.69	0.59	0.63	0.39	2.30
Jurisdictions	4.43	4.23	4.04	4.88	17.58
TOTAL	5.12	4.82	4.67	5.27	19.88

Relationship to National Partnership	
Stage 1	Acute inpatient services – Complete developmental work on an agreed patient classification system and refined casemix costing methodology. - By end of 2009/2010
Stage 2	N/A
Stage 3	N/A
Stage 4	Complete development of an activity-based funding methodology, including methodology for setting price, incentives, and transition arrangements. Subject to COAG decision – Use of an activity-based funding model would begin from 2014-15, with an evaluation undertaken after the first year of operation. - By end of 2013/2014

National Partnership Agreement – Performance Measures	
C11 From the beginning of 2009-10 (baseline 1 July 2010, annual reporting):	(a) Uptake of nationally consistent admitted patient costing methodology (percentage of public hospitals by state). (b) Uptake of agreed national admitted patient classification system (percentage of public hospitals by state).
C14 From the beginning of 2014-15 (baseline 1 July 2015, annual reporting):	f) If agreed by COAG, uptake of activity based funding methodology, including methodology for setting price and incentives (percentage of public hospitals, by state).

Actions					
	2009-10	2011-12			
ABF Elements	Tasks		Responsibility	Lead	NPA stage
Product identification & classification	• Confirm AR-DRG as the appropriate nationally consistent classification of Admitted Acute patients • Develop AR-DRG development program and training tools and courses to support consistent implementation of AR-DRG's across Australia • Establish, formalise and develop appropriate definition of exceptional products (state-wide services, etc.) within the acute workstream that need to be addressed in a manner different to that defined for Admitted Acute patients		National and State/Territory		1

Counting	• Review and ratify current MDS and associated counting rules regarding acute inpatients • Establish, formalise and develop audit program for nationally consistent Counting Rules for admitted acute patients • Establish, formalise and develop appropriate counting rules of exceptional products (state-wide services, etc.) within the acute workstream that need to be addressed in a manner different to that defined for Admitted Acute patients • Develop training documentation and courses for Counting Rules		National and State/Territory		1
Costing	• Develop national standards, including for capital expenditures • Review National Accounting Infrastructure to ensure cost allocation processes and metrics are consistent and producing reliable estimates admitted acute care costs - modify where required • Establish, formalise and develop appropriate costing standards and processes for exceptional products (state-wide services, etc.) within the acute workstream that need to be addressed in a manner different to that defined for Admitted Acute patients • Develop documentation and training modules to promulgate costing standards nationally		National and State/Territory		1
National data management	• Review and refine where appropriate the current "peer" groupings used to present hospital data and costing information • Review, establish or enhance data transmission processes for appropriate clinical and costing data • Enhance access to a national data repository to maximise the utility of jurisdictional data		National and State/Territory		1
Funding		• Building on the strengths of existing jurisdictional and national funding arrangements develop and negotiate national agreement to principles of nationally consistent funding model regarding equity, incentives, special considerations etc in the context of the Stream under development. Calibrate the chosen funding model, test its sensitivity to data variations and readjust calibrations where appropriate, determine price points and ready the model for implementation in the event it is ratified for national implementation	National and State/Territory		4
Governance and management	• Establish mechanisms to ensure governance arrangements include representation of stakeholders views, eg, clinicians, private hospitals, costing/funding experts • Confirm reporting processes in compliance with the National Partnership commitment to reporting and make any necessary adjustments		National and State/Territory		1

National Partnership Agreement – Performance Targets

C15 By 30 June 2011, 100% of admitted episodes classified and costed using the nationally consistent model.

C17 If agreed by COAG, by 30 June 2016, 100% of admitted episodes, emergency department, sub-acute outpatient services and hospital-auspiced community health services funded through a nationally consistent activity based funding model, including 100% application of a nationally consistent approach to funding of small and regional hospitals with community service obligations.

Workstream 2: Emergency

Emergency Department - Expenditure comparison between jurisdictions and Commonwealth					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Commonwealth	0.78	0.89	0.73	0.39	2.78
Jurisdictions	3.16	3.10	6.66	8.14	21.06
TOTAL	3.94	3.99	7.39	8.53	23.84

Relationship to National Partnership	
Stage 1	N/A
Stage 2	N/A
Stage 3	Complete developmental work related to the achievement of a common casemix classification and costing methodology for emergency department services, sub-acute care and outpatient services and hospital-auspiced community health services, undertaken in several parallel stages. - By end of 2012/2013
Stage 4	Complete development of an activity-based funding methodology, including methodology for setting price, incentives, and transition arrangements. Subject to COAG decision – Use of an activity-based funding model would begin from 2014-15, with an evaluation undertaken after the first year of operation. - By end of 2013/2014

National Partnership Agreement – Performance Measures	
C13 From the beginning of 2013-14 (baseline 1 July 2014,annual reporting):	(e) Uptake of common casemix classification and costing methodology for emergency department services, sub-acute, outpatient services and hospital-auspiced community health services (percentage of public hospitals, by state).
C14 From the beginning of 2014-15 (baseline 1 July 2015, annual reporting):	f) If agreed by COAG, uptake of activity based funding methodology, including methodology for setting price and incentives (percentage of public hospitals, by state).

Actions

	2009-10	2010-11	2011-12	2012-13	2013-14			
ABF Elements	Tasks					Responsibility	Lead	NPA stage
Product identification & classification	Review existing classifications in use within Australia and overseas and determine their utility within the Australian setting Build business cases for projects planned for subsequent years	Refine existing systems or undertake development work to test and define a "greenfield" classification	Finalise the classification definition and establish documentation, grouper software, training manuals and supporting documents	Prepare a refinement processes for the classification over time		National and State/Territory		3
Counting	Build business cases for projects planned for subsequent years	Define Counting Rules and gain multilateral agreement to ratify required Minimum Data Sets	Develop documentation and supporting materials to facilitate uniform counting nationally and to support the specification of ICT changes within the different settings across Australia	Establish audit and monitoring processes to ensure compliance with nationally agreed standards		National and State/Territory		3

Costing	Build business cases for projects planned for subsequent years	Established agreed nationally consistent cost allocation processes within the domain of the Workstream and the allocation of hospital overhead and indirect costs to the products of the Workstream	Develop interim service weight structures to assist transition management towards patient costing processes	Prepare Costing Manuals relevant to the Workstream and distribute with supporting training documentation and materials		National and State/Territory		3
National data management			Establish national storage infrastructure to receive, manage, store & distribute data submitted from jurisdictions under multilateral governance arrangements and with nationally consistent edits and validation rules embedded in the data receipt process	In collaboration with the jurisdictions develop controlled data access and reporting facilities to support distributed access to "own source" data and appropriate national benchmarkingdata		National and State/Territory		3
Funding			Develop and negotiate national agreement to the principles of a consistent funding model regarding equity, incentives, special considerations etc in the context of the Workstream under development.	Calibrate the chosen funding model, test its sensitivity to data variations and readjust calibrations where appropriate, determine price points and ready the model for implementation in the event it is ratified for national implementation	Develop documentation and training modules to support a national roll out if ratified by COAG	National and State/Territory		4
Governance and management	As in Admitted Acute							

National Partnership Agreement – Performance Targets
C16 By 30 June 2015, 100% of emergency department services, sub-acute, outpatient services and hospital-auspiced community health services classified and costed using the nationally consistent model.
C17 If agreed by COAG, by 30 June 2016, 100% of admitted episodes, emergency department, sub-acute outpatient services and hospital-auspiced community health services funded through a nationally consistent activity based funding model, including 100% application of a nationally consistent approach to funding of small and regional hospitals with community service obligations.

Workstream 3: Subacute

Sub-Acute & Non-acute - Expenditure comparison between jurisdictions and Commonwealth					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Commonwealth	0.78	0.89	0.73	0.39	2.78
Jurisdictions	2.59	2.74	7.78	9.75	22.86
TOTAL	3.37	3.63	8.51	10.14	25.64

Relationship to National Partnership	
Stage 1	N/A
Stage 2	N/A
Stage 3	Complete developmental work related to the achievement of a common casemix classification and costing methodology for emergency department services, sub-acute care and outpatient services and hospital-auspiced community health services, undertaken in several parallel stages. - By end of 2012/2013
Stage 4	Complete development of an activity-based funding methodology, including methodology for setting price, incentives, and transition arrangements. Subject to COAG decision – Use of an activity-based funding model would begin from 2014-15, with an evaluation undertaken after the first year of operation. - By end of 2013/2014

National Partnership Agreement – Performance Measures	
C13 From the beginning of 2013-14 (baseline 1 July 2014,annual reporting):	(e) Uptake of common casemix classification and costing methodology for emergency department services, sub-acute, outpatient services and hospital-auspiced community health services (percentage of public hospitals, by state).
C14 From the beginning of 2014-15 (baseline 1 July 2015, annual reporting):	f) If agreed by COAG, uptake of activity based funding methodology, including methodology for setting price and incentives (percentage of public hospitals, by state).

Actions

	2009-10	2010-11	2011-12	2012-13	2013-14			
ABF Elements	Tasks					Responsibility	Lead	NPA stage
Product identification & classification	Review existing classifications in use within Australia and overseas and determine their utility within the Australian setting	Refine existing systems or undertake development work to test and define a "greenfield" classification	Finalise the classification definition and establish documentation, grouper software, training manuals and supporting documents	Prepare a refinement processes for the classification over time		National and State/Territory		3
Counting	Build business cases for projects planned for subsequent years	Define Counting Rules and gain multilateral agreement to ratify required Minimum Data Sets	Develop documentation and supporting materials to facilitate uniform counting nationally and to support the specification of ICT changes within the different settings across Australia	Establish audit and monitoring processes to ensure compliance with nationally agreed standards		National and State/Territory		3

Costing	Build business cases for projects planned for subsequent years	Established agreed nationally consistent cost allocation processes within the domain of the Workstream and the allocation of hospital overhead and indirect costs to the products of the Workstream	Develop interim service weight structures to assist transition management towards patient costing processes	Prepare Costing Manuals relevant to the Workstream and distribute with supporting training documentation and materials		National and State/Territory		3
National data management			Establish national storage infrastructure to receive, manage, store & distribute data submitted from jurisdictions under multilateral governance arrangements and with nationally consistent edits and validation rules embedded in the data receipt process	In collaboration with the jurisdictions develop controlled data access and reporting facilities to support distributed access to "own source" data and appropriate national benchmarking data		National and State/Territory		3
Funding			Develop and negotiate national agreement to the principles of a consistent funding model regarding equity, incentives, special considerations etc in the context of the Workstream under development.	Calibrate the chosen funding model, test its sensitivity to data variations and readjust calibrations where appropriate, determine price points and ready the model for implementation in the event it is ratified for national implementation	Develop documentation and training modules to support a national roll out if ratified by COAG	National and State/Territory		4
Governance and management	As in Admitted Acute							

National Partnership Agreement – Performance Targets
C16 By 30 June 2015, 100% of emergency department services, sub-acute, outpatient services and hospital-auspiced community health services classified and costed using the nationally consistent model.
C17 If agreed by COAG, by 30 June 2016, 100% of admitted episodes, emergency department, sub-acute outpatient services and hospital-auspiced community health services funded through a nationally consistent activity based funding model, including 100% application of a nationally consistent approach to funding of small and regional hospitals with community service obligations.

Workstream 4: Outpatient

Outpatient - Expenditure comparison between jurisdictions and Commonwealth					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Commonwealth	0.78	0.89	0.73	0.39	2.78
Jurisdictions	3.19	4.49	9.06	10.75	27.49
TOTAL	3.97	5.38	9.79	11.14	30.27

Relationship to National Partnership	
Stage 1	N/A
Stage 2	N/A
Stage 3	Complete developmental work related to the achievement of a common casemix classification and costing methodology for emergency department services, sub-acute care and outpatient services and hospital-auspiced community health services, undertaken in several parallel stages. - By end of 2012/2013
Stage 4	Complete development of an activity-based funding methodology, including methodology for setting price, incentives, and transition arrangements. Subject to COAG decision – Use of an activity-based funding model would begin from 2014-15, with an evaluation undertaken after the first year of operation. - By end of 2013/2014

National Partnership Agreement – Performance Measures	
C13 From the beginning of 2013-14 (baseline 1 July 2014,annual reporting):	(e) Uptake of common casemix classification and costing methodology for emergency department services, sub-acute, outpatient services and hospital-auspiced community health services (percentage of public hospitals, by state).
C14 From the beginning of 2014-15 (baseline 1 July 2015, annual reporting):	f) If agreed by COAG, uptake of activity based funding methodology, including methodology for setting price and incentives (percentage of public hospitals, by state).

Actions

	2009-10	2010-11	2011-12	2012-13	2013-14			
ABF Elements	Tasks					Responsibility	Lead	NPA stage
Product identification & classification	Review existing classifications in use within Australia and overseas and determine their utility within the Australian setting	Refine existing systems or undertake development work to test and define a "greenfield" classification	Finalise the classification definition and establish documentation, grouper software, training manuals and supporting documents	Prepare a refinement processes for the classification over time		National and State/Territory		3
Counting	Build business cases for projects planned for subsequent years	Define Counting Rules and gain multilateral agreement to ratify required Minimum Data Sets	Develop documentation and supporting materials to facilitate uniform counting nationally and to support the specification of ICT changes within the different settings across Australia	Establish audit and monitoring processes to ensure compliance with nationally agreed standards		National and State/Territory		3

Costing	Build business cases for projects planned for subsequent years	Established agreed nationally consistent cost allocation processes within the domain of the Workstream and the allocation of hospital overhead and indirect costs to the products of the Workstream	Develop interim service weight structures to assist transition management towards patient costing processes	Prepare Costing Manuals relevant to the Workstream and distribute with supporting training documentation and materials		National and State/Territory		3
National data management			Establish national storage infrastructure to receive, manage, store & distribute data submitted from jurisdictions under multilateral governance arrangements and with nationally consistent edits and validation rules embedded in the data receipt process	In collaboration with the jurisdictions develop controlled data access and reporting facilities to support distributed access to "own source" data and appropriate national benchmarking data		National and State/Territory		3
Funding			Develop and negotiate national agreement to the principles of a consistent funding model regarding equity, incentives, special considerations etc in the context of the Workstream under development.	Calibrate the chosen funding model, test its sensitivity to data variations and readjust calibrations where appropriate, determine price points and ready the model for implementation in the event it is ratified for national implementation	Develop documentation and training modules to support a national roll out if ratified by COAG	National and State/Territory		4
Governance and management	As in Admitted Acute							

National Partnership Agreement – Performance Targets
C16 By 30 June 2015, 100% of emergency department services, sub-acute, outpatient services and hospital-auspiced community health services classified and costed using the nationally consistent model.
C17 If agreed by COAG, by 30 June 2016, 100% of admitted episodes, emergency department, sub-acute outpatient services and hospital-auspiced community health services funded through a nationally consistent activity based funding model, including 100% application of a nationally consistent approach to funding of small and regional hospitals with community service obligations.

Workstream 5: Mental Health

Mental Health - Expenditure comparison between jurisdictions and Commonwealth					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Commonwealth	0.49	0.49	0.58	0.34	1.91
Jurisdictions	1.36	2.71	6.70	7.80	18.59
TOTAL	1.85	3.20	7.28	8.14	20.50

Relationship to National Partnership	
Stage 1	N/A
Stage 2	N/A
Stage 3	Complete developmental work related to the achievement of a common casemix classification and costing methodology for emergency department services, sub-acute care and outpatient services and hospital-auspiced community health services, undertaken in several parallel stages. - By end of 2012/2013
Stage 4	Complete development of an activity-based funding methodology, including methodology for setting price, incentives, and transition arrangements. Subject to COAG decision – Use of an activity-based funding model would begin from 2014-15, with an evaluation undertaken after the first year of operation. - By end of 2013/2014

National Partnership Agreement – Performance Measures	
C13 From the beginning of 2013-14 (baseline 1 July 2014,annual reporting):	(e) Uptake of common casemix classification and costing methodology for emergency department services, sub-acute, outpatient services and hospital-auspiced community health services (percentage of public hospitals, by state).
C14 From the beginning of 2014-15 (baseline 1 July 2015, annual reporting):	f) If agreed by COAG, uptake of activity based funding methodology, including methodology for setting price and incentives (percentage of public hospitals, by state).

Actions

	2009-10	2010-11	2011-12	2012-13			
ABF Elements	Tasks				Responsibility	Lead	NPA stage
Product identification & classification	Review compliance with National Mental Health Strategy adoption of MH MDS and MH-CASC across jurisdictions. Build business cases for projects planned for subsequent years	Undertake collaborative research to test enhancements to the predictive power of MH-CASC and implement agreed enhancements within National Partnership timeframes. Examine implications of extraction from the acute inpatient cluster Publish classification and supporting documentation & training modules			National and State/Territory		3

Counting	Build business cases for projects planned for subsequent years	Review consistency and compliance across jurisdictions with MDS - ensure nationally consistent approach, establish audit processes			National and State/Territory		3
Costing	Build business cases for projects planned for subsequent years	Review costing methods across jurisdictions to assess variation and implications of that variation	Determine and have ratified nationally consistent costing standards	Prepare Costing Manuals relevant to the Workstream and distribute with supporting training documentation and materials	National and State/Territory		3
National data management			Investigate the opportunity for integration of the mental health data collection into the mainstream national infrastructure proposed in this implementation plan	In collaboration with the jurisdictions develop controlled data access and reporting facilities to support distributed access to "own source" data and appropriate national benchmarking data	National and State/Territory		3
Funding				Develop and have agreed and ratified a nationally consistent funding model for mental health clients under the care of hospitals or hospital auspiced health services	National and State/Territory		4
Governance and management	As in Admitted Acute						

National Partnership Agreement – Performance Targets

C16 By 30 June 2015, 100% of emergency department services, sub-acute, outpatient services and hospital-auspiced community health services classified and costed using the nationally consistent model.

C17 If agreed by COAG, by 30 June 2016, 100% of admitted episodes, emergency department, sub-acute outpatient services and hospital-auspiced community health services funded through a nationally consistent activity based funding model, including 100% application of a nationally consistent approach to funding of small and regional hospitals with community service obligations.

Workstream 6: Hospital Auspiced Community

Hospital Auspiced Community Services - Expenditure comparison between jurisdictions and Commonwealth					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Commonwealth	0.78	0.89	0.73	0.39	2.78
Jurisdictions	1.18	0.78	3.13	3.84	8.93
TOTAL	1.96	1.67	3.86	4.23	11.71

Relationship to National Partnership	
Stage 1	N/A
Stage 2	N/A
Stage 3	Complete developmental work related to the achievement of a common casemix classification and costing methodology for emergency department services, sub-acute care and outpatient services and hospital-auspiced community health services, undertaken in several parallel stages. - By end of 2012/2013
Stage 4	Complete development of an activity-based funding methodology, including methodology for setting price, incentives, and transition arrangements. Subject to COAG decision – Use of an activity-based funding model would begin from 2014-15, with an evaluation undertaken after the first year of operation. - By end of 2013/2014

National Partnership Agreement – Performance Measures	
C13 From the beginning of 2013-14 (baseline 1 July 2014,annual reporting):	(e) Uptake of common casemix classification and costing methodology for emergency department services, sub-acute, outpatient services and hospital-auspiced community health services (percentage of public hospitals, by state).
C14 From the beginning of 2014-15 (baseline 1 July 2015, annual reporting):	f) If agreed by COAG, uptake of activity based funding methodology, including methodology for setting price and incentives (percentage of public hospitals, by state).

Actions								
	2009-10	2010-11	2011-12	2012-13	2013-14			
ABF Elements	Tasks					Responsibility	Lead	NPA stage
Product identification & classification	Review existing classifications in use within Australia and overseas and determine their utility within the Australian setting Build business cases for projects planned for subsequent years	Refine existing systems or undertake development work to test and define a "greenfield" classification	Finalise the classification definition and establish documentation, grouper software, training manuals and supporting documents	Prepare a refinement processes for the classification over time		National and State/Territory		3
Counting	Build business cases for projects planned for subsequent years	Define Counting Rules and gain multilateral agreement to ratify required Minimum Data Sets	Develop documentation and supporting materials to facilitate uniform counting nationally and to support the specification of ICT changes within the different settings across Australia	Establish audit and monitoring processes to ensure compliance with nationally agreed standards		National and State/Territory		3

Costing	Build business cases for projects planned for subsequent years	Established agreed nationally consistent cost allocation processes within the domain of the Workstream and the allocation of hospital overhead and indirect costs to the products of the Workstream	Develop interim service weight structures to assist transition management towards patient costing processes	Prepare Costing Manuals relevant to the Workstream and distribute with supporting training documentation and materials		National and State/Territory		3
National data management			Establish national storage infrastructure to receive, manage, store & distribute data submitted from jurisdictions under multilateral governance arrangements and with nationally consistent edits and validation rules embedded in the data receipt process	In collaboration with the jurisdictions develop controlled data access and reporting facilities to support distributed access to "own source" data and appropriate national benchmarking-data		National and State/Territory		3
Funding			Develop and negotiate national agreement to the principles of a consistent funding model regarding equity, incentives, special considerations etc in the context of the Workstream under development.	Calibrate the chosen funding model, test its sensitivity to data variations and readjust calibrations where appropriate, determine price points and ready the model for implementation in the event it is ratified for national implementation	Develop documentation and training modules to support a national roll out if ratified by COAG	National and State/Territory		4
Governance and management	As in Admitted Acute							

National Partnership Agreement – Performance Targets
C16 By 30 June 2015, 100% of emergency department services, sub-acute, outpatient services and hospital-auspiced community health services classified and costed using the nationally consistent model.
C17 If agreed by COAG, by 30 June 2016, 100% of admitted episodes, emergency department, sub-acute outpatient services and hospital-auspiced community health services funded through a nationally consistent activity based funding model, including 100% application of a nationally consistent approach to funding of small and regional hospitals with community service obligations.

Workstream 7: Teaching, Training & Research

Teaching, Training and Research - Expenditure comparison between jurisdictions and Commonwealth					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Commonwealth	0.69	0.69	0.63	0.39	2.4
Jurisdictions	0.56	0.59	1.68	4.36	7.19
TOTAL	1.25	1.28	2.31	4.75	9.59

Relationship to National Partnership	
Stage 1	N/A
Stage 2	Complete development of a common approach to costing of small or regional hospitals with community service obligations that will not be adequately funded using activity-based funding, in order to inform funding strategies. Implement funding strategies for training, research and development and other activities not directly related to treatment of individual patients. This work should establish a common public and private funding framework for teaching and research. - By end of 2010/2011
Stage 3	N/A
Stage 4	Complete development of an activity-based funding methodology, including methodology for setting price, incentives, and transition arrangements. Subject to COAG decision – Use of an activity-based funding model would begin from 2014-15, with an evaluation undertaken after the first year of operation. - By end of 2013/2014

National Partnership Agreement – Performance Measures	
C12 From the beginning of 2010-11 (baseline 1 July 2011, annual reporting):	(d) Uptake of a nationally consistent approach to funding activities not related to treatment of individual patients (percentage of relevant participating public hospitals, by state).
C14 From the beginning of 2014-15 (baseline 1 July 2015, annual reporting):	f) If agreed by COAG, uptake of activity based funding methodology, including methodology for setting price and incentives (percentage of public hospitals, by state).

Actions

	2009-10	2010-11			
ABF Elements	Tasks		Responsibility	Lead	NPA stage
Product identification & classification	Assess the return on effort required to develop a comprehensive method of measuring and allocating teaching, training and research compared to deriving an estimate from appropriate research and jurisdictional experience Undertake research into approaches to the management and funding of teaching, training and research and assess the potential for application in the Australian setting If the Business Case supports the development of a comprehensive model proceed with the following stages - Review the variation of arrangement and setting of teaching, training and research in Australian hospitals	Develop a broad classification grouping the arrangements and setting by like characteristics ensuring that all funding sources, cross organisational arrangements and multi-party activities are accommodated	National and State/Territory		2

Counting		Develop documentation and counting rules to support the classification and measurement of teaching, training and research in Australian Hospitals	National and State/Territory		2
Costing		Initiate survey based project to collect counting and expenditure data across an appropriate sample of environments in each setting of the classification	National and State/Territory		2
National data management					2
Funding		Build funding model and ratify through cross jurisdictional processes			4
Governance and management	As in Admitted Acute				

National Partnership Agreement – Performance Targets
C17 If agreed by COAG, by 30 June 2016, 100% of admitted episodes, emergency department, sub-acute outpatient services and hospital-auspiced community health services funded through a nationally consistent activity based funding model, including 100% application of a nationally consistent approach to funding of small and regional hospitals with community service obligations.

Workstream 8: Community Service Obligation

Community Service Obligation - Expenditure comparison between jurisdictions and Commonwealth					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Commonwealth	0.69	0.69	0.63	0.39	2.4
Jurisdictions	0.58	0.61	1.82	5.55	8.56
TOTAL	1.27	1.30	2.45	5.94	10.96

Relationship to National Partnership	
Stage 1	N/A
Stage 2	Complete development of a common approach to costing of small or regional hospitals with community service obligations that will not be adequately funded using activity-based funding, in order to inform funding strategies. Implement funding strategies for training, research and development and other activities not directly related to treatment of individual patients. This work should establish a common public and private funding framework for teaching and research. - By end of 2010/2011
Stage 3	N/A
Stage 4	Complete development of an activity-based funding methodology, including methodology for setting price, incentives, and transition arrangements. Subject to COAG decision – Use of an activity-based funding model would begin from 2014-15, with an evaluation undertaken after the first year of operation. - By end of 2013/2014

National Partnership Agreement – Performance Measures	
C12 From the beginning of 2010-11 (baseline 1 July 2011, annual reporting):	(d) Uptake of a nationally consistent approach to funding activities not related to treatment of individual patients (percentage of relevant participating public hospitals, by state).
C14 From the beginning of 2014-15 (baseline 1 July 2015, annual reporting):	f) If agreed by COAG, uptake of activity based funding methodology, including methodology for setting price and incentives (percentage of public hospitals, by state).

Actions					
	2009-10	2010-11			
ABF Elements	Tasks		Responsibility	Lead	NPA stage
Product identification & classification	Review management of Community Service Obligation (Minimum Volume Hospitals) across jurisdictions and cluster into comparable models Agree national definition of Minimum Volume Hospital (not viably funded through an activity based model through low volume of patient throughput) Ratify agreed definition		National and State/Territory		2
Counting		Establish current inventory of hospitals across Australia	National and State/Territory		2
Costing		Undertake bottom up "roster based" costing to determine appropriate floor funding required maintaining a required Community Service Obliged hospital. Agree appropriate overhead and indirect allocation, capital component where appropriate and derive floor funding level	National and State/Territory		2

National data management			National and State/Territory		2
Funding		Develop nationally consistent approach to funding Minimum Volume Hospitals and pass through formal ratification process as required	National and State/Territory		4
Governance and management	As in Admitted Acute				

National Partnership Agreement – Performance Targets
C17 If agreed by COAG, by 30 June 2016, 100% of admitted episodes, emergency department, sub-acute outpatient services and hospital-auspiced community health services funded through a nationally consistent activity based funding model, including 100% application of a nationally consistent approach to funding of small and regional hospitals with community service obligations.

Appendix A Resource allocations by Workstream

The following resource allocations are based on percentages provided by jurisdictions. They are estimates based on the expected effort by each jurisdiction and by the Commonwealth over the next 4 years and should not be used for acquittal purposes as the break up of funds allocated to annual work plans may change and will be subject to review during and following the development of State Implementation Plans.

Proposed Allocation of Funds to support ABF Implementation Plan ($M)

New South Wales					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Admitted Acute	1.19	1.19	0.79	0.79	3.95
Emergency Department	0.79	1.19	1.19	0.79	3.95
Sub-Acute & Non-acute	0.40	0.79	2.37	2.37	5.93
Outpatient	0.79	2.77	3.56	3.56	10.68
Mental Health	0.0	1.58	3.16	3.16	7.91
Hospital auspiced Community Services	0.00	0.00	1.19	0.79	1.98
Community Service Obligation	0.00	0.00	0.00	3.16	3.16
Teaching, Training and Research	0.00	0.00	0.00	1.98	1.98
Other	0.00	0.00	0.00	0.00	0.00
TOTAL	3.16	7.51	12.26	16.61	39.54
Victoria					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Admitted Acute	1.48	1.58	0.93	1.24	5.23
Emergency Department	0.91	0.96	2.82	3.78	8.47
Sub-Acute & Non-acute	0.91	0.96	2.82	3.78	8.47
Outpatient	0.60	0.64	1.89	2.53	5.66
Mental Health	0.50	0.53	1.59	2.13	4.75
Hospital auspiced Community Services	0.10	0.11	0.31	0.42	0.94
Community Service Obligation	0.10	0.11	0.31	0.42	0.94
Teaching, Training and Research	0.10	0.11	0.31	0.42	0.94
Other	0.00	0.00	0.00	0.00	0.00
TOTAL	4.70	5.00	10.98	14.72	35.40
Queensland					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Admitted Acute	0.48	0.48	1.09	1.46	3.50
Emergency Department	0.41	0.41	0.93	1.25	3.00
Sub-Acute & Non-acute	0.48	0.48	1.09	1.46	3.50
Outpatient	0.55	0.55	1.24	1.66	4.00
Mental Health	0.27	0.27	0.62	0.83	2.00
Hospital auspiced Community Services	0.41	0.41	0.93	1.25	3.00
Community Service Obligation	0.25	0.25	0.57	0.77	1.85
Teaching, Training and Research	0.23	0.23	0.53	0.71	1.70

Other	0.00	0.00	0.00	0.00	0.00
TOTAL	3.09	3.09	7.00	9.38	22.55
Western Australia					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Admitted Acute	0.38	0.38	0.4	0.4	1.56
Emergency Department	0.25	0.25	0.54	0.81	1.85
Sub-Acute & Non-acute	0.12	0.12	0.4	0.55	1.19
Outpatient	0.13	0.25	0.54	0.93	1.85
Mental Health	0.25	0.25	0.65	0.81	1.96
Hospital auspiced Community Services	0.25	0.26	0.13	0.4	1.04
Community Service Obligation	0.12	0.25	0.8	0.81	1.98
Teaching, Training and Research	0.12	0.25	0.65	0.81	1.83
Other	0.00	0.00	0.00	0.00	0.00
TOTAL	1.62	2.01	4.11	5.52	13.26
South Australia					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Admitted Acute	0.05	0.14	0.18	0.23	0.61
Emergency Department	0.07	0.48	0.56	0.75	1.87
Sub-Acute & Non-acute	0.07	0.48	0.56	0.75	1.87
Outpatient	0.09	0.74	0.86	1.15	2.85
Mental Health	0.06	0.27	0.33	0.43	1.1
Hospital auspiced Community Services	0.06	0.35	0.41	0.55	1.38
Community Service Obligation	0.05	0.06	0.1	0.11	0.33
Teaching, Training and Research	0.05	0.06	0.1	0.11	0.33
Other	0.04	0.01	0.48	0.7	1.23
TOTAL	0.54	2.61	3.58	4.8	11.53
Tasmania					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Admitted Acute	0.08	0.08	0.12	0.12	0.40
Emergency Department	0.08	0.12	0.20	0.12	0.52
Sub-Acute & Non-acute	0.00	0.20	0.20	0.28	0.68
Outpatient	0.20	0.20	0.40	0.40	1.20
Mental Health	0.00	0.08	0.16	0.16	0.40
Hospital auspiced Community Services	0.00	0.00	0.12	0.28	0.40
Community Service Obligation	0.00	0.00	0.00	0.20	0.20
Teaching, Training and Research	0.00	0.00	0.00	0.20	0.20
Other	0.00	0.00	0.00	0.00	0.00
TOTAL	0.36	0.68	1.20	1.76	3.99
Australian Capital Territory					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Admitted Acute	0.42	0.32	0.30	0.27	1.30
Emergency Department	0.00	0.05	0.10	0.32	0.47
Sub-Acute & Non-acute	0.00	0.07	0.10	0.22	0.39
Outpatient	0.00	0.00	0.30	0.20	0.50
Mental Health	0.00	0.00	0.13	0.20	0.33

Hospital auspiced Community Services	0.00	0.00	0.00	0.07	0.07
Community Service Obligation	0.00	0.00	0.00	0.00	0.00
Teaching, Training and Research	0.00	0.00	0.05	0.05	0.10
Other	0.00	0.00	0.00	0.00	0.00
TOTAL	0.42	0.44	0.98	1.32	3.16
Northern Territory					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Admitted Acute	0.20	0.20	0.20	0.27	0.87
Emergency Department	0.16	0.12	0.27	0.32	0.87
Sub-Acute & Non-acute	0.12	0.12	0.19	0.24	0.67
Outpatient	0.08	0.08	0.27	0.32	0.75
Mental Health	0.00	0.00	0.19	0.28	0.47
Hospital auspiced Community Services	0.00	0.00	0.04	0.08	0.12
Community Service Obligation	0.00	0.00	0.04	0.08	0.12
Teaching, Training and Research	0.00	0.00	0.04	0.08	0.12
Other	0.00	0.00	0.00	0.00	0.00
TOTAL	0.56	0.52	1.24	1.66	3.98
Commonwealth					
YEAR	2009/10	2010/11	2011/12	2012/13	TOTAL
Admitted Acute	0.69	0.59	0.63	0.39	2.30
Emergency Department	0.78	0.89	0.73	0.39	2.78
Sub-Acute & Non-acute	0.78	0.89	0.73	0.39	2.78
Outpatient	0.78	0.89	0.73	0.39	2.78
Mental Health	0.49	0.49	0.58	0.34	1.91
Hospital auspiced Community Services	0.78	0.89	0.73	0.39	2.78
Community Service Obligation	0.69	0.69	0.63	0.39	2.40
Teaching, Training and Research	0.69	0.69	0.63	0.39	2.40
Other	0.00	0.00	0.00	0.00	0.00
TOTAL	5.69	6.01	5.39	3.07	20.16
NATIONAL TOTAL	22.74	25.25	46.74	58.84	153.57