Department of Health

Tasmanian Government

Tasmanian Health Service
2021-22 Service Plan

Contents

Approval

The Tasmanian Health Service (THS) 2021-22 Service Plan (the Service Plan) has been developed in accordance with the *Tasmanian Health Service Act 2018* (the Act) and is administered by the Minister for Health (the Minister).

In accordance with the Act, the THS and Secretary carry out their functions consistent with the Ministerial Charter issued under the Act. The THS provides the health services and health support services required under the Service Plan, to the standards and within the budget set out in the Service Plan.

The Secretary and THS are given distinct but complementary roles and functions in the Act, each aimed at ensuring the Tasmanian community's public health system is well managed, providing the right care to the Tasmanian community, in the right place, at the right time.

Signed by:

Kathrine Morgan-Wicks

Secretary, Department of Health

Date signed: 31 May 2021

Approved by:

The Honourable Jeremy Rockliff MP

Tasmanian Minister for Health

Date signed: 30 June 2021

Preface

The timing of the state election and ongoing national and state response to the COVID-19 pandemic have impacted the current funding environment of our health system. This first issue of the Service Plan has been developed before the handing down of the 2021-22 State Budget which will not be released until 26 August 2021. Accordingly, the Service Plan has been prepared based on funding estimates identified in the Revised Estimates Report 2020-21 (RER) released by Department of Treasury and Finance.

New budget initiatives, such as those associated with the recently announced election commitments will be included in an amendment to the Service Plan following the release of the State Budget in August 2021. Given the impacts on the provision of a comprehensive Service Plan, an abridged version has been developed until a detailed amendment can be finalised.

The Service Plan also includes an updated suite of Key Performance Indicators (KPI) which will continue to be monitored through the THS Performance Framework. A review of all Service Plan KPI is currently in progress and the inclusion of new and amended performance indicators and targets will inform a more comprehensive Service Plan later in 2021-22.

Tasmanian Health Service 2021-22 Service Plan

The Service Plan applies from 1 July 2021 to 30 June 2022. It does not override existing laws, agreements, public sector codes, statutes, government policies or contracts.

The evaluation of THS performance against the requirements of the Service Plan will be undertaken as outlined in the Performance Framework (refer to Part E of the Service Plan).

The THS Executive will ensure that structures and processes are in place to:

- comply with the requirements of the Service Plan
- fulfil its statutory obligations
- ensure good corporate governance (as outlined in the Act) and
- follow operational directives, policy and procedural manuals and technical bulletins as issued by the Department in its role as system manager.

The Service Plan consists of the following sections:

- **Part A**: Tasmanian Public Health System – Responsibilities
- **Part B:** Health Planning
- **Part C:** Election Commitments
- **Part D:** Funding Allocation and Activity Schedule
- **Part E:** Performance
- **Part F:** Key Performance Indicators

This Service Plan operates within the Performance Framework and in the context of the Department's Purchasing and Funding Guidelines and financial requirements. This Service Plan does not specify every responsibility of the THS; however, this does not diminish other applicable duties, obligations or accountabilities, or the effects of the Department's policies, plans and Ministerial Directions.

Amendments to the Service Plan

As outlined in Section 11 of the Act, the Secretary may provide to the Minister a proposed amendment to the Service Plan.

If the Minister approves a proposed amendment of the Service Plan under subsection 11(2)(a), the Service Plan is amended in accordance with the amendment, on and from the date on which notice of the amendment is given to the Secretary and the THS Executive under subsection 11(6).

The Service Plan may be amended at any time before or during the financial year.

Standards, Requirements and Agreements

Financial Management Standards

In accordance with Section 17(e) of the Act, the THS must manage its budget, as determined by the Service Plan, to ensure the efficient and economic operation and delivery of health services and use of its resources. Accordingly, it is critical that the THS has strong financial management and accountability.

The THS and relevant staff must comply with the following financial instruments:

- *Tasmanian Health Service Act 2018*
- *Financial Management Act 2016*
- *Audit Act 2008*
- *Financial Agreement Act 1994*
- Treasurer's Instructions
- Australian Accounting Standards

As an Accountable Authority under the *Financial Management Act 2016*, the Secretary is responsible to the Minister for the financial management of the THS, including:

- ensuring that expenditure by the THS is in accordance with the law
- ensuring the effective and efficient use of resources in achieving the Government's objectives
- ensuring that appropriate stewardship is maintained over the assets of the THS and the incurring of liabilities of the THS
- ensuring that the THS's financial management processes, records, procedures, controls and internal management structures are appropriate
- ensuring the custody, control and management of, and accounting for, all public property, public money, other property and other money in the possession of, or under the control of, the THS
- ensuring the proper collection of all money payable to, or collectable under, any law administered by the THS
- conducting reviews of fees and charges collected by or payable to the THS; and
- meeting the audit requirements of the Auditor-General.

Safety and Quality

The Australian Commission on Safety and Quality in Health Care

The National Safety and Quality Health Service (NSQHS) Standards, and associated Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme, were developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC), community, technical expert and stakeholder consultation to drive the continuous improvement of the quality and safety of health care in Australia. The NSQHS Standards (2012) became mandatory for all hospitals, day procedure centres and public dentists from 1 January 2013.

The THS is required to be accredited to the relevant NSQHS Standards (2nd edition) (2017) by an approved accrediting agency. This includes:

- acute, sub-acute services, acute and community services that provide care for children, mental health services, and statewide services such as forensic health, alcohol and drug related services and oral health services
- community sector organisations funded by the THS to provide sub-acute public hospital beds such as palliative care beds, in-patient care type facilities, or any day procedure type services
- services operated by the THS are required under the safety, quality and strategic performance expectations of the Ministerial Charter to achieve accreditation to safeguard high standards of care and continuous quality improvement.

Aged Care Accreditation

The Australian Government's *Aged Care Quality and Safety Commission Act 2018* established the Aged Care Quality and Safety Commission (ACQSC). The ACQSC's Aged Care Quality Standards (Quality Standards) (2019) came into effect for organisations providing Commonwealth subsidised aged care services from 1 July 2019, following the Aged Care Royal Commission and in response to the Aged Care Legislation Amendment (Single Quality Framework) Principles 2018.

The ACQSC is the appointed independent accreditation body for aged care services and assess approved providers' compliance to the Quality Standards to provide assurance to recipients of aged care services. The Quality Standards strengthen the focus upon client centred care requiring providers to work with their consumers to ensure they receive safe, high quality care shaped to the clients needs, goals and preferences. The Quality Standards apply to residential care; home care; and flexible care in the form of short-term restorative care.

The Quality Standards also apply to care provided in a person's own home or the community, including short-term restorative care delivered in a home setting, and care delivered under the Commonwealth Home Support Programme (CHSP) as set out in the ACQSC Guide to Assessment of CHSP Services depending upon the types of care and services being delivered.

Professional Training Accreditation

Accredited training requires an onsite review by the appropriate professional body's College and other accrediting agencies to assess a hospital's ability to provide training and supervision of the required standard, and its degree of compliance with the College's professional documents.

The THS is expected to notify the Secretary of upcoming accreditation assessments (of all types) and inform the Secretary if there is a risk that the services they provide may be assessed as not meeting the accreditation standards to which they ascribe.

Sentinel Events and Hospital Acquired Complications

The addendum to the National Health Reform Agreement (NHRA) includes a commitment for the Australian Government and state and territory governments to implement a number of reforms designed to improve patient safety and support greater efficiency in the health system, by reducing sentinel events, hospital acquired complications (HACs), and avoidable hospital readmissions. This will deliver better health outcomes, improve patient safety and support greater efficiency in the health system.

The 2021-22 Tasmanian Activity Based Funding (ABF) Model applies the National Safety and Quality pricing adjustments for HACs and zero funding of sentinel events.

More details regarding HACs and sentinel events are provided in Appendix 2.

Data Compliance and Provision

Since implementation of the NHRA and ABF, the importance of complete, accurate, timely and transparent health and hospital casemix data has become more important than ever in terms of the level of hospital funding, decision making for planning and resource allocation.

For 2021-22 there are six ABF patient service categories which are being used nationally and have their own classification system. These are:

- Admitted acute care
- Sub-acute and non-acute care
- Non-admitted care
- Mental health care
- Emergency care
- Teaching, training and research.

The Department submits a range of data to national and state agencies or bodies, including the Independent Hospital Pricing Authority (IHPA), National Health Funding Body (NHFB), the Australian Institute of Health and Welfare (AIHW), the Department of Veterans Affairs (DVA), National Joint Replacement Register, and the Australian Bureau of Statistics.

Data reporting to national bodies and performance reporting against the KPI in the Service Plan will require the Department to regularly import data from hospital systems. The THS is to ensure that such data is recorded in accordance with the requirements of each data collection, ensuring data quality and timeliness. The references/standards for each element are as follows:

- Coding and Classification Standards:
    - ICD-10-AM (International Statistical Classification of Diseases and Related Health Problems, Eleventh Edition, Australian Modification)
    - ACHI Australian Classification of Health Interventions
    - Australian Coding Standards
    - Australian National Subacute and Non-Acute Patient (AN-SNAP), Australian Emergency Care Classification (AECC), Urgency Disposition Groups (UDG) and Tier 2 classification business rules
    - Tasmanian directions:
        - Tasmanian Casemix Technical Bulletins
        - Tasmanian ABF Policy Instruction
- Costing: Australian Hospital Patient Costing Standards
- Counting: data definitions outlined in Tasmanian:
    - Admission and Transfer Discharge Policy Manual
    - Hospital Admitted Care Types Guidelines
    - Health Data Dictionary

More detail can be found at:

www.health.tas.gov.au/intranet/system/activity_based_funding_abf

www.ihpa.gov.au/publications/pricing-framework-australian-public-hospital-services-2021-22

www.ihpa.gov.au/publications/national-efficient-price-determination-2021-22

www.ihpa.gov.au/publications/national-efficient-cost-determination-2021-22

Provision of Health Services and Health Support Services under Contractual Arrangements

The THS is required to provide the health services and health support services set out in Column 2 of the table below to the corresponding party Column 1 pursuant to contractual arrangements entered between that party and the THS from time to time.

Column 1 (Party)	**Column 2 (health services and/or health support services)**
Commonwealth of Australia	*Health Services* The provision of such medical services, paramedical services and any other services which fall within the meaning of paragraphs (b), (c) and (f) of the definition of "health service" in s 3 of the Act as may be required to treat and/or stabilise and/or evacuate patients from Australia's Antarctic Territory and/or the Southern Ocean region to a public hospital in Tasmania. Such services are to include where appropriate the provision of medical services comprising professional advice or diagnostic services either remotely or in person. *Health support services* The provision of a health support service within the meaning of paragraph (b) of the definition of 'health support service' in the Act being the supply of a service in the form of training of Commonwealth personnel in Antarctic and remote medicine and/or the sterilisation of the entity's medical and scientific equipment for use in the Antarctic and Southern Ocean region to the Party in its capacity as a provider of health services.
Any party that is a provider of health services (within the meaning of the definition of 'health service' in s.3 the Act)	The provision of a health support service within the meaning of paragraph (b) of the definition of 'health support service' in the Act being the supply of a good or substance, in the form of Ant venom extracts for use in venom immunotherapy and diagnosis of allergy, to the party in its capacity as a provider of health services.
Healthe Care Burnie Pty Ltd	The provision of such medical services, paramedical services and any other services which fall within the meaning of paragraphs (b), (c) and (f) of the definition of "health service" in s 3 of the Act as may be required in a medical emergency to stabilise patients of the North West Private Hospital and/or transfer those patients from the North West Private Hospital to a public hospital

National and Other Agreements

The 2021-22 THS funding allocation includes funding provided under a range of National Partnership Agreements (NPAs), Commonwealth Own Purpose Expenditure (COPEs) payments and other government sector agreements. These agreements may generate their own specific program, financial and performance reporting requirements that, while not encapsulated in the Service Plan, require THS compliance.

National Health Reform Agreement

The Service Plan complies with the requirements of the 2020-25 NHRA.
www.federalfinancialrelations.gov.au/content/national_health_reform.aspx

The NHRA requires state governments, as the system managers of public hospitals, to establish service agreements (or a Service Plan in the Tasmanian context) with each Local Hospital Network. These are to include:

- the number and broad mix of services to be provided by the Local Hospital Network
- the quality and service standards that apply to services delivered by the Local Hospital Network, including the Performance and Accountability Framework and Australian Health Performance Framework
- the level of funding to be provided to the Local Hospital Networks
- the teaching, training and research functions to be undertaken at the Local Hospital Network level.

Funding Arrangements

The 2020-25 NHRA provides for a continuation of existing public hospital funding arrangements, through which the Australian Government's annual funding contribution is its prior year contribution plus 45 per cent of the efficient growth in the price and volume of activity. Annual growth in total Australian Government funding is capped at 6.5 per cent. The amount of National Health Reform (NHR) funding received by Tasmania during the five-year term of the NHRA is dependent on the annual level of public hospital activity.

Minimum Funding Guarantee

The Australian Government has agreed to extend Tasmania's existing bilateral guarantee of a minimum annual level of NHR funding growth for the term of the 2020-25 NHRA. The guarantee provides for Tasmania's NHR funding to be indexed by at least the rate of growth in the Consumer Price Index and the national population.

Health Reform

The 2020-25 NHRA includes a commitment for the Australian Government and the states to work in partnership to implement arrangements for a nationally unified and locally controlled health system to improve patient outcomes, patient experience and access to services. This commitment includes supporting innovative models of care and trialling new funding arrangements. This is consistent with existing Tasmanian initiatives and priorities, including the Community Rapid Response Service and the Hospital in the Home (HiTH) program.

The 2020-25 NHRA also includes principles for the six long-term reforms, being: enhanced health data, nationally cohesive health technology assessment, paying for value and outcomes, joint planning and funding at a local level, empowering people through health literacy, and prevention and wellbeing.

The Australian Government and the states will continue to work together to consider implementation of the six long-term reforms outlined in the 2020-25 NHRA and their interaction with broader health reforms, including the maintenance and expansion of reforms expedited as a result of the response to COVID-19.

High cost and highly specialised therapies

High cost and highly specialised therapies include new and emerging cellular therapies, gene therapies, stem cell therapies, 3D printing, and regenerative medicine approved for therapeutic use in public hospitals.

The 2020-25 NHRA contain specific arrangements for new high cost, highly specialised therapies recommended for delivery in public hospitals by the Medical Services Advisory Committee. Under the cross boarder or interstate charging arrangements in the 2020-25 NHRA, Tasmanian is required to meet the cost of these services (exclusive of the Commonwealth contribution component).

Tasmanian residents, based on clinical criteria, will have access to main land facilities for the following cost and highly specialised therapies in 2021-22:

- Kymriah® – for the treatment of acute lymphoblastic leukaemia in children and young adults
- Kymriah® or Yescarta® – for the treatment of diffuse large B-cell lymphoma, primary mediastinal large B-cell lymphoma and transformed follicular lymphoma
- Qarziba® – for the treatment of high-risk neuroblastoma
- Luxturna™ – for the treatment of inherited retinal disease

Private patients in public hospitals

The 2020-25 NHRA specifies that the Australian Government and states' funding models will be financially neutral with respect to all patients, regardless of whether they elect to be treated as private or public patients.

Project Agreement for the Community Health and Hospitals Program

During the 2019 Federal Election campaign, the Australian Government announced it would provide $20 million over four years to provide for additional elective surgery and endoscopy procedures in Tasmania. An initial payment of $5 million was provided to Tasmania in 2018-19 for activity in 2019-20 and future years.

In November 2019 the Australian Government announced the remaining $15 million for this commitment would be payable in 2019-20. The Australian Government provided Tasmania with the flexibility for activity purchased with this funding to be performed in 2020-21 and future years.

National Partnership on COVID-19 Response

In response to the COVID-19 pandemic, the National Partnership on COVID-19 Response (NPCR) was implemented on 13 March 2020 to provide states and territories with financial assistance to effectively respond to the COVID-19 outbreak.

The NPCR will remain in place for the period of the activation of the *Australian Health Sector Emergency Response Plan for Novel Coronavirus 2019* as declared by the Australian Health Protection Principal Committee (AHPPC), and then for sufficient additional time to allow for the final reconciliation of any payments made under the agreement.

More details regarding the NPCR are provided in Appendix 1.

National Partnership Agreement: Mersey Community Hospital

This NPA on Transfer of the Mersey Community Hospital (the Mersey NPA) facilitated the transfer of the Mersey Community Hospital (MCH) to the Tasmanian Government. On 1 July 2017, the State Government resumed ownership of the MCH and became responsible for providing public hospital services at the MCH and for reporting on the delivery of those services to the Australian Government.

The Australian Government provided a financial contribution to Tasmania of $736.6 million to support the implementation of the Mersey NPA.

MCH activity is now included in the Tasmanian total National Weighted Activity Unit (NWAU) values for the NHRA payments. However, to ensure Tasmania does not receive double funding for the MCH for the period 2017-18 to 2026-27 inclusive, Tasmania will not be entitled to receive an ABF payment under the NHRA, or any subsequent agreement, for the agreed funding profile described in the Mersey NPA. Any activity delivered at the MCH above the agreed funding profile will be eligible for ABF payments.

National Partnership Agreement: Public Dental Services for Adults

The NPA for Public Dental Services for Adults provides additional funding to states and territories to alleviate pressure on adult public dental waiting lists. The current agreement expires on 30 June 2021. The 2021-22 Federal Budget indicates further funding will be provided in 2021-22. The Department of Health will seek to commence negotiations with the Australian Government in the near future to formalise an extension to the agreement.

Other Agreements

In addition to the above, COPEs and other government sector agreements relevant to the Service Plan include:

<u>COPEs</u>

- Aged Care Assessment Program
- Commonwealth Home Support Program
- Multi-Purpose Services Program
- Transition Care Program
- WP Holman Clinic Radiation Health Program Grant

<u>Other government sector agreements</u>

- Head Agreement in relation to Funding for Organ and Tissue Donation for Transplantation

Funding relating to each of these agreements is contained within the overall THS funding envelope for 2021-22.

Part A: Tasmanian Public Health System - Responsibilities

Tasmania's health system is comprised of a wide network of public, private and not-for-profit services that collectively seek to deliver positive health outcomes for all Tasmanians. The health system covers the full range of services, from population and allied health services, general practitioners, allied health and community services, and tertiary and community hospitals.

A significant part of Tasmania's health system (including services provided under the Service Plan) is delivered under the Act. For the purposes of the Service Plan, the high-level responsibilities of the Minister, the Department, the THS Executive and the THS are summarised below.

Minister for Health

The Minister is responsible for the administration of the Act. Ministerial guidance and direction are provided through:

- the Ministerial Charter - which sets out the broad policy expectations for the THS and is issued by the Minister. The THS and Secretary must comply with the Ministerial Charter.
- the Service Plan - the Minister approves the Service Plan that is to apply to the THS each financial year.

The Secretary, Department of Health

The Secretary is responsible to the Minister for the performance of the THS and THS Executive, including ensuring that the THS Executive is performing and exercising the functions and powers of the THS.

In line with this responsibility, the Secretary is assigned several functions and powers to guide, monitor and manage the THS in undertaking its functions and powers, including;

- the ability to give direction to the THS in relation to the performance of its functions, and the exercise of its powers. This includes issuing policy or directing the THS to undertake actions to improve performance, including actions under the Performance Framework and
- responsibility for developing the Service Plan, including KPI, service volumes and performance standards. The Service Plan is the key accountability document and is intrinsically linked to the performance of the THS in undertaking its functions and powers.

Tasmanian Health Service Executive

The role of the THS Executive is to administer and manage the THS. This includes:

- performing and exercising the functions and powers of the THS and
- ensuring that the THS delivers the services set out in the Service Plan including the agreed volume and performance standards in accordance with the budget set out in the Service Plan.

The Tasmanian Health Service

The THS, through its Executive, is accountable to the Minister via the Secretary for performing its functions and exercising its powers in a satisfactory manner. Through its Executive, the output of the THS must be in accordance with the requirements of the Service Plan.

The functions of the THS are to:

- ensure that that the broad policy expectations of the Minister, as specified in the Ministerial Charter, are achieved
- provide the health services and health support services required under the Service Plan, and to provide those services to the specified quality standards and within the specified funding allocation
- conduct and manage public hospitals, health institutions, health services, and health support services, that are under the THS's control
- ensure quality and effective provision of health services and health support services that are purchased by the THS
- manage the funding allocation, as determined by the Service Plan, and its other funds, to ensure:
    - the efficient and economic operation of public hospitals, health facilities, health services, and health support services, that are under the THS' control
    - the efficient and economic delivery of health services, and health support services, that are purchased by the THS and
    - the efficient and economic use of its resources
- consult and collaborate, as appropriate, with other providers in the planning and delivery of health services and health support services
- provide training and education relevant to the provision of health services and health support services
- undertake research and development relevant to the provision of health services and health support services
- assist patients, and their carers, to travel to and from, and be accommodated close to where the patient is to receive health services
- collect and provide health data, for the purposes of research, quality improvement, accreditation, reporting and for any other purposes including for quality governance and
- collect and provide health data to enable the statewide planning and coordination of the provision of relevant services.

Health Executive Governance Structure

In March 2020, a new executive structure for the state's health system came into effect. The new structure saw the abolishment of the two separate Executive committees across the Department of Health (the Department) and the THS, and the establishment of one streamlined Health Executive. The new governance structure provides a clear and consistent strategic direction across the Department and THS, and strengthens systems coordination and local accountability and authority; whilst still ensuring the focus remains on delivering high quality, safe and sustainable health services for all Tasmanians.

The Health Executive is chaired by the Secretary, Department of Health, and includes 12 other members representing various functions of the Department and the THS. The new governance structure is consistent with the Act, with seven of the Health Executive membership roles deemed to comprise the THS Executive for the purposes of the Act.

As part of the new structure, executive sub-committees have been established to support the Secretary and provide focus and consistency within decision making, as well as drive improved and more timely

decisions by the Health Executive, and monitoring of the delivery of key projects, outcomes and risks. Of relevance to the Service Plan is the System Performance and Forecasting Committee (SPFC) which is responsible for providing strategic oversight and direction of the Departments performance management responsibilities. The SPFC utilises input from experts and clinical leaders to identify, assess and prioritise emerging performance concerns and oversee the appropriate interventions to address underperformance. In 2021-22 the newly formed SPFC are overseeing a review of all Service Plan KPI and associated targets which will inform an amendment to the KPI suite.

Part B: Health Planning

In 2015, the *One State, One Health System, Better Outcomes* reforms, as part of the Tasmanian Government's long-term reform agenda to consult, design and build a highly integrated and sustainable health service, took the first step of designing and implementing a single, statewide service. These Stage One reforms focused on the four major hospitals and clearly defining their roles within the health system, with significant investment in health system infrastructure and additional staffing and operational costs across our health system occurring since this time.

Despite this investment, demand for care continues to grow. Tasmania's social and demographic factors, including an ageing population and high number of people living with co-morbid health conditions, are a major cause behind this increase in demand. Like other states and territories facing this issue, Tasmania also has people being cared for in hospital because the Tasmanian health system does not have enough subacute, primary, community and home-based services. Care in the wrong place isn't best for people and comes at a high cost.

Consequently, the Stage Two reforms as announced in *Our Healthcare Future,* will take the important next step of focusing on the delivery of better care in the community, as part of a balanced and sustainable health system – right care, in the right place, at the right time. It will also address other long-term challenges the health system faces, including ensuring the health workforce and infrastructure are aligned to current and future needs of the Tasmanian community.

In November 2020, the Tasmanian Government released the *Our Healthcare Future Immediate Actions and Consultation Paper*. As feedback received in response to the consultation paper is considered, implementation of the immediate actions is already underway across the three key improvement areas of 1) Better Community Care, 2) Modernising Tasmania's Health System, and 3) Planning for the Future.

Our Healthcare Future will build a sustainable health system for the future by connecting and rebalancing care across our acute, subacute, rehabilitation, mental health and primary health sectors, through to care in the community. As the reforms to be undertaken through *Our Healthcare Future* are progressed and embedded in the Tasmanian health system, they will guide the planning, funding and purchasing of health care services, and inform future iterations of the Service Plan.

Part C: Election Commitments

The 2021-22 State Budget will not be released until August 2021. Accordingly, the Service Plan has been prepared based on the 2020-21 State Budget and Forward Estimates. Funding announcements, such as those made in the RER are included within the 2021-22 funding estimates for the THS.

Announcements made during campaigning for the 2021 State Election are not included in these estimates. Those initiatives will be included once the 2021-22 State Budget and Forward Estimates are released. Those investments include an additional $120 million, on top of the $36.4 million investment already budgeted for 2021-21. Further information regarding the elective surgery investment is detailed below.

Elective Surgery

Commencing in 2021-22, the State Government will invest an additional $120 million, on top of the $36.4 million investment already budgeted for 2021- 22, for a total investment of $156.4 million to deliver a record program of elective surgery to slash waiting lists and deliver an additional 22 300 elective surgeries and endoscopies over four years. This investment is estimated to deliver nearly 20 000 more elective surgeries and over 2 300 extra endoscopies over the four-year period.

While this investment is over four years, 2021-22 has been prioritised with an investment of $66.4 million, to provide an estimated additional 8 300 elective surgeries State-wide, bringing the expected total volume in 2021-22 to more than 22 800 surgeries.

Over the next four years, it is estimated that this level of investment will deliver:

- an additional 11 100 surgeries and endoscopies for the State's South, with a funding boost of $78.2 million;
- an additional 7 400 surgeries and endoscopies for the State's North, with a funding boost of $52.1 million, and
- an additional 3 700 additional surgeries and endoscopies for the State's North West, with a funding boost of $26.1 million.

In addition, in order to assist the public sector to cope with this massive investment into elective surgery, a further one-off $20 million will be made available in a fund to allow private hospitals to support our public hospitals to manage demand by;

- assisting the public hospital sector to meet the elective surgery program outlined above;
- allowing for the purchase of beds from private hospitals to improve patient flow and access to care, and
- enabling private hospitals to support public hospitals with demand in other areas, including community nursing and home care.

The final volume of surgeries and endoscopies for each hospital each year will be dependent on the complexity of patients and the types of surgery, which will be determined in consultation with clinicians. To that end, the State-wide Surgical Services Committee are finalising the development of a four year State-wide Surgical Services Plan, which when finalised, will inform the establishment of agreed elective surgery volume, access and NWAU targets for inclusion in an amended 2021-22 Service Plan. An amended 2021-22 Service Plan will be developed following delivery of the State Budget on 26 August 2021.

Part D: Funding Allocation and Activity Schedule – Purchased Volumes and Grants

2021-22 Activity and Funding Schedule

Table 1.1 Tasmanian Health Service	Measure	Activity	Funding ($'000)
Activity Funding			
Admitted			
Acute Patients (Excl Elective Surgery)	NWAU	88 061	492 876
Acute Elective Surgery	NWAU	27 273	152 647
Acute - Scopes	NWAU	4 090	22 892
Acute Facilities Mental Health	NWAU	8 155	45 646
Sub-Acute and Non-Acute	NWAU	8 449	47 288
Non-admitted			
Outpatients - Non-Admitted Patients	NWAU	19 785	110 737
Emergency Department	NWAU	23 482	131 428
Total Activity Funding		**179 295**	**1 003 514**
Block Grants for Activity Based Funded Hospitals			
RHH K-Block Commissioning	Block Funded		18 714
Partnered Pharmacist Medication Charting - Statewide	Block Funded		1 738
Medical Cannabis	Grant		920
Blood	Block Funded		8 782
Boarders	Block Funded		100
Home and Community Care (HACC)	Block Funded		213
Home Ventilation - ABF Block payment model	Block Funded		2 770
Non-ABF Activity	Block Funded		62 758
Organ Procurement	Block Funded		287
Patient Travel Assistance Scheme (PTAS)	Block Funded		6 949
Admitted Acute Patients Supplementation	Block Funded		52 289
Admitted Mental Health Patients Supplementation	Block Funded		3 722
Sub & Non-Acute Inpatients Supplementation	Block Funded		3 563
Emergency Department Supplementation	Block Funded		16 442

Table 1.1 Tasmanian Health Service (continued)	Measure	Activity	Funding ($'000)
Outpatients Supplementation	Block Funded		13 498
Transition Care Program	Block Funded		5 067
Teaching, training and research	Block Funded		47 384
Total Block grants for Activity Based Funded Hospitals			**245 196**
THS Operational Grants			
Health Demand Funding (incl. Budget Commitment: Demand+Beds)	Grant		82 406
Mersey Community Hospital Funding[1]	Grant		25 454
Primary Health	Grant		44 796
Primary Health - NEC Hospitals	Grant		69 851
Stand Alone Mental Health Facilities	Grant		37 515
Mental Health Hospital Avoidance Strategies	Grant		11 782
Child and Adolescent Mental Health Service	Grant		14 947
Mental Health Services	Grant		56 646
Alcohol and Drug Services	Grant		9 313
Alcohol and Drug Services Detoxification Unit (SMHS)	Grant		4 656
Correctional Mental Health Services	Grant		2 814
Oral Health	Grant		21 949
CHAPS	Grant		13 632
Cancer Screening	Grant		6 437
Forensic Medical Services	Grant		1 633
Statewide Ops Command Centre	Grant		1 500
Nurse Graduates Program	Grant		2 951
Palliative Care Clinical Nurse Educators	Grant		400
Interstate Charging	Grant		28 350
Enhancing Retrieval and Referral Services	Grant		144
MedTasker Annual Costs	Grant		303
Total Operational Grants			**437 479**
TOTAL Tasmanian Health Service			**1,686,189**

Notes:

1 $89.7 million is provided in Mersey Community Hospital Funding from TasCorp. In 2021-22 a further $1 million from a 2018 Election Commitment is provided by the State Government. The remaining balance of $58.9 million is incorporated into the THS NWAU activity target of 179 295.

2021-22 Funding Source

Table 1.2 Funding Source	Funding ($'000)
State Funding[1]	1 188 375
Commonwealth Funding[2]	497 814
Sub Total	**1 686 189**
THS Retained Revenue[3]	185 759
Pharmaceutical Benefits Scheme	93 714
Sub Total	**279 473**
Total	**1 965 662**

Notes:

1 State Funding includes State ABF, State Block and $86.6 million provided for Mersey Community Hospital.

2 Commonwealth Funding includes Commonwealth ABF and Block.

3 THS Retained Revenue includes funding for NPAs, COPEs, private funding agreements and operationally driven revenue from patient fees etc (excluding PBS).

NWAU Estimates 2021-22

Table 1.3 Annual NWAU Estimate 2021-22						
Tasmanian Health Service	**Acute Admitted Incl. Elective Surgery**	**Admitted Mental Health**	**Sub-acute and Non-acute (admitted)**	**Emergency**	**Non-admitted**	**Total**
RHH, LGH, NWRH and MCH	119 424	8 155	8 449	23 482	19 785	179 295

The NEP is $5 597 per national weighted activity unit 2021–22 (NWAU (21)).

Part E: Performance

The Service Plan and Performance Framework are instruments that assist the Department in its role as system manager. There are several components of system management that together with these enabling instruments, inform and complement each other within an integrated management system.

This Service Plan is accompanied by a Performance Framework that provides a high level of transparency and accountability across the THS and the Department and will be used to drive better outcomes for Tasmanians.

Performance management and the *Tasmanian Health Service Act 2018*

The Act sets out the obligations of the Department and the THS. The Ministerial Charter provides further practical elaboration of those obligations, including the Minister's expectations of the Department and the THS.

In addition to obligations under the Act, the Performance Framework draws upon key learnings from a range of national and international inquiries, that clearly demonstrate the link between poor patient outcomes and a range of organisational failures. Accordingly, the Performance Framework will include additional information about underlying risk factors to provide a comprehensive view of performance.

Roles and responsibilities of the Secretary and the Executive

The Secretary

- The Act invests the Secretary with the function of:
    - monitoring delivery of health services, and health support services, by the THS in accordance with the Service Plan
    - ensuring the THS Executive performs the functions and powers of the Executive and the THS

The Executive

- The functions of the Executive are to:
    - administer and manage the THS
    - manage, monitor, and report to the Secretary on, the administration and financial performance of the THS, as required by the Secretary
    - establish appropriate management and administrative structures for the THS
    - any other functions specified by the Secretary

Ministerial Charter

On 1 July 2018 the Ministerial Charter came into effect. It sets out the following:

Overall expectations

- The Minister expects the Secretary and THS to work in support of continued improvements in the quality of healthcare in Tasmania
- A robust and integrated culture of research, innovation, high performance and excellence will be fostered.

Specific expectations of the Secretary

- implement the governance framework to support performance monitoring and management of the THS
- develop a consultation and engagement framework that ensures that the views, advice, input, feedback and involvement of consumers, carers, their families, the broader community, clinicians and other partners are sought and integrated into the design and evaluation of health services
- exercise the Secretary's statutory powers, including the power to give directions to the THS in relation to the performance of its functions or exercise of its powers, as necessary.

Specific expectations of the Tasmanian Health Service

- operate as a single statewide service to deliver high quality and safe health services to Tasmanians
- deliver services safely to the levels and standards specified in the Service Plan within the level of funding provided by government
- develop and maintain clear operational governance and accountability structures that ensure that there is appropriate delegated local decision-making
- develop positive organisational cultures that focus on improving the experience and outcomes for Tasmanians and which promote high standard of conduct and ethical behaviour.

The Performance Framework

Performance Objectives

The Performance Framework will provide a high level of transparency and accountability across the THS and the Department and will continue to drive better outcomes for Tasmanians.

The Performance Framework incorporates reporting against underlying factors identified in the *Report of the Auditor-General No.11 of 2018-19: Performance of Tasmania's four major hospitals in the delivery of Emergency Department services* as being of concern, and which are being addressed by the joint THS/Department implementation of the Auditor General's recommendations.

The objectives of the Performance Framework are to monitor, report and respond to THS performance with the aim of ensuring that the following are provided:

- high quality and safe care
- timely and equitable access to care
- efficient and sustainable services
- the right volume of services
- effective financial management
- strong governance, leadership and culture.

The key components of the Performance Framework are:

- clear identification of domains of performance
- descriptions of the underlying performance risks
- clear identification of KPI

- regular reporting of performance against KPI and the underlying performance risks
- a mandated, regular, structured discussion of performance by the Health Executive
- a clearly structured process for interventions and actions where KPI targets are not met
- a clearly structured process for monitoring and reporting of performance of escalation actions.

The Performance Framework will focus on:

- KPI for the Service Plan
- factors underpinning performance against KPI
- achievement of government priorities and funded initiatives
- other factors as deemed relevant by the Minister or the Secretary.

Part F: Key Performance Indicators

The Department and THS will continue to focus on a range of KPI to measure, monitor and assess performance and activity and to support patient safety and health service quality.

KPI have been grouped under several domains described in the *Australian Health Performance Framework 2017* to better organise information and thinking around the complexity of health services delivery. The domains and associated KPI are categorised and numbered below:

- **Effectiveness** – care, intervention or action achieves the desired outcome from both the clinical and patient perspective.
    1. Breast cancer detection
- **Safety** - mitigate risks to avoid unintended or harmful results.
    2. Hospital Safety – reduced risk of hospital acquired infections
    3. Hospital Safety – mental health seclusion
    4. Hospital Safety – reportable events
- **Appropriateness** – service is person centered and culturally appropriate. Consumers are treated with dignity, confidentiality and encouraged to participate in choices related to their care.
    5. Consumer experience
- **Continuity of care** – ability to provide uninterrupted care or service across programs, practitioners and levels over time. Coordination mechanisms work for health care providers and patients.
    6. Mental Health transition from inpatient to community care
    7. Acute Care transition from inpatient to community care
    8. Ambulance offload delay
- **Accessibility** – people can obtain health care at the right place and right time, taking account of different population needs and the affordability of care.
    9. Elective Surgery waiting list reduction – surgery within recommended time*
    10. Elective Surgery waiting list reduction*
    11. Patient flow from Emergency Departments
    12. Emergency Department service provision
- **Efficiency and sustainability** – the right care is delivered at a minimum cost and human and physical capital and technology are maintained and renewed, while innovation occurs to improve efficiency and respond to emerging needs.
    13. Service activity
    14. Financial control
    15. Admitted patient episode coding

** Elective surgery KPI will be confirmed, via a Service Plan amendment, following the development of the four year Statewide Surgical Services Plan.*

In addition to the Service Plan KPI performance monitoring may also include KPI contained in the Department's Monitoring Suite, progress towards milestones contained in performance improvement plans and additional information provided by the THS.

2021-22 Key Performance Indicator Schedule[1]

KPI No.	Key Performance Indicator	Target	Measured Statewide or Facility Level
Effectiveness			
1	**Breast cancer detection**		
1.1	Eligible women screened for breast cancer	35 860	Statewide
1.2	Clients assessed within 28 days of a screen-detected abnormality	Not less than 90 per cent	Statewide
Safety			
2	**Hospital Safety – reduced risk of hospital acquired infections**		
2.1	Hand hygiene compliance	Not less than 80 per cent	All specified facilities
2.2	Healthcare associated infections – staphylococcus aureus bacteraemia	Not more than 1.0 per 10 000 patient days	All specified facilities
3	**Hospital Safety – mental health seclusion**		
3.1	Mental health inpatient seclusion	Less than 8 per 1 000 patient days	Statewide
4	**Hospital Safety – reportable events**		
4.1	Initial reportable event briefs provided within two business days	Not less than 80 per cent	Statewide
4.2	Root cause analyses provided within 70 calendar days	Not less than 80 per cent	Statewide
Appropriateness			
5	**Consumer experience**		
5.1	Consumer experience survey response rate	Not less than 30 per cent	All specified facilities
5.2	Consumer satisfaction with the quality of treatment and care	Not less than 80 per cent	All specified facilities

KPI No.	Key Performance Indicator	Target	Measured Statewide or Facility Level
Continuity of care			
6	**Mental health transition from inpatient to community care**		
6.1	Re-admissions within 28 days	Not more than 14 per cent	Statewide
6.2	Post discharge community care follow up within seven days	Not less than 85 per cent	Statewide
7	**Acute care transition from inpatient to community care**		
7.1	Discharge summaries transmitted within 48 hours of separation	100 per cent	Statewide
8	**Ambulance offload delay**		
8.1	Ambulance offload delay – within 15 minutes	Not less than 85 per cent	All specified facilities
8.2	Ambulance offload delay – within 30 minutes	100 per cent	All specified facilities
Accessibility			
9	**Elective Surgery waiting list reduction – surgery within recommended time**		
	Specific elective surgery KPI will be confirmed, via a Service Plan amendment, following the development of the four year Statewide Surgical Services Plan *(See Part C: Election Commitments)*.		
10	**Elective Surgery waiting list reduction**		
	Specific elective surgery KPI will be confirmed, via a Service Plan amendment, following the development of the four year Statewide Surgical Services Plan *(See Part C: Election Commitments)*.		
11	**Patient flow from Emergency Departments**		
11.1	Patients admitted through the ED with an ED length of stay of less than eight hours	Not less than 90 per cent	All specified facilities
11.2	Patients (non-admitted) through the ED with an ED length of stay less than 12 hours	Not less than 100 per cent	All specified facilities
12	**Emergency Department service provision**		
12.1	ED presentations seen within recommended time – triage 1	100 per cent	All specified facilities

KPI No.	Key Performance Indicator	Target	Measured Statewide or Facility Level
12.2	ED presentations seen within recommended time – all triage categories	Not less than 80 per cent	All specified facilities
12.3	ED presentations who do not wait to be seen	No more than 5 per cent	All specified facilities
Efficiency and sustainability			
13	**Service activity**		
13.1	National weighted activity units (NWAUs)	179 295[2]	Statewide
13.2	Elective surgery admissions	18 283[3]	Statewide
13.3	Dental Weighted Activity Units (DWAUs)	39 853	Statewide
13.4	Dental – Additional Dental Funding	12 261[4]	Statewide
14	**Financial control**		
14.1	Variation from funding – full year projected	Expenditure within funding allocation	Statewide
15	**Admitted patient episode coding**		
15.1	Clinical coding of admitted patient episodes completed on time within 42 days of separation	100 per cent	Statewide
15.2	Clinical coding errors corrected within 30 days	100 per cent	Statewide

Notes:

1 All Service Plan KPI will undergo a review, led by the Department in consultation with the THS, in 2021-22. The outcome of this review may inform future changes to the KPI.

2 The target for KPI 13.1 National weighted activity units (NWAUs) may be amended, via a Service Plan amendment, following the release of the State Budget in August 2021.

3 The target for KPI 13.2 Elective surgery admissions may be amended, via a Service Plan amendment, following the release of the State Budget in August 2021.

4 The target for KPI 13.4 Dental – Additional Dental Funding reflects the 2021-22 component of the total 20 000 target for the full 2020/21 – 2022/23 period.

Appendix 1. COVID-19 Response

In response to the COVID-19 pandemic, the NPCR was implemented on 13 March 2020 to provide states and territories with financial assistance to effectively respond to the COVID-19 outbreak. Under the NPCR, in addition to an up-front advance payment, there are two sets of payments provided by the Australian Government to the State: the Hospital Services Payment, and the State Public Health Payment.

The NPCR will remain in place for the period of the activation of the *Australian Health Sector Emergency Response Plan for Novel Coronavirus 2019 (COVID-19)* as declared by the AHPPC, and then for sufficient additional time to allow for the final reconciliation of any payments made under the agreement.

Hospital Services Payment (HSP)

The HSP includes activities in-scope for payment through the NHRA that are related to the outbreak of COVID-19. Activities related to the outbreak of COVID-19 include:

- services to assess, diagnose and treat people with COVID-19 or suspected of having COVID-19, such as respiratory clinics and testing and diagnostics
- services related to factors associated with the outbreak of COVID-19, such as rescheduled elective surgery.

These include activities that can be expressed in NWAU such as services reported in a state's ABF data submission or that would normally be reported in a state's block funding submission however can be expressed as NWAU.

The Australian Government will provide a 50 per cent contribution for costs incurred by the State under the HSP.

State Public Health Payment (SPHP)

The SPHP includes activities for public health system costs not in-scope for payment through the NHRA that are related to the NHRA. Activities related to the outbreak of COVID-19 include:

- services to assess, diagnose and treat people with COVID-19 or suspected of having COVID-19, such as but not limited to:
    - expenses associated with border force, airport screening and quarantine
    - health expenditure related to costs of care outside hospitals, for example, outreach to rural, remote and/or Indigenous patients, paramedic and ambulance services, patient transport, primary and/or community care, and staffing support for aged care facilities
    - public health communications, operations and telehealth
- services related to factors associated with the outbreak of COVID-19, such as but not limited to:
    - non-clinical costs for hospital services or costs associated with service disruption
    - capital expenditure to respond to increased service demand
    - personal protective equipment
    - treatment of Medicare ineligible patients where there is no other non-out-of-pocket means of funding the patients' service

- investment in public health activities to respond to the outbreak of COVID-19 and protect the Australian community.

The SPHP also includes a COVID-19 Vaccination Dose Delivery Payment, which provides an Australian Government contribution for each COVID-19 vaccination delivered by the states, based on an agreed fixed price per dose.

The Australian Government will provide a 50 per cent contribution for costs incurred by the State under the SPHP, with the exception of the below:

- The SPHP also includes an estimated Financial Viability Payment for all private hospitals in the State, for which the Australian Government agrees to provide the State 100 per cent of the estimated monthly funding
- All activity associated with the NPCR is considered separate to that which underpins the activity volumes outlined in this Service Plan.

Appendix 2. Safety and Quality: Sentinel Events and Hospital Acquired Complications

To improve patient safety and support greater efficiency in the health system, the 2017 NHRA Addendum incorporated a pricing signal for safety and quality. The pricing signal effects the National Efficient Price (NEP) and the National Efficient Cost (NEC) funding models and were progressively implemented from 1 July 2017 and lead to a range of objectives for delivery. These safety and quality pricing signals are continued in the 2020-25 NHRA.

Sentinel Events

In 2017, the ACSQHC undertook a review of the Australian sentinel events list on behalf of the states, territories and the Australian Government. The updated Australian sentinel events list (Version 2.0) was endorsed by Australian Health Ministers in December 2018. Further information on its development and specifications is available on the ACSQHC website.

The national sentinel events (v2.0) are:

- Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
- Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
- Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
- Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death
- Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
- Medication error resulting in serious harm or death
- Use of physical or mechanical restraint resulting in serious harm or death
- Discharge or release of an infant or child to an unauthorised person
- Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death.

All admitted episodes of care in ABF Hospitals (all ABF streams) will see the NWAU set to zero for sentinel events. For ABF block funded hospitals, the funding deduction associated with a sentinel event will be calculated by multiplying the NEP by the NWAU for that episode and that amount deducted from the ABF block payment. The NHFB and the State will make the adjustments during the final reconciliation phase of the annual NHRA payment for ABF NWAU and ABF Block payments.

Hospital Acquired Complications

In accordance with the 2020-25 NHRA, the funding level for admitted acute episodes and Diagnosis-related group (DRG) funded sub-acute and non-acute episodes of care will be reduced where a HAC is present. Separate adjustments have been determined for each HAC. Where an episode contains multiple HACs, the HAC with the largest adjustment determines the funding adjustment.

A HAC refers to a complication which is acquired in hospital for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. The list of HACs was determined by a Joint Working party of the Commission and IHPA.

Version 3.0 of the HAC list will be used for pricing in 2021–22. Further information on the HAC list including diagnosis codes used to identify each HAC, is available on the ACSQHC website.

The funding adjustment for HACs has been risk adjusted to take account of the increased predisposition of some patients to experiencing a HAC during their hospital stay and adjusts the reduction in funding accordingly.

List of hospital acquired complications

Number	Complication
1	Pressure injury
2	Falls resulting in fracture or intracranial injury
3	Healthcare associated infection
4	Surgical complications requiring unplanned return to theatre
5	Unplanned intensive care unit admission [1]
6	Respiratory complications
7	Venous thromboembolism
8	Renal failure
9	Gastrointestinal bleeding
10	Medication complications
11	Delirium
12	Incontinence
13	Endocrine complications
14	Cardiac complications
15	Third and fourth degree perineal laceration during delivery [2]
16	Neonatal birth trauma [2]

[1] *No funding adjustment for 'Unplanned intensive care unit admission' will be applied in 2021–22 as it cannot be identified in current datasets.*

[2] *No funding adjustment for 'Third degree perineal laceration during delivery' and 'Neonatal birth trauma' will be applied in 2021–22 due to small patient cohorts or other issues that have prevented development of a robust risk adjustment approach at this time.*

Avoidable hospital readmissions

Under the Addendum, IHPA is required to develop a pricing model for avoidable hospital readmissions, for implementation by 1 July 2021, following approval from the Council of Australian Governments Health Council.

Unplanned hospital readmissions are a measure of potential issues with the quality, continuity and integration of care provided to patients during or subsequent to their initial hospital admission (the index admission). Reducing the number of avoidable hospital readmissions improves patient health outcomes and decreases avoidable demand for public hospital services.

The list of clinical conditions considered to be avoidable hospital readmissions was approved by the Australian Health Ministers' Advisory Council in June 2017. The avoidable hospital readmission conditions are as follows:

- Pressure injury
- Infections
- Surgical complications
- Respiratory complications
- Venous thromboembolism
- Renal failure
- Gastrointestinal bleeding
- Medication complications
- Delirium
- Cardiac complications
- Other (constipation, nausea and vomiting)

Version 1.0 of the avoidable hospital readmissions list will be used for pricing in 2021–22. Further information on the list, including diagnosis codes used to identify each readmission condition, is available on the ACSQHC website.

The funding adjustment for avoidable hospital readmissions has been risk adjusted to account for the increased predisposition of some patients to experiencing an avoidable hospital readmission during their hospital stay and adjusts the reduction in funding accordingly with use of a risk adjustment factor.

Further information on the risk adjustment model for avoidable hospital readmissions, including the risk factors for each readmission condition, is contained in the National Pricing Model Technical Specifications 2021–22.

Appendix 3. Tasmanian Funding Framework

Principles of the Tasmanian ABF Model

To increase transparency and allocate funding to where resources are required, the Tasmanian ABF Model aims to:

- assists by assigning accountability for the high-level outcomes and targets to be met during the period to which the Service plan applies
- increase the level of public hospital activity for a given level of inputs through technical efficiency
- ensure public hospital resources are allocated to those activities which maximise health outcomes through allocative efficiency
- provide incentives for technological and clinical innovations that lead to better health outcomes
- ensure that public hospitals are funded on a comparable basis for the activity they provide, and that unavoidable differences in costs between hospitals are considered through equitable funds distribution and
- provide incentives to support continuous improvement in patient safety and quality.

Purchasing Health Services

The Service Plan determines the price at which the Department purchases health services from the THS, and the purchasing model determines the volume and complexity of services that are purchased. In terms of the ABF model:

- There are three public hospitals funded through the Tasmanian ABF model (RHH, LGH and NWRH). The Tasmanian ABF model is based largely on the national ABF model but includes some modifications to reflect the local Tasmanian environment.
- While funded through the Mersey NPA, the MCH public hospital services have been included in the NWAU estimates in the Tasmanian ABF model with any deficit between the ABF contribution and the NPA allocation being provided as a supplementation or block grant.
- The NHRA block funding models in the Service Plan broadly define the health services to be provided by the THS through 18 small regional and rural hospitals, Six specialist public mental health hospitals (including the forensic mental health facility), eligible ambulatory community mental programs (including Child and Adolescent Mental Health Services (CAMHS), Clinical Teaching, Training and Research in the major hospitals and Non-Admitted home Ventilation Services.
- The ABF model determines the volume of services that the Department agrees to purchase from the THS, as articulated through the Service Plan. The volume of activity purchased is informed by projected demographic modelled data, One State, One Health System, Better Outcomes – White Paper, State Government commitments and known/forecast service developments in negotiation with the THS,

Tasmanian funding model

The Tasmanian Funding model is in place for 12 months and is effective on 1 July 2021. As the Tasmanian model is based on the national ABF model, which is developed by the IHPA, the Tasmanian model uses the annual National Efficient Price (NEP) and the National Efficient Cost (NEC) determinations produced by IHPA for the specific financial year.

The *Pricing Framework for Australian Public Hospital Services* outlines the principles, scope and methodology adopted by IHPA in the determinations.

Educational and training resources on the topic of ABF are available on IHPA's website.

National Efficient Price

The NEP is developed in close consultation with all Australian governments on an annual basis. The NEP is a single National price based on the average cost of public hospital activity from all states and territories. It underpins national efficient price for health care services provided by public hospitals.

This NEP is applied to admitted services, emergency and non-admitted services. ABF services are priced using a single unit of measure, the NWAU. The Tasmanian funding amount is derived using the formula.

NWAU x NEP = ABF Funding amount.

The NEP is $5 597 per national weighted activity unit 2021–22 (NWAU (21)).

Educational and training resources on the topic of ABF are available on IHPA's website.

National Weighted Activity Units

The NWAU is the national unit for counting hospital service activity, based on the complexity of patients and legitimate variations in costs. The 'average' hospital service is equivalent to one NWAU. More intensive and expensive activities are funded by multiples of NWAUs, and simpler and less expensive activities are funded by fractions of an NWAU.

The NHRA allows for a Commonwealth funding contribution for patients who elect to use their private health insurance when they are admitted to a public hospital. For 2021-22 IHPA has calculate a Tasmanian specific NWAU, which takes into account all other revenue sources available to the hospital included Health Insurance payments. The reduction in the NWAU for private patients is, on average, around 30%, but varies according to the type of DRG or AN-SNAP end class. For example, surgical DRG's generally have higher reductions due to the cost of prostheses.

Educational and training resources on the topic of ABF are available on IHPA's website.

National Efficient Cost

The NEC is for health care services provided by public hospitals where the services are too low to be fully funded on a full activity basis. The NEC cost model is determined using the in-scope activity and expenditure data for services to be block funded. The NEC model has 2 components:

- The NEC for small rural public hospitals:
    - The NEC for small rural public hospitals is the sum of the fixed cost component and the variable cost component. The fixed component is determined as:
        - $2.199 million for hospitals with an annual NWAU (20) less than or equal to 187.

    - $2.199 million less 0.029 per cent per-NWAU (20) for hospitals with an annual NWAU (20) greater than 187. There is an additional loading of 30.2 per cent for 'very remote' hospitals.
    - The variable component of the efficient cost is determined as $5 762 per-NWAU (20) for hospitals with an annual NWAU (20) greater than 187.
- Efficient cost for other hospitals:
    - Other block-funded hospitals are treated separately from the 'variable and fixed' cost model. In Tasmania these are defined as:
        - Standalone hospitals providing specialist mental health services (for example, Roy Fagan Centre, Mistral Place, Millbrook Rise, Tolosa Street, Wilfred Lopes Centre and Alcohol and Drug Services Detoxification Unit)
        - Non- admitted Mental Health services
        - Child & Adolescent Mental Health Service
        - Non- admitted Home Ventilation and
        - Teaching, Training and Research in the major hospitals.
    - The IHPA has determined that for 2021–22, the efficient cost of these hospitals and service will be based on their total in-scope expenditure reported in the Local Hospital Networks/Public hospital Establishments National Minimum Data Set (LHN/PHE NMDS) from 2018−19 and NWAU activity levels reported by the facility.

The NEC is a prospective payment for hospitals without an end of year reconciliation as occurs for NEP hospitals.

Educational and training resources on the topic of ABF are available on IHPA's website.

Block Grants and Operational Grants

For services and initiatives provided where existing data does not accurately describe current activity or the service is not in scope of the NHRA, the service will be funded through a specific grant. The block and grant funding are based on historical expenditure profiles and other known factors.

The 2021-22 Tasmanian Activity Based Funding

ABF is a method of funding hospitals, whereby they are funded based on the mix and volume of patients treated.

Classification systems within each service stream are applied uniformly across all available data. Although these systems have been developed in part to explain variation in cost between different outputs within the stream, additional systematic variation still occurs. To account for this, various adjustments are modelled and where justified, implemented into the NWAU.

Admitted - Admitted Acute

The Australian Refined Diagnosis Related Group (AR-DRG) v10.0 classification system and ICD-10-AM Eleventh Edition will be used to classify and calculate NWAU 21 price weights for acute admitted services under the national ABF model which Tasmania has adopted.

Activity data at AR-DRG v10.0 level is used to set the acute activity volume and complexity of acute admitted services to be funded, where the admitting care type is 'Acute including qualified newborn' and the treatment is eligible for an NWAU weighting. The only exception to using the admitting care type is in the instance where an 'unqualified newborn' becomes qualified during the same episode of care. This is identified in the iPatient Manager (iPM) admissions system when the Admission care type is Neonate (unqualified) and the discharge care type of 'Acute including qualified newborn'.

Further details pertaining to the Acute NWAU adjustments and NWAU can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2021-22* or the NEP determination 2021-22.

Admitted - Sub and Non-Acute

Sub and Non-Acute activity includes patients admitted in the iPM admission system under the care types of Rehabilitation, Palliative Care, Psychogeriatric, Geriatric Evaluation & Management, Social, Other Maintenance, Nursing Home Type and non-residential care clients admitted under Respite.

The AN-SNAP classification will be used as the primary classification system for Sub and Non-Acute patient services under the National and Tasmanian ABF models. However, as there have been difficulties experienced in implementing AN-SNAP across the THS, the DRG or acute inpatient funding model will be used instead of the AN-SNAP classes where admitted data cannot be assigned to an AN-SNAP class.

Further details pertaining to the Sub and Non-Acute NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2021-22* or the NEP determination 2021-22.

Admitted - Mental health care

IHPA has developed the Australian Mental Health Care Classification (AMHCC) to classify and price mental health services across admitted and non-admitted settings in the National ABF model. IHPA will use AMHCC Version 1.0 to shadow price admitted mental health services for 2021–22 and will continue to provide pricing using the AR-DRG Version 10.0 and ICD-10-AM Eleventh Edition for NEP20.

Further details pertaining to the Acute NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2021-22 or* the NEP determination 2021-22.

Non-Admitted - Outpatients

Non-admitted outpatient care will be classified using Tier 2 Version 7.0 for 2021-22. Tasmania has adopted the IHPA classification.

The Tasmanian ABF Model treats the following categories as non-admitted activity:

- Public, Specialist and General outpatient services
- Private, Specialist and General outpatient services (often referred to as Medicare Bulk Billed or Privately Referred Non-Inpatient (PRNI))
- Compensable, (Motor Accident Insurance Board, DVA etc.) Specialist and General outpatient services
- All Bulk Billed admitted service events for which the doctor and patient have elected to treat the patient as non-admitted. These are broadly categorised as Medical Benefits Scheme Type B procedures. These are non-admitted patients that the THS has chosen to record on the admission system to enable categorisation for statistical and clinical data purposes. These services are classified using a map between the International Statistical Classification of Diseases and Related Health Problems, Tenth

Revision, Australian Modification (ICD-10-AM) and the Tier 2 clinic class. (often referred to as Outside Referred Patient or Privately Referred Non-Inpatient (PRNI))

Further details pertaining to the price weights for Tier 2 Non-Admitted Care classification version 7.0 can be found in Appendix J of the NEP determination 2021-22.

Emergency Care

The Australian Emergency Care Classification (AECC) version 1 will be used to classify and price ED (major Hospital) and Urgency Disposition Groups (UDG) version 1.3 will be used to classify Emergency Service (ES) care under the 2021-22 National ABF model. Tasmania has adopted the National ABF model for ED and ES services.

NWAU Price weights for AECC version 1 can be found in Appendix K of the NEP determination 2021-22.

NWAU Price weights for URG version 1.3 can be found in Appendix L of the NEP determination 2021-22.

Further details pertaining to the Emergency Department NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2021-22* for price weights for AECC 1 or UDG 1.3 can be found in the NEP determination 2021-22.

Teaching, Training and Research

The IHPA developed the Australian Teaching and Training Classification (ATTC) as a national classification for teaching and training activities which occur in public hospital service. IHPA has determined that for 2021–22, the efficient cost of Teaching, Training and Research (TT&R) will be determined in consultation with the state with reference to the efficient cost of in-scope expenditure identified as TT&R.

Educational and training resources on the topic of Teaching and Training are available on IHPA's website.

Supplementation Grants

In recognition that the THS has reported average cost greater than the NEP, a Supplementation Grant at the ABF stream level has been incorporated into the Funding Model for 2021-22. The Supplementation Grant is a mechanism for "keeping the system safe and operating" while the THS develops strategies to transition to the NEP.

The Supplementation Grants have been developed at the facility to recognise operational challenges faced by each ABF Facility.

2021-22 ABF Stream Supplementation Grants	Funding ($'000)
ABF Stream Supplementation - RHH	
Admitted Acute	32 106
Admitted Mental Health	2 697
Sub & Non-Acute	2 823
Emergency Department	11 903
Outpatients	10 195
ABF Stream Supplementation - LGH	
Admitted Acute	15 771
Admitted Mental Health	654
Sub & Non-Acute	739
Emergency Department	4 539

2021-22 ABF Stream Supplementation Grants	Funding ($'000)
Outpatients	2 833
ABF Stream Supplementation - NWRH	
Admitted Acute	4 412
Admitted Mental Health	371
Sub & Non-Acute	2
Emergency Department	0
Outpatients	469

The THS is encouraged to use the data available in the National Benchmarking Portal to identify the key cost drivers affecting their overall cost performance.

NHRA Public Hospital Funding

In line with the NHRA, a single National Health Funding Pool (NHFP) been established, comprising a Reserve Bank of Australia account for each state and territory. The pool is operated by the NHFP Administrator (the Administrator), an independent statutory office holder.

All Australian Government funding for the NHRA is deposited into the State Pool Account along with the State's contribution to activity-based public hospital funding. NHR funding is paid to THS in accordance with the Service Plan.

The Administrator has responsibility for calculating the Australian Government contributions to states and ensuring Australian Government deposits into the NHFP are in line with the NHRA (ABF and NHRA Block models):

- Australian Government and State ABF Funding are deposited into the NHFP, then distributed directly to the State Pool Account; this is distributed directly to the THS. The ABF Funding is determined by the NWAU activity itemised in the Service Plan.
- Australian Government NHRA block funding is deposited into the NHFP, then distributed directly to the THS though the State Managed Fund (SMF). Similarly, State Block Funding is transferred directly to THS through the SMF, in accordance with the Service Plan.

During the annual ABF reconciliation process The Administrator may make a further adjustment to the price of an admitted activity to account for private insurance benefits paid for activity in public hospitals that has not been accounted for by the combined adjustments in the national efficient price (NEP) and state or territory funding models.

Further details pertaining to the Commonwealth National Health Reform funding to States and Territories can be found in the National Health Funding Bodies website.

Other State Health budget funds are paid though the SMF and do not form part of the NHR funding arrangements.

Adjustments to funding for any activity variance (increase/decrease) will be actioned via amendments to the Service Plan and as a result of the year activity/funding reconciliation process with the NHFB.