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1 Introduction

1.1 Purpose of the NSW Funding Guidelines 2004/2005

Health Services are required to allocate funds across all program areas within their funding allocation. This task is fundamental to achieving Health Service plans for service delivery that reflects government and local priorities and strategies.

The primary purpose of the *NSW Funding Guidelines 2004/2005* is to assist Health Services to implement the output based funding models described in the *Guidelines* and further develop the link between funding and planned activity.

The *Guidelines* do not concern broad strategic issues in the allocation of Health Service funding but are designed to complement existing policies and planning guidelines prepared by both NSW Health and Health Services. It is important to recognise that, before being in a position to allocate budgets to facilities and services within the scope of the output based funding models, Health Services must decide on how they will allocate resources across all programs. This task is fundamental to strategic and service planning at the Health Service level and requires Health Services to take into account a range of considerations, including:

- Additional funding provided by the Government linked to specific service requirements.
- The Health Service's plans for strategically changing the shape of service delivery to better reflect Government and local priorities and strategies.
- The current shape of service delivery compared to State averages. Such comparisons may help to identify issues where greater priority should be given.
- Major service and capital developments that will impact on the level, cost and mix of services provided.

1.2 Application

The *Guidelines* apply to the NSW public health system, which comprises rural and metropolitan Health Services and the Children's Hospital at Westmead. There are other services such as the Ambulance Service of NSW and Justice Health that are also part of the NSW public health system. However, these *Guidelines* do not extend to these services.

1.3 Scope

The *Guidelines* for 2004/05 describe, and provide guidelines for the implementation of, output based funding models covering the following program areas:

- Acute inpatients;
- Emergency department (ED); and
- Intensive care (IC).

In addition, a new funding model for sub- and non- acute patients (SNAP) will be introduced on a shadow funding basis from 1 July 2004. As this is a new model, it is described in detail in a separate document entitled *NSW Funding Guidelines for Rehabilitation and Extended Care 2004/05* (NSW Health 2004).

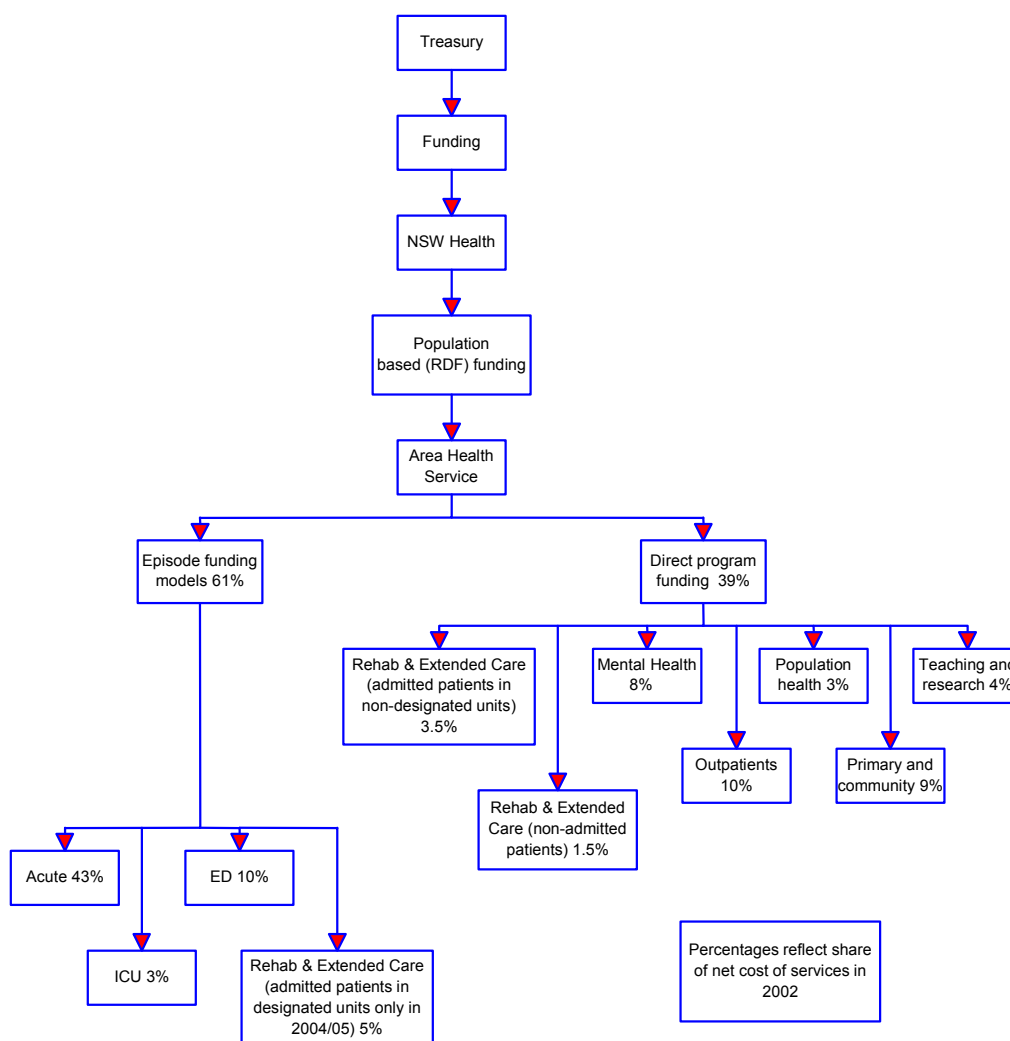
Although separate funding models exist for the above program areas, the *Guidelines* are intended to be used to inform the overall budgets allocated to facilities. They are not designed to be used

to allocate budgets within facilities to particular clinical services. Health Services and facilities should jointly determine the process of funding clinical units within facilities, within the overall funding framework, considering any incentives provided by acute inpatient funding at the facility level.

NSW Health will continue to negotiate global activity targets with Health Services, particularly in the context of ensuring value in the use of enhancement funding. Health Services will continue to be responsible for service planning and for determining the mix of services within global activity targets, subject to any state-wide planning guidelines and requirements.

1.4 Overview of Health Funding in NSW

Figure 1.1 sets out the flow of funds within NSW Health for 2004/05:



Source: NSW Health Annual Report 2002/03. Program 4.1 splits based on the analysis in the *NSW Funding Guidelines for Rehabilitation and Extended Care Services 2004/05*.

Under the Government’s Action Plan for Health introduced in 2000, funding for Health Services was substantially increased and guaranteed over three years. The second funding cycle formally incorporating output based funding will commence in 2004/05.

NSW Health's population funding approach, the Resource Distribution Formula (RDF) will also continue. It is used to guide the allocation of funding between Health Services and to address historical funding inequities.

Within their population based funding allocation, Health Services are required to allocate funds across all program areas. These *Guidelines* describe the output-based funding models to be used for the Acute Inpatient, Emergency Department and ICU, whilst a separate document describes the new SNAP funding model. Direct program funding will continue for other programs where an output based funding model has not yet been developed.

1.5 Key Changes to the *Guidelines* from 2003/04

The *NSW Funding Guidelines 2004/2005* supersedes the *NSW Funding Guidelines 2003/2004* (NSW Health 2003a). The key changes to the *Guidelines* since last year are:

- Replacing “cost benchmark” terminology with “Peer Reference Cost” (PRC) to more accurately reflect their intended purpose;
- Revised PRCs for 2004/05;
- Revised policy on justification grants following the work of the NSW Peer Hospital Benchmarking Steering Committee;
- Incorporation of reporting requirements to NSW Health for 2004/05.

In addition, a new funding model for sub- and non- acute patients (SNAP) will be introduced on a shadow funding basis from 1 July 2004. As this is a new model, it is described in detail in a separate document entitled *NSW Funding Guidelines for Rehabilitation and Extended Care 2004/05* (NSW Health 2004).

The document has also been streamlined to improve readability and to focus on the principles.

1.6 Future Developments

Output based funding will continue to be expanded in future years to encompass entire episodes of illness. This will require the use of classification and costing systems that capture other settings and types of care.

Existing methods of funding will continue for the remaining services until there are standard measures of output and implementation of agreed service classifications in program areas such as mental health, community health and outpatient services.

1.7 Related Documents

These *Guidelines* should be read in conjunction with a range of other policies and documents produced by NSW Health. These documents are listed in Section 9.

In particular, the development of the acute inpatient, ED and ICU funding models is documented in detail in *NSW Episode Funding Guidelines for Acute Inpatient Services 2002/2003* (2002a), *NSW Funding Guidelines for Emergency Department Services 2002/2003* NSW Health (2002b) and *NSW Funding Guidelines for Intensive Care Services 2002/2003* NSW Health (2002c).

2 Overview of Output Based Funding Models

2.1 Output Based Funding Model Objectives

Output based funding models seek to derive budgets that are linked to the expected outputs (such as episodes of care) for a particular program area. The objectives of output based funding models are:

- To create an explicit relationship between funds allocated and services provided;
- To encourage a shift of focus of management to outputs, outcomes and quality;
- To encourage clinicians and facility managers to identify variations in costs and practices so that these can be managed at a local level in the context of improving efficiency and effectiveness, and
- To provide mechanisms to reward good practice and support quality initiatives.

The funding models are intended to equitably share financial risk between Health Services and facilities and to create incentives that are in the best interests of patients. Health Services will need to ensure that facilities carry the financial risk for those factors that are within their control (eg efficiency). However, facilities should not be required to carry all financial risk for factors outside their control (eg differences in severity or complexity between patients that are not adequately measured in the AR-DRG classification, differences in severity or complexity between ED and IC patients).

Efficiencies arising from implementing the funding models will be retained by Health Services and will be used to meet increased service demand, expand services in high priority areas, introduce better models of care and invest in research, technology and training.

2.2 Output Based Funding Models 2004/05

In these *Guidelines*, separate output based funding models are described for the following services:

- Acute inpatient care services;
- Emergency department (ED) services; and
- Intensive care (IC) services.

A new funding model for sub- and non- acute patients (SNAP) will be introduced on a shadow funding basis from 1 July 2004. As this is a new model, it is described in detail in a separate document entitled *NSW Funding Guidelines for Rehabilitation and Extended Care 2004/05* (NSW Health 2004).

With the introduction of SNAP in 2004/05, the structure of output based funding models now is as follows:

Setting / Type of Care	Primary and Community Care	Acute			Sub- and Non-Acute
Inpatient	N/A	Emergency Department	AR-DRGs	ICU	AN-SNAP
Same day	N/A		AR-DRGs with same day weights		AN-SNAP
Outpatient	N/A		Select / modify available clinic based system		AN-SNAP
Community	Progressive development of specific modules for Primary and Community Care. Linkage with SNAP & MH-CASC.				AN-SNAP

2.3 Funding Model Details

For each funding model, it is necessary to define the scope, the measure of activity and the Peer Reference Cost applicable. The following Sections of the *Guidelines* deal with each of these in turn.

The implementation of the funding models also requires Health Services to:

- Determine incentive and optional volume components for the acute inpatient funding model;
- Assess activity and infrastructure components of facility budgets;
- Assess transition and justification grants for 2004/05; and
- Comply with reporting requirements to NSW Health.

These aspects are also dealt with in the following Sections of these *Guidelines*.

3 Scope of Output Based Funding Models

With separate funding models for acute inpatient, ED, ICU and SNAP, it is important to establish the scope of each model to ensure appropriate consistency between the models. The design of the models reflects the result of extensive consultation between clinicians, administrators and others.

The following provides further detail on the establishing the scope of each funding models for 2004/05.

3.1 Acute Inpatient Funding Model

All services and costs included within Programs 2.2 and 2.3 (Overnight and Same Day Acute Inpatient Services) in A1a to C2 peer hospitals are within the scope of the acute inpatient funding model apart from the following:

- Designated mental health care acute units;
- Patients treated in designated psychiatric facilities (Psychiatric Patient Status = “1”);
- Patients whose service category is one of Rehabilitation Care, Palliative Care, Maintenance Care (non-acute care including NHTP), Geriatric Evaluation and Management, Psychogeriatric and other non-admitted activity reported via a patient administration system. Where any of these have been identified and funded under Programs 2.2 and 2.3, their costs should be excluded from the inpatient funding model at the rates set out in Appendix B;
- Renal dialysis. Appendix C provides the rationale for excluding these services and a suggested payment method on a patient basis.
- Same day chemotherapy. This should be funded with chemotherapy provided on an outpatient basis.

Some additional ED and ICU services and / or costs have also been included in the acute inpatient funding model as described below:

3.1.1 ED Services

The types of emergency departments falling within the scope of the ED funding model are defined in Section 3.2 below.

Table 3.1 below sets out the boundaries between the acute inpatient and ED funding models for 2004/05. This remains unchanged from previous years:

Table 3.1: Boundaries between acute inpatient and ED funding models

	Emergency Departments in Scope of ED Funding Model	Emergency Departments not in Scope of ED Funding Model
Patients Admitted and Discharged from ED, and non-admitted	Entirely within the scope of the ED funding model	No output based funding model
Patients Presenting in ED and transferred to a ward	Costs for diagnostic and prescribed pharmacy ordered whilst patient was in ED fall within the scope of acute inpatient funding model	Entirely within the scope of the acute inpatient funding model

The above boundaries were formulated in recognition that clinical management of patients treated in EDs is often shared between the ED and the attending medical officer who will ultimately manage treatment in the ward, and that frequently diagnostic tests are ordered whilst the patient is still located within the ED but not utilised until the patient is in the ward.

Where patients admitted and discharged from an ED without being transferred to a ward cannot be identified, same day admissions through the ED should be excluded from the acute inpatient funding model.

3.1.2 Intensive Care Services

The types of IC services falling within the boundary of the ICU funding model is defined in Section 3.3 below. However, some “intensive care” activity falls within the scope of the acute inpatient funding model. These are:

- Neonatal Intensive Care Units (NICUs), as DRGs provide a suitable description of the activity in these units.
- Coronary Care Units, as DRGs provide a suitable description of the activity in these units.
- High dependency patient bed-days, as DRGs provide a suitable description of this activity. This includes high dependency care provided in joint ICU / HD units that fall within the scope of the ICU funding model. Further detail on issues relating to high dependency patient services may be found in Appendix B.
- Units that do not fall within the scope of the IC funding model, but which have the capacity for short term mechanical ventilation (MV). This includes all MV activity whether provided in an ICU or elsewhere within the facility. Such activity is subject to a co-payment in addition to the base acute inpatient payment. Further detail on mechanical ventilation co-payments are contained in Appendix D.

3.1.3 Quaternary Services

Only low volume, high cost services such as Nationally Funded Centres and organ transplant units should be considered for exclusion from the acute inpatient funding model. The preferred position is that quaternary services should be included in the acute inpatient funding model.

3.2 Emergency Department Funding Model

Facilities with an ED with a delineated role of Level 4 or above are within the scope of the ED funding model. EDs with a delineated role of Level 4 and above “can manage most emergencies, including stabilisation and assisted ventilation” and have experienced medical officers on site 24 hours a day.

EDs with a role delineation of less than Level 4 are excluded from mandatory inclusion in the ED funding model. This is because these EDs generally do not have 24 hour access to the range of services available to higher level ED, and do not incur a similar level of fixed availability costs. However, Health Services may include a Level 3 unit in applying the ED funding model if appropriate.

All services provided in the in-scope EDs are included within the ED funding model, including the ED component of a subsequently admitted patient’s stay. The only exception to this are costs for diagnostic and prescribed pharmacy ordered whilst the patient was in ED (as described in Section 3.1.1). This is based on the general principle that the scope of ED activity to be

subject to separate funding should encompass the full range of services managed by clinical managers of EDs so funding and clinical decisions are aligned.

Services provided in 'short-stay wards' (however named) that are part of the ED and under the clinical management of the Director of ED fall within the scope of the ED funding model. However, services that are a substitute for outpatient activity (such as methadone clinics funded through the drug and alcohol program but run in the ED) are not within the scope of the ED funding model. Appendix B contains a suggested basis for excluding these services from the ED funding model.

3.2.1 ED Services Not Within Scope of ED Funding Model

Health Services need to resolve how to fund ED-type services in facilities where the ED has a delineated role of less than Level 4. Appendix B contains suggestions on how this might be done.

3.3 Intensive Care Funding Model

The IC funding model is to apply to facilities with a delineated ICU of Level 5 or 6 (including Paediatric ICUs and Cardiothoracic ICUs). 20 facilities with such units in NSW are to be included in 2004/05. They are:

Bankstown	Blacktown
Children's Hospital at Westmead	Concord
Gosford	Hornsby
John Hunter	Lismore
Liverpool	Nepean
Prince of Wales	Royal North Shore
Royal Prince Alfred	St George
St Vincent's	Sutherland
Sydney Children's	Westmead (General ICU only)
Wollongong	Tamworth

Rural Level 4 units that meet the following criteria for inclusion in the model need to be identified and included in the model in 2004/05:

- Be staffed to provide a minimum nursing ratio of 1:2 for a minimum of 6 beds, and
- Have a minimum throughput of 150 ventilated patients or 600 IC bed-days per year.

On this basis, 8 additional units meet these criteria and are as follows – Albury, Bathurst, Coffs Harbour, Dubbo, Orange, Manning, Port Macquarie and Tweed Heads.

The intensive care services that fall within the scope of the acute inpatient funding model (listed under Section 3.1.2) are not within the scope of the ICU funding model.

The following specific costs are to be included in the IC funding model for 2004/05 (as in previous years):

1. IC patient clinical costs (pathology and diagnostic imaging ordered for patients within the ICU, and drugs prescribed for patients treated within the ICU). Where these cannot be directly allocated to the ICU funding stream (e.g. because they are incurred under other cost centres), the adjustment factors set out in Appendix D may be used.
2. Consultation and liaison costs undertaken by ICU staff.

4 Activity Level Determination for 2004/05

The application of the output based funding models requires activity levels for 2004/05 to be determined.

Activity levels are to be measured as follows:

- **Acute inpatient activity:** AR-DRGs (excluding ED, ICU and depreciation components). The classes and cost weights are set out in the *NSW Costs of Care Standards 2004/05* (NSW Health 2004).
- **Emergency care activity:** Urgency and Disposition Groups (UDGs, NSW adaptation). The classes and cost weights are set out in the *NSW Costs of Care Standards 2004/05* (NSW Health 2004).
- **Intensive care activity:** number of IC bed-days or MV hours. Further detail on issues relating to high dependency patient services may be found in Appendix B.

For acute inpatient services, Health Service may choose to fund either:

- Facilities; or
- “Clinical streams” (however termed) that may cut across inpatient, outpatient and community based services.

Both are valid approaches and the core principle applies to each: that funding is linked to planned output. For convenience, these *Guidelines* refer to ‘facilities’, but this term can be taken to mean clinical stream or any other organisational unit that is allocated a budget for the provision of acute inpatient care. Nevertheless, reporting requirements (see Section 8) remain specified by facility, so where “clinical streams” are adopted, facility by facility reporting will still need to be maintained.

The determination of activity levels for 2004/05 is a matter for Health Services to assess. However, the following broad guidelines are suggested:

- The determination should be carried out in consultation with clinicians;
- The formal processes established by Health Services for planning and managing elective workloads that link to the activity targets set for acute inpatient care in episode funded facilities should be used. Appendix E provides a more detailed discussion of how this might be done.
- Other relevant factors such as strategic service development plans and government initiatives should be considered.

5 Peer Reference Costs 2004/05

Peer Reference Costs (PRCs, previously referred to as “cost benchmarks”) provide a basis for comparing the cost of individual facilities against other peers. The PRCs are also compared against proposed facility budgets (discussed further in Section 7).

5.1 Peer Groups

PRCs for the acute inpatient and emergency department funding models for 2004/05 have been set. The peer groups applicable for 2004/05 are as defined in *NSW Peer Hospital Groups 2001/02* (NSW Health 2003b).

5.2 Acute Inpatient

The level of funding implied by the PRCs in 2004/05 can be derived by multiplying the target level of case weighted activity¹ by the relevant PRC as shown in Table 3.4.1 below.

Table 5.1

Peer group	2004/05 PRC
A1a Principal referral 1a	\$ 3,050
A1b Principal referral 1b	\$ 2,775
A2 Specialist paediatric	\$ 3,275
A3 Ungrouped acute	\$ 2,775
B1 Major metropolitan	\$ 2,775
B2 Major non metropolitan	\$ 2,900
C1 District group 1	\$ 2,950
C2 District group 2	\$ 2,850

Further detail on the derivation of these PRCs is contained in Appendix A.

5.3 Emergency Department

The PRCs for ED for 2004/05 are shown in Table 3.4.2 below.

Table 5.2

ED Peer Group	PRC per case weighted ED presentation
ED Peer Group A1/B1 and Sydney Hospital (all A1 and B1 hospitals)	\$380
ED Peer Group A2 (The two Children’s Hospitals)	\$310
ED Peer Group B2/C1 and Newcastle Mater Hospital (All B2 and C1 hospitals)	\$285

¹ The cost weights should be those excluding the ED and ICU component.

Further detail on the derivation of these PRCs is contained in Appendix A.

5.4 Intensive Care

The PRCs for intensive care for 2004/05 are shown in the table below.

Table 5.3

Patient type	PRC per IC patient day
Chargeable patients	\$3,009
Non chargeable patients	\$3,307

5.5 Process for Updating PRCs for 2005/06

Historically the PRCs have been updated each year using the most recent costing data and / or surveys available. Where Health Services are attempting to drive the costs of particular facilities towards the PRC, it has been pointed out that this potentially creates a “moving target”.

PRCs for 2005/06 will therefore be based on indexing the 2004/05 PRCs, rather than “resetting” the PRCs using the 2003/04 HCDC. This will provide greater stability and certainty in assessing facility costs against the PRCs. This would be subject to any one-off adjustments that may be required due to external factors such as cost weight changes.

6 Incentive and Volume Components of the Inpatient Funding Model

6.1 Incentive Funding

6.1.1 *Description and Purpose*

Health Services are expected to achieve performance targets set by NSW Health such as targets for the number of long wait (over 12 months) patients on waiting lists. Health Services must identify locally determined performance issues and strategies to meet these targets. In doing so, Health Services are required to determine, in addition to other strategies, how this can be achieved through some form of incentive funding. The establishment of an Incentive Pool is considered best practice although Health Services have discretion over the size and nature of the incentive funding arrangements.

Health Services are to identify required performance improvement targets and strategies, and then decide which, if any, will be eligible for funding from an Incentive Pool allocated *retrospectively*, or which will be built into a *prospective* payment to the facility.

6.1.2 *Retrospective Incentive Funding*

Retrospective incentive funding can be structured so that payments at an agreed level are made for performance that exceeds a specified threshold. The incentive payments can also be expressed as a proportion of an agreed target. For example, the payment for meeting waiting time targets could be in proportion to the progress made, with full payment reached when the target is exceeded. Such approaches require a proportion of funding to be held in an Incentive Pool and allocated retrospectively if the target is met.

Arrangements are required to ensure that incentive payments do not exceed the size of the Incentive Pool established. For example, where claims on the Incentive Pool are larger than anticipated due to better than expected performance, the rate used to calculate the incentive payment could be reduced proportionately.

6.1.3 *Prospective Incentive Funding*

Prospective incentive funding can be used to fund increased activity for specific services or support performance and quality enhancing activities. For example, if the Health Service wishes to encourage increased activity in particular procedures to address the size of the waiting list, it could agree to pay facilities at a variable rate for agreed levels of additional procedures above historic or target levels. In addition, Health Services may choose to provide facilities with a fixed prospective payment on the condition that they participate in specified benchmarking and quality improvement activities.

6.2 Volume Adjustment

Volume adjustment provides a means for facilities to share part or all of the financial risk that arises from variations in activity with Health Services. The use of a Volume Adjustment Pool is at the discretion of each Health Service.

Risk sharing boundaries may be established as a part of these arrangements. For example, thresholds may be agreed so that volume payments are made only if activity varies outside of these thresholds (eg, +/- 5%, +/-2% or different thresholds for different services). Health

Services may also seek to establish requirements for facilities to explain activity variation before Volume Adjustments are made.

In addition to determining the quantum of funds to be allocated to the Volume Adjustment Pool, Health Services also need to agree on how surplus funds are to be distributed. Surplus funds could arise either because a hospital budget is reduced in response to low volumes or because claims on the pool are less than anticipated.

7 Budget Allocation, Transition Grants and Justification Grants

As part of the budget allocation process for facilities, Health Services will be required to advise NSW Health of the proposed expenditure budget allocation for 2004/05 for their facilities and services.

These budgets are set within the context of the overall funding allocation of a Health Service. However, they must also be compared against the funding that would be implied using the Peer Reference Costs (PRCs) described in Section 5.

Transition grants refer to variances between proposed budgets and the funding implied using the Peer Reference Costs that are expected to be phased out over a defined period following the introduction of an output-based funding model for a particular service.

Justification grants refer to variances between proposed budgets and the funding implied using the Peer Reference Costs that reflect the unavoidable cost that other facilities in the peer group do not incur.

This Section provides further detail on these aspects of the *Guidelines*.

7.1 Activity and Infrastructure Components

For each in-scope service, Health Services are to divide facility budgets into an *activity* and an *infrastructure* component.

7.1.1 Activity Component

The activity component of a facility's budget is intended to reflect those costs that vary either directly or reasonably significantly with activity levels.

Standard activity payment rates are not prescribed in these *Guidelines*. Health Services will need to determine their own activity payment rates. However, the following activity payment rates have historically been suggested in the *Guidelines*:

Program	Activity Payment Basis
Acute Inpatient	Approximately 65% of the lowest PRC for acute inpatients.
Emergency Department	Approximately 20% of the PRC for ED as set out in Table 3.4.2.
Intensive Care	Approximately 20% of the PRC for ICU as set out in Table 3.4.4.

The activity component is then derived by applying the activity payment to the projected activity level for 2004/05 for acute inpatient, emergency department and intensive care services.

7.1.2 Infrastructure Component

The infrastructure component of a facility's budget is intended to reflect those costs that either do not vary with or are reasonably fixed relative to activity levels.

7.2 Transition Grants

There are no transition grants for 2004/05.

For the SNAP funding model, 2004/05 is a shadow funding year to allow data and implementation issues with the new model to be resolved, and the design of the model to be refined in the light of experience. Transition grants in relation to these services are then expected to commence in 2005/06.

7.3 Justification Grants

In previous years, requirements for justified grants were specified for each of acute inpatient, emergency department and intensive care services in-scope of the output funding models. Health Services should continue to review individual facility budgets in this way.

For 2004/05, the *total* proposed budget for a facility for acute inpatient, emergency department and intensive care services in-scope of the output funding models is to be compared against the *total* budget implied by the Peer Reference Costs set out in Section 5.

The NSW Peer Hospital Benchmarking Steering Committee has examined the issues concerning justified grants and potential methodologies for quantifying the grants. This year's *Guidelines* have been modified to reflect the findings of the Committee.

Where the total budget (as described above) proposed for a facility is different to (higher or lower than) the total budget implied by the Peer Reference Costs, Health Services are required to explain and quantify the unavoidable cost that other facilities in their peer group do not incur. In carrying out this exercise, Health Services should:

- Assess casemix, admission status and patient transport cost drivers and quantify the extent to which the facility incurs unavoidable cost to a greater or lesser extent than other facilities in its peer group. The total of these factors would comprise the justified grant. Other factors may be examined provided that the effect is quantified.
- Provide justification that these costs are essential and unavoidable to the operation of the facility and achievement of its designated role and function;
- Identify whether these costs are fixed or variable costs.

It is acknowledged that precise quantification of the above factors is a complex exercise. However, the completion of the process:

- Provides a formal means for investigating the potential reasons for facility costs higher than Peer Reference Costs;
- Provides a formal means for identifying potential improvements (either identification of inefficiencies or the need for increased funding to improve services) for facilities with costs lower than Peer Reference Costs; and
- Provides a formal basis for comparisons between facilities within the same peer group.

Health Services may be requested to submit a formal written statement to NSW Health regarding the proposed budget for individual facilities. This may occur, for example, where the variances against PRCs are significant (either higher or lower).

8 Implementation and Reporting

8.1 Implementation Guidelines

The implementation of these *Guidelines* should be seen as an opportunity for Health Services to realise the objectives of output based funding models as described in Section 2. This Section provides some broad guidelines on the overall implementation process at a Health Service level.

Health Services need to bring together clinicians, facility managers, and other staff to review the implementation of the funding models at a Health Service and facility level. Health Services are expected to continue to involve clinicians in the process of determining and monitoring funded activity and budgets.

8.1.1 Funding Service Agreements with Facilities

Health Services should consider the following in constructing Funding Service Agreements with individual facilities:

- Specify the agreed target levels of activity in 2004/05 as described in Section 4.
- Specify the agreed rules of any prospective and retrospective components to be included as described in Section 6.
- Specify the agreed level of funding that combines:
 - The activity and infrastructure components as described in Section 7. The difference between these amounts and those implied by applying the Peer Reference Costs should be provided to facilities;
 - Prospective / retrospective components; and
 - Funding for programs and other services not within scope of the output based funding models.
- Specify the agreed reporting requirements to the Health Service.

These Agreements also need to be considered in the broader context of other factors such as waiting list targets.

8.2 NSW Health Reporting Requirements

NSW Health's reporting requirements for 2004/05 will broadly continue the requirements established in 2003/04. The requirements are designed to:

- Reconcile Health Service program budgets to those allocated to individual facilities;
- Provide the information required for state-wide feedback reports that will allow comparison between peer hospitals within the scope of the output based funding models; and
- Provide ongoing (quarterly) monitoring of progress against individual facility budgets during the year.

Detailed instructions and a spreadsheet template will be issued to Health Services.

8.3 Aids for Implementing the Funding Models

NSW Health has been working with Health Services to provide support and information necessary to implement the funding models. The following aids and tools are available:

The Health Information Exchange (HIE) provides cost weighted data for Health Services to monitor progress against targets and generate their own activity reports. The cost weights to be applied in 2004/05 are available through the HIE.

A database will be released to Health Services that contains costs by cost component for all hospitals that submitted data to the 2002/03 NSW Hospital Cost Data Collection. It has a number of built-in reports that show the cost by cost component for different hospitals for the same DRG and can be used for comparison purposes.

Section 9 contains other reference documents that should be consulted. Information on funding, costs of care standards and cost weights can be found at
<http://www.health.nsw.gov.au/pubs/index.html>.

9 References

NSW Health (2004a) *NSW Costs of Care Standards 2004/05*, NSW Health Department.

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Appendix A: Peer Reference Cost Derivation for 2004/05

This Appendix provides details on the derivation of Peer Reference Costs for 2004/05.

Historically, the term “cost benchmark” has been used for Episode Funding purposes. It has been noted that the term “benchmark” implies a measure that reflects an objective standard of best practice. The Episode Funding costs historically derived provide a reference point for each peer group, given the historic costs incurred by that peer group. This is not a “benchmark” in the sense defined above. Consequently, “cost benchmark” terminology has been replaced with *Peer Reference Cost (PRC)*.

Acute Inpatient

The PRCs for 2004/05 for acute inpatients have been based on the 2002/03 HCDC results. The cost weights applied were the cost weights from the *NSW Cost of Care Standards 2004/05* (NSW 2004a).

2002/03 HCDC Results

The 2002/03 HCDC results provide the starting point for the derivation of the PRCs.

The preparation of this data is a very complex process. Firstly, the data from the various files provided by the hospitals for the Collection is edited and reconciled. In particular, the activity files are matched with the cost-per-episode file for the cost modelling hospitals, and any large mismatches are noted and fixed. For cost modelling hospitals, a range of checks such as cost centre mapping and the application of inpatient fractions are checked and the results re-processed if required.

Secondly, the data from the HCDC is merged with the Inpatient Statistics Collection (ISC) contained in the HIE. In some instances the costs are at an episode level (ie for clinical costing hospitals), and in others they are at a DRG level, separate for same day and overnight cases, and for public and private patients (ie for cost modelling hospitals). The totals for each hospital resulting from this process are checked with the original totals provided by the hospitals through their HCDC files. Again, large discrepancies are checked and corrected. Mismatched cases between the two collections are excluded (ie episodes in the HIE but not in the HCDC and vice versa).

Thirdly, cases outside the scope of Episode Funding are excluded from the analysis (as described in Section 3).

Fourthly, the average cost per casemix weighted separation is calculated for each episode using the rules in the NSW Costs of Care Standards. The Standards adjust for long stay outliers (per diem inflation), indigenous status, same day (discounted cost weight for selected DRGs), private patients, and transfers (discounted cost weights for transfers with a one day length of stay). In addition, ED and ICU costs are removed for hospitals with ED and ICU services in-scope of the ED and ICU funding models, and depreciation is removed for all hospitals. The calculation is as follows:

Cost per Casemix Weighted Inpatient Excl ED & ICU, Excl Deprec=

$$\frac{(\text{Total Acute Expenditure Excl ED, ICU \& Deprec Costs})}{(\text{Total Acute AR-DRG Weighted Seps Excl ICU \& ED})}$$

The 2002/03 HCDC has been carried out on a basis consistent with the 2001/02 HCDC used to set the 2003/04 “cost benchmarks”.

Use of Averages

The weighted average cost for each peer group from above data is used as the starting point for the PRC.

Indexation Factors

Updated indexation factors for 2003/04 and 2004/05 have been sourced from Finance Branch. The indexation factors represent the current best estimate of the weighted cost escalation for the relevant periods for health costs incurred by Health Services.

The factors adopted for indexing the 2002/03 HCDC results are:

2003/04	4.61%
2004/05	2.00%

Efficiency Adjustments

The efficiency adjustment implied in the 2003/04 “cost benchmarks” has been converted to a uniform percentage across all peer groups for the purpose of the 2004/05 PRCs.

The 2003/04 “cost benchmarks” were set using the 33 1/3rd percentile for each peer group rather than the average, which resulted in efficiency adjustments that varied between peer groups.

The average implied efficiency adjustment across all peer groups was approximately 3%. In order to maintain broad consistency with the 2003/04 methodology, a uniform efficiency adjustment of 3% has been adopted in deriving the 2004/05 PRCs.

Minimum PRC from 2003/04

The PRC for 2004/05 has been set at the greater of the above calculation, and the 2003/04 cost “benchmark” indexed by 2% (being the 2004/05 indexation factor), in order to mitigate any discontinuity with historic benchmarks. This affects the final PRC derived for the A1b, B2, C1 and C2 peer groups.

Summary

The following table sets out the results of the above calculations and compares the result to the 2003/04 “cost benchmarks”:

Table A1: Calculation of Acute Inpatient PRCs for 2004/05 and comparison to 2003/04

Peer Hospital Group		Peer	Indexed	Apply	Minimum	PRC	Cost	% Chg
		Average	to	Efficiency			Benchmark	
		2002/03	2004/05	Adjustment		2004/05	2003/04	
		(1)	(2)	(3)	(4)	(5)		
A1a	Principal Referral Group A	2,951	3,149	3,055	3,009	3,050	2,950	3.4%
A1b	Principal Referral Group B	2,650	2,828	2,743	2,780	2,775	2,725	1.8%
A2	Specialist Paediatric	3,153	3,364	3,263	3,188	3,275	3,125	4.8%
A3	Ungrouped Acute	2,671	2,850	2,765	2,754	2,775	2,700	2.8%
B1	Major Metropolitan	2,672	2,851	2,765	2,729	2,775	2,675	3.7%
B2	Major Non-Metropolitan	2,609	2,784	2,701	2,907	2,900	2,850	1.8%
C1	District Group 1	2,779	2,965	2,876	2,958	2,950	2,900	1.7%
C2	District Group 2	2,735	2,918	2,830	2,856	2,850	2,800	1.8%

Emergency Department

Historically, the ED “cost benchmarks” were based on an ED costing survey carried out for the period 2000/01.

The approach adopted for the PRCs this year was to use UAR ED costs and VolumeBuilder activity as the basis for the PRCs for 2002/03.

It should be noted that under this approach differs from the costing survey results in two respects:

- Teaching and research costs are excluded (as in the UAR these would be allocated under a separate program). The previous costing survey included an allowance in the “cost benchmarks” for these.
- Cross charges or costs of prescribed pharmacy and diagnostic tests for ED patients were included, whether or not they were subsequently admitted. This was at variance with the design of the ED funding model. The current approach means that the PRCs reflect the *average* treatment of these costs within a peer group. Whilst variation in costing and allocation practice exists, this is an area of ongoing refinement.

ED Cost Weights

The ED weights have been recalibrated for 2002/03 data. This has resulted in minor changes to the ED cost weights for 2004/05 as shown below:

Table A2: ED Cost Weights for 2004/05

UDG	2004/05	2003/04
Subsequently Admitted Triage 1	2.650	2.665
Subsequently Admitted Triage 2	1.658	1.668
Subsequently Admitted Triage 3	1.497	1.505
Subsequently Admitted Triage 4	1.339	1.346
Subsequently Admitted Triage 5	1.321	1.328
ED Only Triage 1	1.374	1.381
ED Only Triage 2	1.184	1.191
ED Only Triage 3	1.003	1.008
ED Only Triage 4	0.843	0.848
ED Only Triage 5	0.692	0.695
Did Not Wait	0.494	0.497
Average	1.000	1.000

2002/03 ED Costs

Individual results from the revised approach described above do show a significant degree of variation. For the purpose of setting the PRCs the average for each ED peer group has been adopted unchanged. Whilst there are some potential anomalous individual facility results, no specific adjustment from the average has been made at this stage. These will be investigated further to determine whether they are the result of data issues or genuine underlying variation.

Indexation Factors

Updated indexation factors for 2003/04 and 2004/05 have been sourced from Finance Branch. The indexation factors represent the current best estimate of the weighted cost escalation for the relevant periods for health costs incurred by Health Services.

The factors adopted for indexing the 2002/03 HCDC results are:

2003/04	4.61%
2004/05	2.00%

Summary

The following table sets out the results of the above calculation and compares the result to the 2003/04 “cost benchmarks”:

Table A3: Calculation of ED PRCs for 2004/05 and comparison to 2003/04

ED Peer Hospital Group	Peer Average 2002/03 (1)	Indexed to 2004/05 (2)	PRC 2004/05 (5)	Cost Benchmark 2003/04	% Chg
A1/B1	358	382	380	360	5.6%
A2	289	309	310	305	1.6%
B2/C1	269	287	285	270	5.6%

Intensive Care

The PRCs for intensive care continue the approach adopted in previous years as follows:

- Is based on 2000/01 information provided by Health Services and facilities in a special ICU cost data collection undertaken in the first half of 2002.
- Includes all of the direct costs of running the ICU.
- Includes Health Service and facility overhead costs of running the ICU. Where these were available from the Health Service or facility through the 2000/2001 cost of care collection, each facility’s own overhead costs were used. Where these were not available, the State-wide average rate of 30.1% was applied.
- Excludes depreciation.
- Includes superannuation and workers compensation for all hospitals, including those where these items are retained at the Health Service level. Where actual figures were available, each facility’s own costs were used. Where these were not available, State-wide average rates were applied.
- Includes all costs associated with T&R currently included in ICU cost centres.
- Includes cross-charges or costs of pharmacy and diagnostic tests for IC patients. Facility-specific costs were used where these were reported. If not, State-wide average costs were applied. These State-wide average costs are calculated across all IC patients in those facilities able to report cross-charges, whether or not the patient received pharmaceuticals or

diagnostic services. No overhead costs were applied to these costs, irrespective of whether they were cross-charged. The rates are shown in Table B3.

- Excludes the cost of HD patient care provided in integrated ICU/HDUs. Costs were split on a 2:1 basis so that the cost of an IC patient day was calculated as being twice the cost of a HD patient day. This ratio is based on Faculty standards on the nursing staff levels to be provided for IC and HD patients. Total weighted bed-days were calculated based on the results of the periodic surveys held in 2001/02. The funding of HD bed-days in ICUs then occurs through the acute inpatient funding stream.
- Includes a cost escalation factor of 10.8% from 2000/2001 to 2004/2005.
- Includes a discount of 9% for chargeable patients. This is the same method used in the acute inpatient funding model.

Table A4: Intensive Care PRCs for 2004/05

Patient type	PRC per IC patient day
Chargeable patients	\$3,009
Non chargeable patients	\$3,307

Appendix B: Adjustment Factors

The design and implementation of the funding models for 2004/05 means that various adjustment factors may be required in setting budgets and making comparisons against the Peer Reference Costs.

This Appendix sets out adjustment factors that may be adopted by Health Services in the absence of more reliable data.

There are six areas in the 2004/05 funding model where these may need to be considered:

- SNAP Inpatient Adjustment
- Prescribed pharmacy and diagnostics in ED
- Prescribed pharmacy and diagnostics in ICU
- 'Outpatient' services provided in EDs
- High dependency care
- Funding of EDs not in scope of the ED Funding Model

SNAP Adjustment

As described in Section 3.1, in some cases patients in sub-acute and non-acute service categories may be treated in units funded by facilities under either Program 2.2 or 2.3 (Overnight and Same Day Acute Inpatient Services.) In these instances patients funded by facilities under Programs 2.2 or 2.3 are to be excluded from the acute inpatient funding model at the bed day rates identified below. These rates are sourced from the Guidelines for Rehabilitation and Extended Care.

Table B1 Sub- and non-acute inpatient adjustment factors

Service category	2004/05 bed day rate (\$)
Palliative Care	696
Rehabilitation	638
Psychogeriatric	645
GEM	546
Maintenance	438

Source: NSW Funding Guidelines for Rehabilitation and Extended Care 2004/05.

Prescribed Pharmacy and Diagnostics in ED

As described in Section 3.1.1, costs for prescribed pharmacy and diagnostics ordered in the ED for patients who are subsequently transferred to a ward are within the scope of the acute inpatient funding model. Where these costs cannot be appropriately allocated to the acute inpatient funding model for budget setting purposes, the following average cross charges may be used. These cross charges reflect state-wide averages derived from the 2000/01 ED costing survey:

Table B2 NSW ED average cross charges

Cost type	Average cost per case weighted attendance
Pharmacy	\$10
Pathology	\$21
Radiology	\$40
All	\$71

Prescribed Pharmacy and Diagnostics in ICU

As described in Section 3.3, costs for prescribed pharmacy and diagnostics for ICU patients are within the scope of the ICU funding model. Where these costs cannot be directly allocated to the ICU funding stream (e.g. because they are incurred under other cost centres), the adjustment factors set out below may be used. These cross charges reflect state-wide averages derived from the 2000/01 ICU costing survey:

Table B3 NSW ICU average cross charges

Cost type	Average cost per IC patient day
Pharmacy	\$196
Pathology	\$221
Radiology	\$114
All	\$531

'Outpatient' Services Provided in ED

As discussed in Section 3.2, services provided in an ED that are a substitute for outpatient activity (such as methadone clinics funded through the drug and alcohol program but run in the ED) are not within the scope of the ED funding model. Where the costs for such activity cannot be accurately determined, an adjustment may be made to exclude these costs by assuming they are activity classified as ED Only, Triage Category 5.

High Dependency Costs and Activity

As described in Section 3.1.2, high dependency patient bed-days fall within the scope of the acute inpatient funding model.

Where facilities are not able to directly allocate the costs in relation to these bed-days to acute inpatient funding stream, an adjustment may be made on the basis that a high dependency bed-day costs half as much as an intensive care bed-day.

As in previous years, Health Services and facilities may select one of the following methods for separating high dependency activity:

- Establishment of 'virtual wards' within the ICU in the Patient Administration System. This is the preferred method;
- A periodic survey approach to identify the proportion of activity that is ICU versus high dependency.

Funding of EDs Not Within the Scope of the ED Funding Model

As discussed in Section 3.2.1, Health Services need to resolve how to fund ED-type services in facilities where the ED has a delineated role of less than Level 4. Three possibilities are suggested in these *Guidelines*:

1. If the ED service has appropriate medical staffing, provides primarily an ED service and has the EDIS system, include it in the funding model in ED Peer Group C irrespective of the formally delineated role or general peer group. As a general guide, these units would be expected to treat more than 15,000 (weighted) attendances in 2004/05.
2. If the ED service does not have the EDIS system or does not provide sufficient volume and level of services to be included in the ED funding model, then the costs of patients treated solely in the ED ('ED Only patients) should be funded using a block grant. The costs associated with patients who are subsequently admitted to a ward should be met through the acute inpatient funding allocation to the facility.
3. If the ED service provides primarily a primary care/outpatient service, classify it as an outpatient service for funding purposes. If so, it is out of scope for ED funding in 2004/05 and is funded in a block grant based on the actual costs of running the unit until appropriate funding models are developed for outpatient services.

Appendix C: Funding of Renal Dialysis

Health Services should pool funds for renal dialysis services provided across all settings. This is the approach used in other states. It recognises the long term treatment provided to people with end stage renal failure and the fact that patients move between settings as their condition changes.

The approach suggested is to identify the current budget for admitted and non-admitted dialysis (including home maintenance) and the average annual number of patients funded by the current budget. The relative values implied by the Victorian payment rates can be used to derive annual payments per patient year. Based on projected patient numbers by modality, an expenditure budget can be derived for 2004/05.

Treatment Modality	Total recommended payment per patient per year ^a , 2004/05 prices ^b	Relative value
In-Centre dialysis	\$47,161	1.40
Home haemodialysis	\$33,597	1.00
Continuous ambulatory peritoneal dialysis	\$42,472	1.26
Satellite dialysis	\$48,578	1.43

^a Figures based on the Victorian funding model 2003/04. Source: <http://www.health.vic.gov.au/pfg2003/>

^b Escalation factor used is 2.00%, representing escalation from 2003/04 to 2004/05.

For example, consider a Health Service that had 25 patients on average in each of the four modalities in 2003/04 and expended \$3m in direct and associated hospital overheads. By applying the relative values above, the price for a home haemodialysis patient would have been at a rate of \$23,576 per patient (calculated by dividing \$3m by {25*1.40+25*1.43+25*1.00+25*1.26}).

If the annual average growth in patients in 2004/05 is expected to result in an 6 additional patients on average, comprising 2 home haemodialysis, 2 satellite and 2 in-centre patients, then an additional expenditure of \$180,592 is required (calculated by {2*1.43+2*1.40+2*1.00}* \$23,576).

The Report of the NSW Dialysis Casemix Development Project has suggested the following classification:

Maintenance	In-centre Dialysis	Country Unit
		Metro/Urban
	Satellite dialysis	to 14 km
		to 25 km
to 299 km		
	plus 300 km	
Home dialysis	CAPD	
	Haemodialysis	
Training		HD training
		CAPD training
Not on dialysis		Transplantation
		Predialysis

Appendix D: Guidelines for Mechanical Ventilation Co-payments

Definition of mechanical ventilation

Continuous ventilatory support (CVS) also known as mechanical ventilation (MV) is a process by which gases are moved into the lungs by means of a mechanical device that assists respiration by augmenting or replacing the patient's own respiratory effort. With ventilatory support, a patient is intubated or has a tracheostomy and receives continuous variable degrees of assistance to meet respiratory requirements in an uninterrupted continuous fashion. It includes CPAP and BiPAP when they are via an endotracheal tube or tracheostomy tube but not when they are via a mask. It excludes IPPB².

Calculation of Mechanical Ventilation Co-Payments

Scope

As discussed in Section 3.1.2, facilities that do not fall within the scope of the IC funding model, but which have the capacity for short term mechanical ventilation (MV) are entitled to a mechanical ventilation co-payment (on top of the acute inpatient payment) to recognise the extra resources that are consumed during the periods that the patient is being ventilated. This includes all MV activity whether provided in an ICU or elsewhere within the facility.

However, the following types of MV are excluded as the basic acute inpatient payment adequately reflects the additional costs:

- Neonatal MV; and
- MV provided only in the operating theatre during the course of a surgical procedure. However, MV provided after the operating theatre procedure should be included.

Rate

The co-payment for 2004/05 is \$80 per MV hour. This co-payment is based on the number of MV hours expected to be required in 2004/05, whether the MV is provided in an ICU or elsewhere in the facility. This is equivalent to \$1,920 per 24-hour period.

Conditions of facilities receiving MV co-payments

As part of inpatient Funding Service Agreements with each facility, Health Services are required to include an explicit agreement about the conditions under which the MV co-payment will be paid. These conditions are designed as a quality assurance mechanism and facilities will need to gain agreement from relevant clinicians prior to entering into an agreement with the Health Service.

- MV co-payment for rural facilities with Level 4 ICU services: Agreement to provide a consultation service for facilities with Level 3 ICU services.

² This definition is based on the definition in the current ICD-10-AM Australian Coding Standards. Note however that the required information cannot be collected simply by using existing coded data as the current national coding standards include 3 codes for MV based on grouping the number of hours of MV. For example, MV of less than 24 hours duration is coded as 13882-00. Actual hours of MV are used in the funding model. Some hospitals, but not all, routinely record actual hours of MV in the ISC while others simply record the code.

- MV co-payment for metropolitan facilities with Level 4 ICU services. MV to be provided for no more than 3 days without a consultation with a Level 5 or 6 ICU.
- MV co-payment for both rural and metropolitan facilities with Level 3 ICU services. MV to be provided for no more than 24 hours without a consultation with a Level 4, 5 or 6 ICU.

Method of funding

The MV co-payment should be incorporated into the infrastructure component of the acute inpatient funding stream rather than through the ICU funding stream. The acute inpatient funding model also includes prospective and retrospective elements and there are thus several options about how the MV co-payment is paid, each of which allocates financial risk in different ways. The method to be used is a matter for each Health Service to determine:

- A prospective allocation paid at the beginning of the year based on the estimated hours of MV to be provided in 2004/05 with no adjustments throughout the year if the number of hours of MV actually provided is significantly more or less than originally estimated.
- A prospective allocation paid at the beginning of the year based on the estimated hours of MV to be provided in 2004/05 with retrospective adjustments throughout the year if the number of hours of MV is significantly more or less than originally estimated.
- A retrospective allocation paid throughout the year (perhaps monthly or quarterly) based on the hours of MV actually provided during the period.

The MV co-payment is to be specified as a 'justifiable additional cost' line item in the acute infrastructure component of the model. MV co-payments will be excluded from the calculation of the PRC for acute inpatient services.

Appendix E: Linking Targets for Booked Surgery and Inpatient Activity

Several Health Services have been using the activity target setting process under acute inpatient funding to manage their waiting lists and access to booked surgery. The Hunter Area Health Service has been using their booked surgery model for several years to better manage the available resources for surgery and to maximise patient access.

The benefits of such models are:

- Greater certainty for hospital managers and surgeons, within overall planning for emergency, chronic and obstetric activity.
- Fairer mix of surgery for Health Service residents and more equitable access to specialties and procedures with historically longer waiting times.
- More rational planning of booked surgical activity, particularly during peak times.
- Funding incentives through acute inpatient funding can support achievement of performance targets in relation to waiting lists.

Health Services may use their own model or can adapt the Hunter Area Health Service model to local use. The key elements expected in the procedures to be implemented by each Health Service are the following:

- Analysis of historical data on elective workloads and waiting list trends.
- Definition of waiting list targets as negotiated with the NSW Health Department.
- Definition of the requisite elective activity targets to be incorporated in inpatient funded activity targets, both as separations and case-weighted separations.
- Determination of the distribution of these elective activity targets and associated funding between hospitals as part of inpatient funding activity and budget setting.
- Monthly review of performance of hospitals in meeting the elective activity targets and waiting list targets.

Where targets are not being met, Health Services may need to consider if a redistribution of both activity and associated funding is required between hospitals to achieve targets.

Step 1. Assess Trends in Elective Workloads and Waiting Lists

Health Services will have good historical data on patterns of elective admissions, both for elective surgery and for other elective procedures. There will be trends over time in additions to waiting lists, admissions from waiting lists and in the numbers on the waiting lists. This information is available either from WLCOS or from the local Health Information Exchange. In analysing trends, seasonal variations will have to be taken into account.

These data can provide information on current elective activity and on the patterns of change in waiting lists, both in total and by indicator procedure codes (IPCs) or speciality grouping used by the Health Service. Assuming previous levels of additions to waiting lists and admissions from waiting lists, it is possible to estimate with reasonable accuracy the level of elective activity in separations required to maintain stable waiting lists.

As a related process Health Services would also be assessing trends in obstetric care and emergency admissions when projecting overall activity targets for acute inpatient funded hospitals.

Step 2. Assess Impact of Waiting List Targets

NSW Health and Health Services will negotiate targets for waiting list benchmarks and the size of the total waiting list for elective surgery in each financial year.

Review of current waiting lists in the Area, either from WLCOS or in the Health Information Exchange, can be used to define required reductions in waiting lists, both in total and by IPCs or disciplines. These numbers should be added to those defined in Step 1, to provide the level of elective activity in separations required to meet waiting list targets.

Step 3 Definition of Elective Activity Targets

Elective activity targets will have to be defined in terms of both separations and case weighted separations. Step 2 has provided information on the required separations. However, conversion of this information to case weighted separations is essential for determination of the financial resources required to fund elective activity targets. This conversion can only be achieved by analysis of the DRG casemix in each relevant speciality group or IPC.

By linking previous data from both the WLCOS and ISC systems in the local Health Information Exchange, it is possible to determine the relationship in each facility between IPCs or speciality groups and associated DRGs. For example, each IPC can be related to a number of DRGs. It is important to note that this relationship will vary from facility to facility, and that use of the relationship for predicting future requirements in terms of case weighted separations is dependent on the quality and reliability of IPC coding in each facility's Admission Office.

The historical relationship between IPCs or speciality group and DRGs may be expressed either in terms of an IPC cost weight or in terms of the actual mix of DRGs for the hospital. Using either of these measures, the projected required activity in separations may be converted to weighted separations and consequently to the requirements for funding.

Step 4 Distribution of Elective Activity Targets

A variety of factors, such as the planned level of emergency activity, the roles of facilities, AMO appointments, availability of operating theatre time, availability of beds, capacity to increase activity (where this is required) and efficiency of service provision may be taken into account in determining the distribution of elective activity targets among hospitals in each Health Service. As Health Services become increasingly confident in projecting requirements for elective workload, it is expected that the processes for distribution of workload between facilities will become more open and transparent.

The basis for estimating the targets and the expectation of the Health Service for each facility should be communicated as clearly as possible and involve consultation with affected clinicians.

Step 5 Monitoring of Performance

Achievement of the activity targets that have been defined for each facility and for the Health Service as a whole must be reviewed monthly. The review process should ensure that the more urgent cases are given priority over less urgent cases within the overall requirement to meet the Health Service wide targets negotiated with NSW Health. In this regard, Health Services may wish to monitor performance by hospitals at the IPC level, specialty or DRG level for each urgency category.

Where significant reductions in waiting lists are required during the year, Health Services are encouraged to set progressive monthly targets of the number of patients on the list to facilitate monitoring of progress.

Step 6 Redistribution of Activity Targets and Funding, where Required

Health Services may decide to establish a process for redistribution of activity targets and associated funding between facilities during the year where monitoring of performance indicates failure to meet targets in a particular facility. There should be active involvement of relevant managers and clinicians in coming to such decisions and such an arrangement should be agreed as part of the activity setting process. This arrangement could be included in the incentive component of inpatient funding.