

STATEMENT OF PURCHASER INTENT 2017-18

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I Introduction

The objective of the State's public sector health system is to deliver safe, high quality services to improve, promote, protect and maintain the health of Tasmanians.¹ This objective supports the vision for Tasmania to have the healthiest population in Australia by 2025.

As per authority delegated by the Minister for Health, it is the responsibility of the Department of Health and Human Services (the Department), as System Manager, to purchase services (the Purchaser) on behalf of Tasmanians, using funds provided by the Tasmanian and Commonwealth Governments (the Funders) from suppliers of health services (the Provider/s).

The Department subsequently has a clear responsibility to the people of Tasmania to ensure that it is able to demonstrate that it is receiving the services it purchases and is obtaining value for money.

The SoPI serves a number of functions:

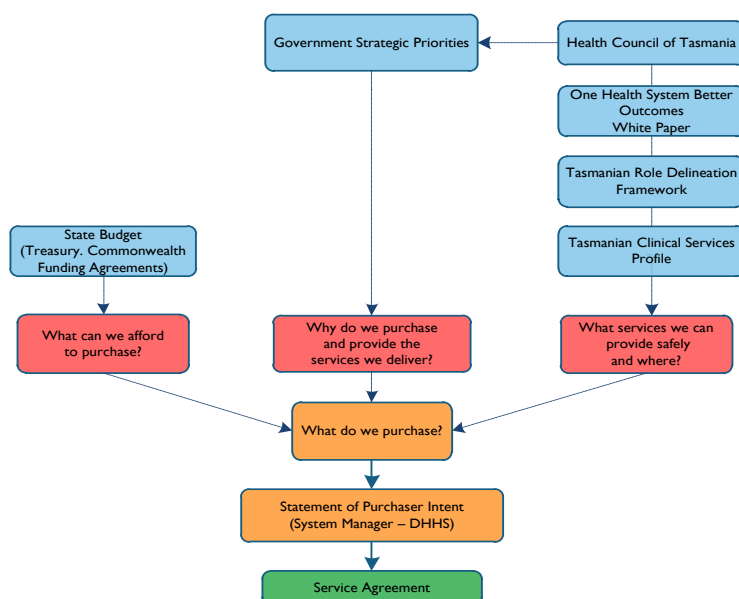
- It is a synthesis of Government priorities and a response to health trends across the State.
- It signals the Department's intentions over the coming five years in order to assist the Provider/s with their forward planning.
- It creates the basis for the Service Agreement between Purchaser and Provider.
- It articulates purchasing intent in specific and measurable terms in order that the Department as Purchaser is able to clearly ascertain and account for what is being purchased.

A key mechanism for system management is through informed, appropriate purchasing. The nature and volume of services purchased will impact on the effectiveness and value-for-money of the Tasmanian health system. However, purchasing is a necessarily transactional process, and so must be contextualised to be effective as a mechanism to enact Government policy in health, and to ensure that purchasing decisions reflect the application of a longer term strategy. As part of this purchasing process, the Department must also signal as far as possible its future purchasing intentions to support service providers' planning capacities.

The Statement of Purchaser Intent document acts as the bridge between the Strategic Priorities of the Health System and the transactional activity of purchasing. This is represented in Figure I below.

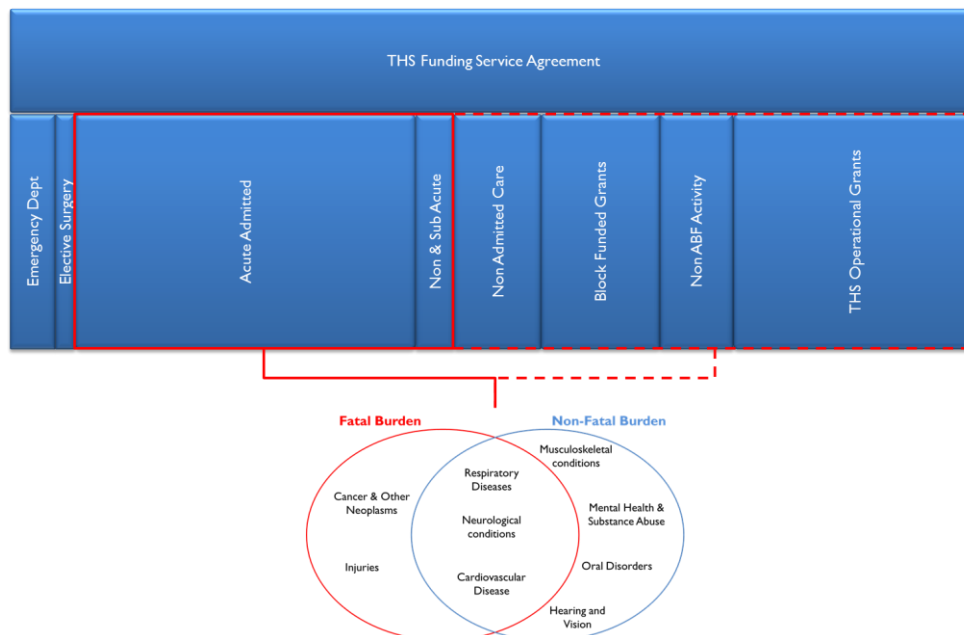
¹As reflected in the *Tasmanian Health Organisations Act 2011* s3
http://www.austlii.edu.au/au/legis/tas/num_act/thoa20115/o2011346/s3.html

Figure 1: Translation of Strategic Priorities into purchasable activities



This SoPI will drive the Service Agreement (SA) via purchasing actions targeted at Acute Admitted Care episodes in the SA schedule (Figure 2, solid red box). The purchasing actions in this iteration of the SoPI do not constitute the full volume of acute admitted care. This will maintain the integrity of the link between the funding model and purchasing actions. This will thus have no effect on the funding model.

Figure 2: Proportional funding allocation of 2016_17 THS Service Agreement



Future SoPIs will expand to include other sectors such as Community Care and conditions that are partly serviced via Block Funding, Non ABF activity or Grant Funded (Figure 2, dotted red box). This will create flexibility for providers to shift care between sectors as appropriate according to resourcing and community needs.

The actual proportion of funding assigned to each condition and its portion of the total funding envelope will be calculated during the development of the funding model. The episode volumes shown in the purchasing actions table in Section 6 are based on projections using the Hardes modelling.

Articulation of purchasing actions in the SA will therefore shift in time from the administrative classification of purchasing actions (e.g. Acute Admitted episodes, Non Admitted Care, etc.) to condition focused actions. The apportioning of the total funded episodes is based on current activity. In time, the apportioning of episodes may shift according to strategic directions and future population needs and a more sophisticated understanding of future need.

The strategic intent behind this move is to create a common language between the DHHS as purchaser, the Government as funder, clinicians as providers and the Tasmanian community as users. This will enable meaningful conversations between the various parties about lifestyle choices, livability of communities and funding choices.

One of the challenges going forward will be how to apportion funding of conditions in services that are block / grant funded service multiple conditions.

Some purchasing actions such as Injuries / Trauma are targeted specifically at services highlighted in the White Paper and are aimed at capacity building within the service rather than purchasing specific episodes of care.

Lastly, other purchasing actions are aimed at qualitative improvements and will be articulated either via KPIs or the DHHS Monitoring Suite e.g. surgery wait in turn and Mental Health referral for follow after attempted deliberate self harm.



Michael Pervan

Secretary, DHHS

3 October 2016

2 Executive Summary

The purchasing intentions outlined in this SoPI (2017-18) are shaped primarily by identifying and responding to the causes of the greatest burden of disease for Tasmanians, alongside previously articulated Government health priorities. It aims to ensure that health service delivery is planned, purchased and managed to deliver high quality patient outcomes at both individual and community levels within the available financial resources.

The evidence base used for this SoPI consists, in part, of a range of reports, the most central being the Australian Institute of Health and Welfare (AIHW) report on '*Australian Burden of Disease Study 2011*' with specific reference to Tasmanian data, and the Department's '*Health Indicators Tasmania 2013*' which brings together the key markers of the health of Tasmanians.

The SoPI is informed by three key inputs:

- Health priorities (supported by evidence for health needs of Tasmanians as articulated by independent agencies and Government health priorities)
- Tasmanian Role Delineation Framework (TRDF) and Tasmanian Clinical Service Profile (TCSP)
- Treasury budget input.

To support the Government's agreed vision, principles and strategic priorities, the Planning, Purchasing and Performance Group has developed a set of Purchaser Principles to guide health service planning and delivery in Tasmania, that:

- targets the health needs of Tasmanians
- supports equitable access to quality care
- prioritises access to care that is fair and affordable, and
- supports new, innovative and affordable models of care.

The SoPI (2017-18) focuses on the outcomes of the key health drivers in Tasmania with emphasis on:

- i) those conditions that drive the greatest burden of disease for Tasmanians and
- ii) Elective Surgery requirements based around the status of the Elective Surgery Waiting List (ESWL).

The followings groupings of health conditions account for eighty percent of the burden of disease for the Tasmanian population:

- Respiratory Disease
- Neurological Disease
- Cardiovascular Disease
- Cancer and Other Neoplasms
- Injuries (including Deliberate Self Harm)
- Musculoskeletal conditions
- Oral Disorders
- Hearing and Vision Disorders

Purchasing actions will centre on these conditions.

Elective Surgery purchasing actions focus on baseline volumes required to achieve and maintain acceptable elective surgery waiting times and to ensure fairness in waiting list management. Greater sophistication in Elective and Emergency surgery purchasing will characterize future SoPIs.

Future SoPIs will develop purchasing intentions and priorities in the following areas:

- Purchasing for complexity in Chronic Disease e.g. Multi-morbidity, in-community management (i.e. Hospital avoidance) or quality of life measures
- Target other contributory health conditions such as smoking, overweight and substance abuse
- Sector purchasing (e.g. community, private and interstate purchasing)
- System reform, whether it is at the local, hospital or state-wide service level

Other purchasing intentions and priorities that will be developed in future SoPIs are:

- New and emerging technologies – e.g. new cancer chemotherapy targeted treatment to reduce chemotherapy chair treatment time for patients and provide greater efficiency
- Innovative mechanisms to address social determinants of health, such as educational status and health literacy
- Education, training and research as both costs of and drivers for health service delivery

3 Context

3.1 Purchasing and System Management

It is important for the Department in its role as system manager to be clear on how it applies and articulates priorities, including what they are, how they are derived, how services will be purchased, and how delivery will be monitored.

In order to articulate this, the Department produces the following documents:

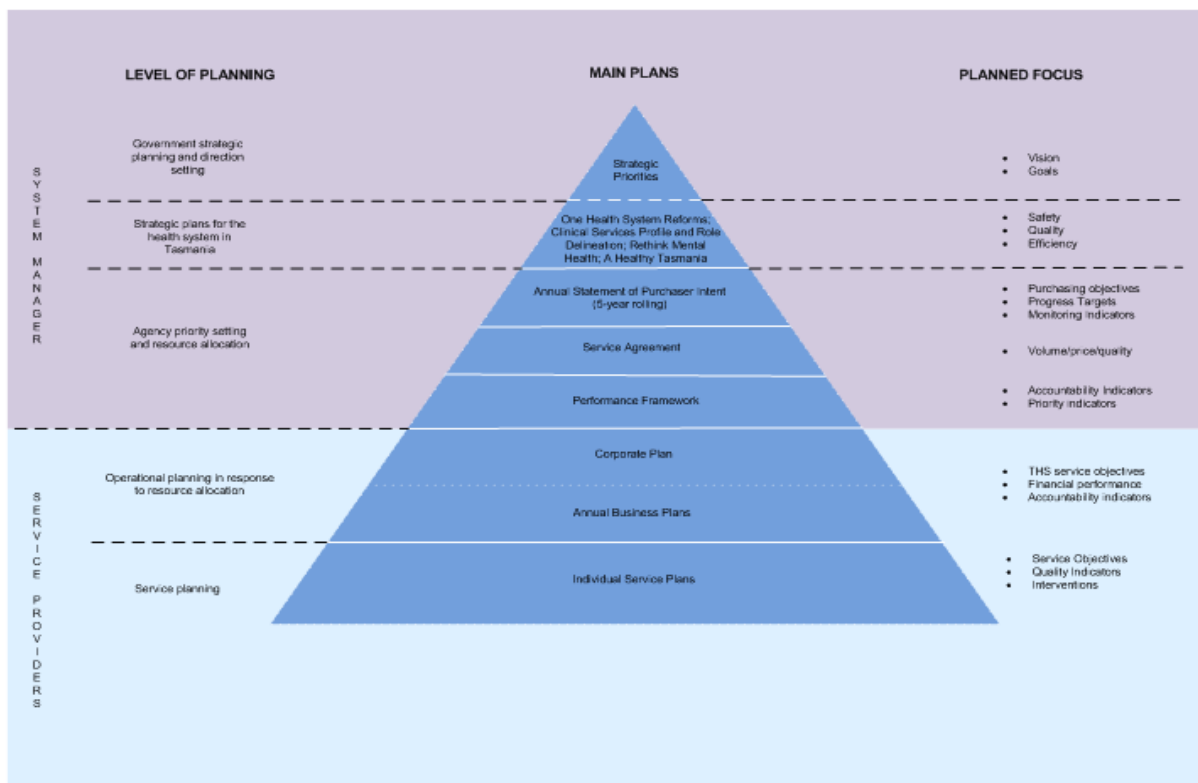
- This document, the '*Statement of Purchaser Intent (SoPI)*', an annually updated document, outlining the purchasing intentions for the upcoming five financial years.
- The annual '*Service Agreement between the Minister for Health and the Tasmanian Health Service (THS)*', outlining the financial allocation, service delivery requirements and performance expectations for the THS.
- The '*Service Agreement Performance Framework*' outlining the performance management mechanisms available to the Minister (or delegate) under the Act in response to unsatisfactory performance against the requirements of the Service Agreement.

Other operational documents governing the Department's broader system manager functions and further contextualise and support the SoPI include:

- The DHHS as System Manager
- Tasmanian Clinical Governance Framework, and
- The Monitoring Suite Operational Guidelines.

It is intended that these purchasing and system management documents will correspond to, and inform, planning documents produced for and by the THS. This relationship is demonstrated in Figure 3.

Figure 3: Corresponding documents for the system manager and service provider (THS).



3.2 Purpose of the SoPI

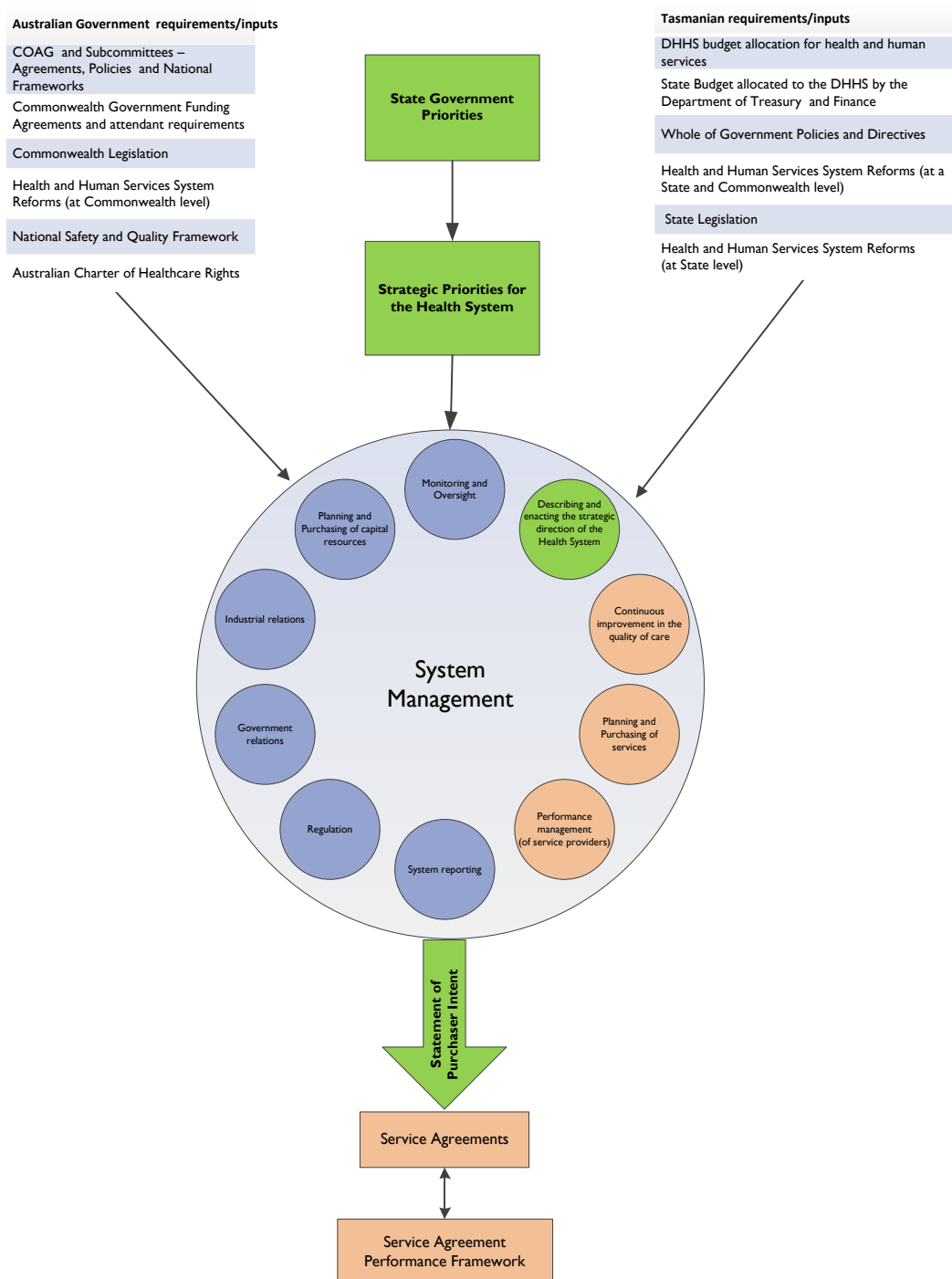
The SoPI is the translational device between the Department's twin functions of system manager and purchaser. This is demonstrated in Figure 4.

The establishment of an iterative annual (rolling) SoPI, signalling the Purchaser's intentions for the upcoming five years, provides:

- the ability to articulate clearly the priorities for health in coming years, and how these will impact on purchased activity.
- the mechanism to translate System Manager priorities into purchasable actions for inclusion in Service Agreements.
- an indicator of intentions to purchase in future, which will be refined and clarified on an iterative basis as the period to which they relate draw closer, and
- information for the THS to inform the development of its rolling Corporate Plan, incorporating the signals provided by the Purchaser as to what movements are likely in purchasing.

Each year an updated SoPI will be released, in the September before the year in which it will take effect. The finalised intentions and the details of the Service Agreement for that period will be developed contemporaneously.

Figure 4: Inter-relationship of the System Management Functions of the DHHS.



3.3 Scope

The scope of the SoPI currently relates to State Government funded services purchased by the Department from the THS, although services purchased by the Commonwealth Government and managed through the Department will be included. For services purchased from the THS but subsequently subcontracted to either Government or non-government organisations, broad intentions may be articulated but accountability for legislative and contractual requirements resides with the THS.

Linkages between the THS and other service providers, may be articulated where relevant, particularly where service integration is an objective, or to target potentially avoidable hospitalisations.

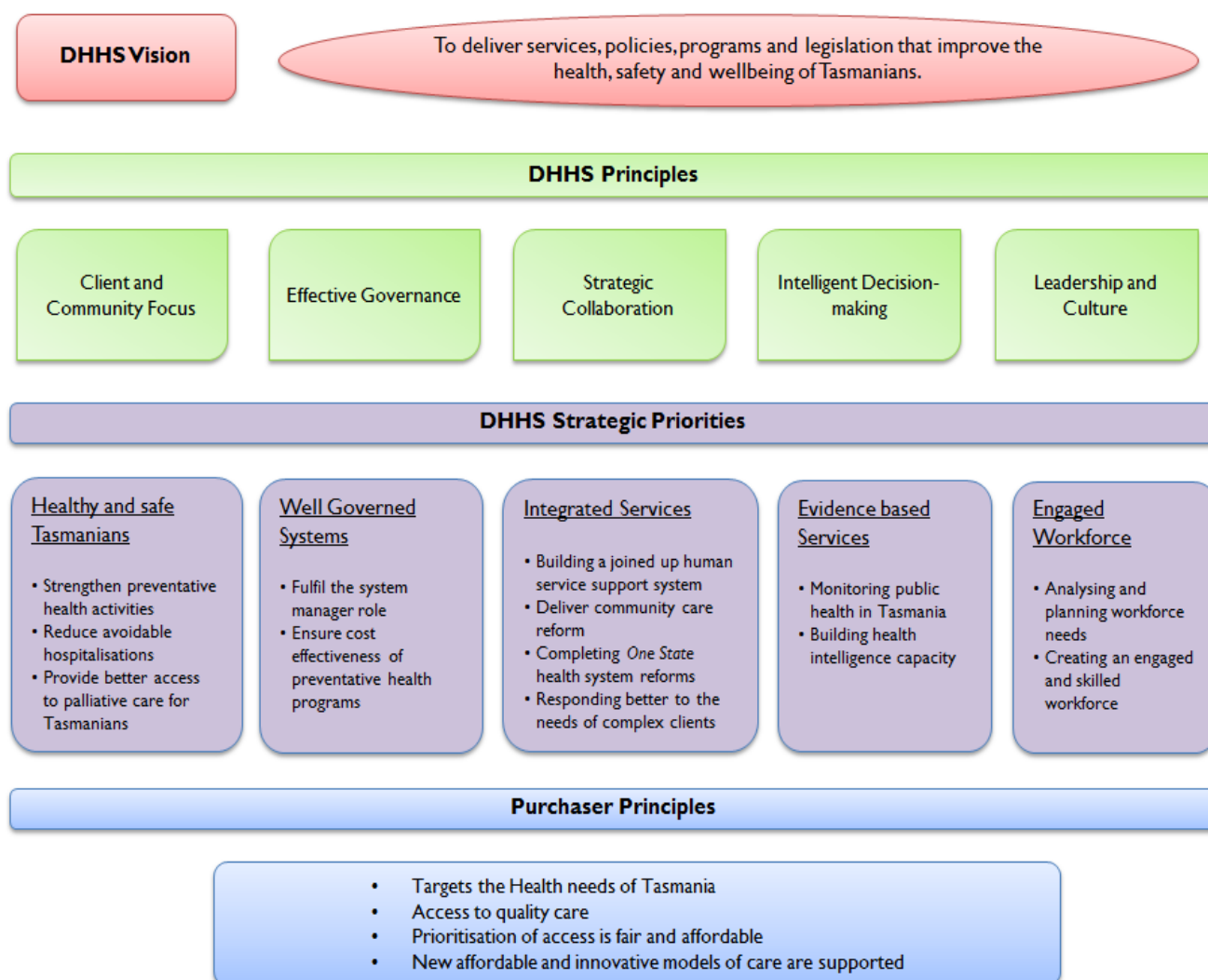
3.4 Purchasing Principles

The DHHS will work in accordance with the vision, principles and strategic priorities outlined in the 'DHHS Corporate Plan 2016-18' to keep Tasmanians safe, healthy and well.

The Tasmanian Health System Purchasing Framework (see Figure 5) outlines the Purchaser Principles to support the DHHS to guide health service planning and delivery in Tasmania that:

- **targets the health needs of Tasmanians by:**
 - focussing on the broader health burden across the State.
 - supporting the Tasmanian community to become healthier and focussing on promoting healthy habits and behaviours and improved health literacy, and
 - reducing avoidable hospitalisations to improve patient outcomes.
- **supports access to quality care through:**
 - purchasing services that meet the needs of Tasmanians at the right time and are delivered as close to home as safely and sustainably practicable
 - ensuring agreed standards are met and minimum service volumes are maintained, and
 - putting in place measures that ensure Tasmanians are obtaining value for money from Providers.
- **prioritises access to care that is fair and affordable by:**
 - ensuring that care is delivered at a location that meets the needs of most people in a reasonable manner
 - providing holistic, evidence-based health services that deliver the best patient outcomes at affordable costs
 - strengthening the safety and efficiency of delivered clinical services through an agreed role delineation framework, and
 - fostering and enhancing high value-for-money improvements and innovations.
- **new innovative and affordable models of care are supported, which are:**
 - innovative and flexible enough to adapt to changing circumstances and to meet new challenges, and
 - clinically integrated and coordinated for better care.

Figure 5: Tasmanian Health System Purchasing Framework



4 Key Health Drivers in Tasmania

The use of information and data on the health impacts and distribution of different diseases, injuries and risk factors is crucial in providing an evidence base to inform health policy, program and service delivery. In turn, this helps to ensure health resources are directed towards services that are cost-effective, equitable and optimise the health of Tasmanians.

The Australian Institute of Health and Welfare (AIHW) is established by the Australian Government to provide reliable, regular and relevant information and statistics on Australians' health and welfare. The AIHW produced a report, the '*Australian Burden of Disease Study 2011*' (AIHW, 2011) which provides updated, comparable evidence on the health of the Australian population and provides estimates of the total, fatal and non-fatal disease burdens for the Australian population, including by state and territory.

The DHHS' '*Health Indicators Tasmania 2013*' (DHHS, 2013) compiles the key markers of the health of Tasmanians, including the latest demographics, health equity, population ageing, lifestyle risk factors, major causes of morbidity and mortality, primary care issues and other issues of concern. Monitoring the health of Tasmanians is fundamental to generating evidence-based service planning and health promotion strategies.

4.1 Tasmanian Health Indicators

4.1.1 Population distribution (DHHS, 2013)

At the 2011 ABS Census, the net population of Tasmania was approximately 495 354, and had been steadily growing, at a variable rate. State Treasury projections (Treasury, 2014) anticipate the Tasmanian population will begin to plateau at around 2045, reaching a population of approximately 589 000 by 2062.

Tasmania has a geographically dispersed population, with 98% of the Tasmanian population spread between the "inner regional" and "outer regional" national population categories. The remaining 2% falls into either "remote" or "very remote". Distribution of the population for each of the regions within Tasmania is shown in the table below.

| Regions | Number | % of Tas |
|-------------------------------------|---------|----------|
| South | 247,461 | 50.0% |
| North | 137,561 | 27.8% |
| North West | 109,147 | 22.0% |
| Unincorporated Tas/No usual address | 1,185 | 0.2% |
| Tasmania | 495,354 | 100.0% |

ABS, Census 2011, Table Builder

4.1.2 Life Expectancy (DHHS, 2013)

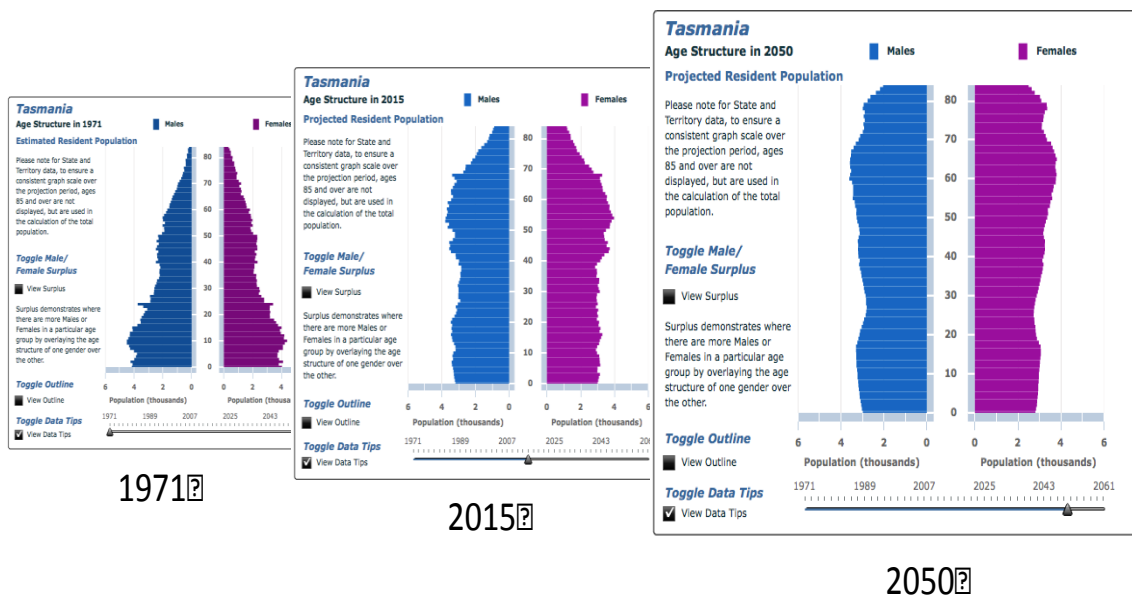
Life expectancy in Tasmania, while increasing, is still somewhat lower than the national average. Between 1985 and 2000, Tasmania was catching up to the National average life expectancy levels (see figure below). Between 2000 and 2010 life expectancy relative to the national average again declined to levels last seen in the mid 1980s. This trend slowed and showed early signs of reversal in 2011.



Figure derived from ABS data.

4.1.3 Ageing Population (DHHS, 2013)

Tasmania, like other OECD countries, is experiencing an overall ageing of its population by this, it is meant that the age profile of the state's population is moving to the right. Tasmania has the oldest median age of all Australian jurisdictions, at 41.5 years compared with 37.3 years as the national average. The Tasmanian population is also ageing faster than the rest of the country. The figure below shows the projected growth of the proportion of people in Tasmania over the age of 65 years. Between 2009-10 and 2013-14, there have been large increases in public hospital separations for people aged between 65 and 74 years and for those over 85 years (AIHW, 2016).

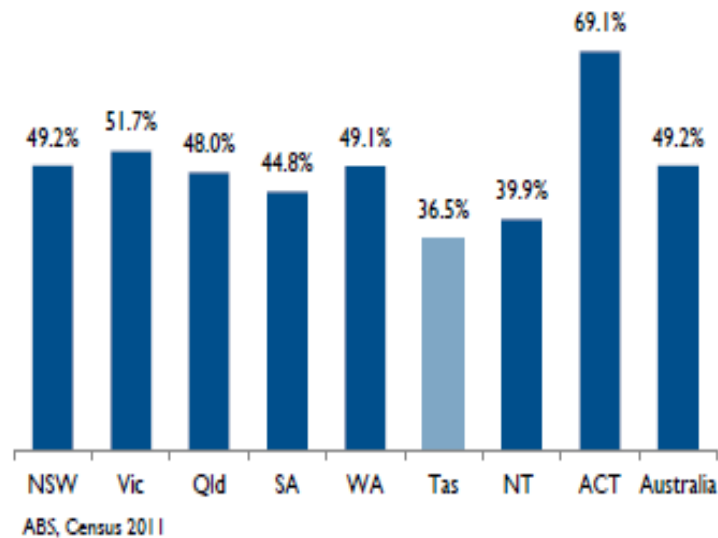


4.1.4 Education, Employment and Socio Economics (DHHS, 2013)

The association between education levels, socio-economic status, employment rates and health outcomes is well recognised. While socio-economic, employment and education indicators vary from year to year, Tasmania consistently performs at the lower end of the scale for these outcomes nationally.

4.1.4.1 Education

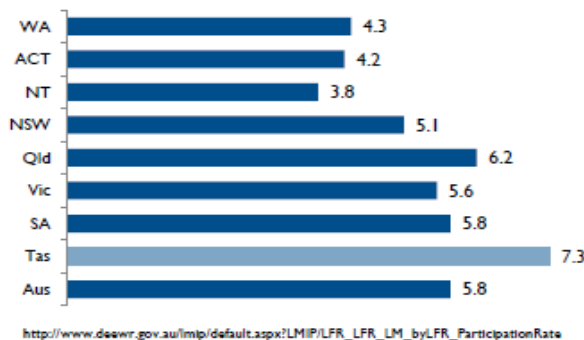
As at 2011, Tasmania has the lowest rates of all jurisdictions for Year 12 completion rates.



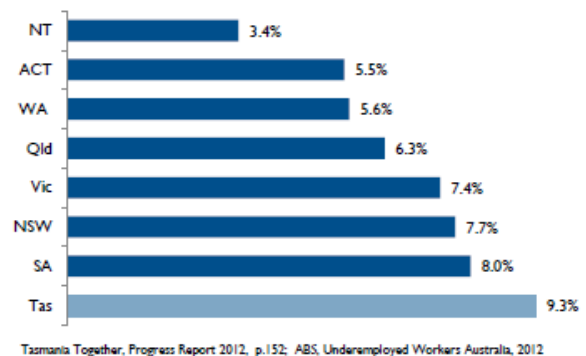
4.1.4.2 Employment

Tasmania also has some of the highest rates of under and unemployment across all jurisdictions.

Unemployment by Jurisdiction, Dec 2012



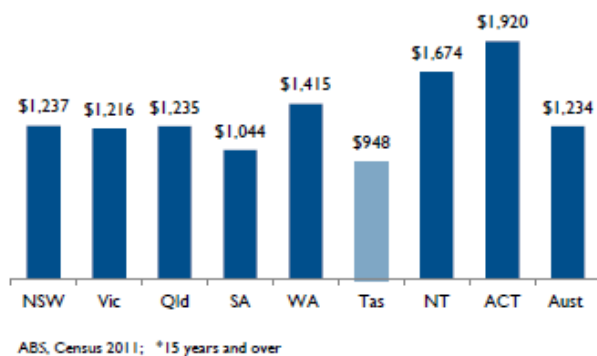
Under employment rates by jurisdiction, 2011



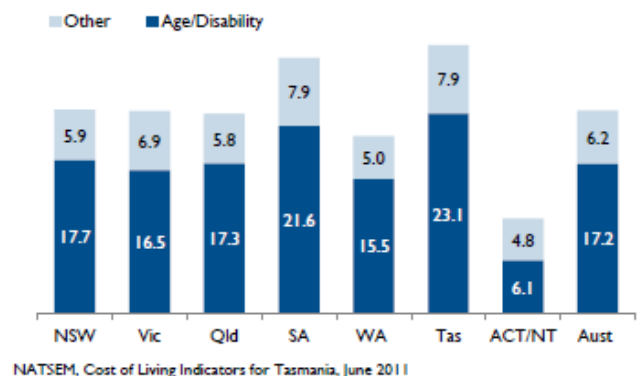
4.1.4.3 Socio Economics

Tasmania has the lowest median household income in the country, with the greatest proportion of household income being derived from income support payments.

Median weekly gross household income* by jurisdiction, 2011

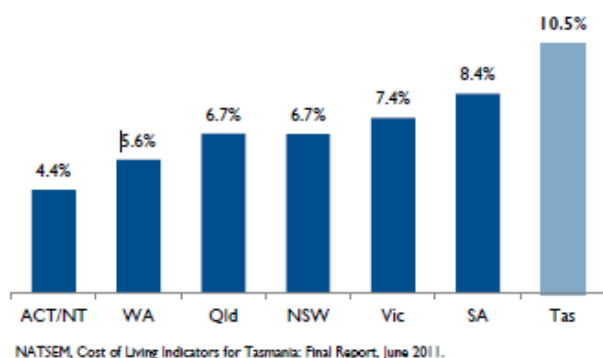


Income support payments as a proportion of all households by jurisdiction, 2011

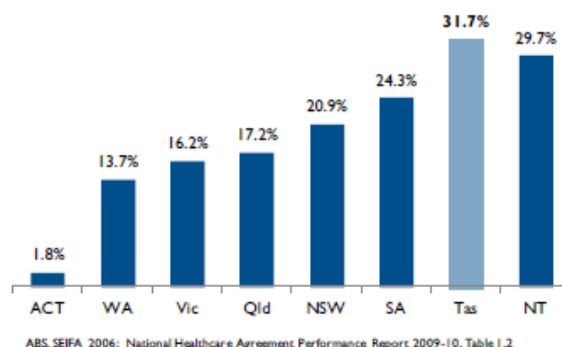


As at 2011, Tasmania had the highest poverty rates in the country, and in 2007-8 we had the highest proportion of its population in the lowest quintile of the Socio-Economic Indexes for Areas (SEIFA) of relative disadvantage by jurisdiction. People in the lowest socio economic groups make the highest use of our public hospitals (AIHW, 2016)

Estimated poverty rates for States and Territories



Proportion of population in lowest SEIFA quintile

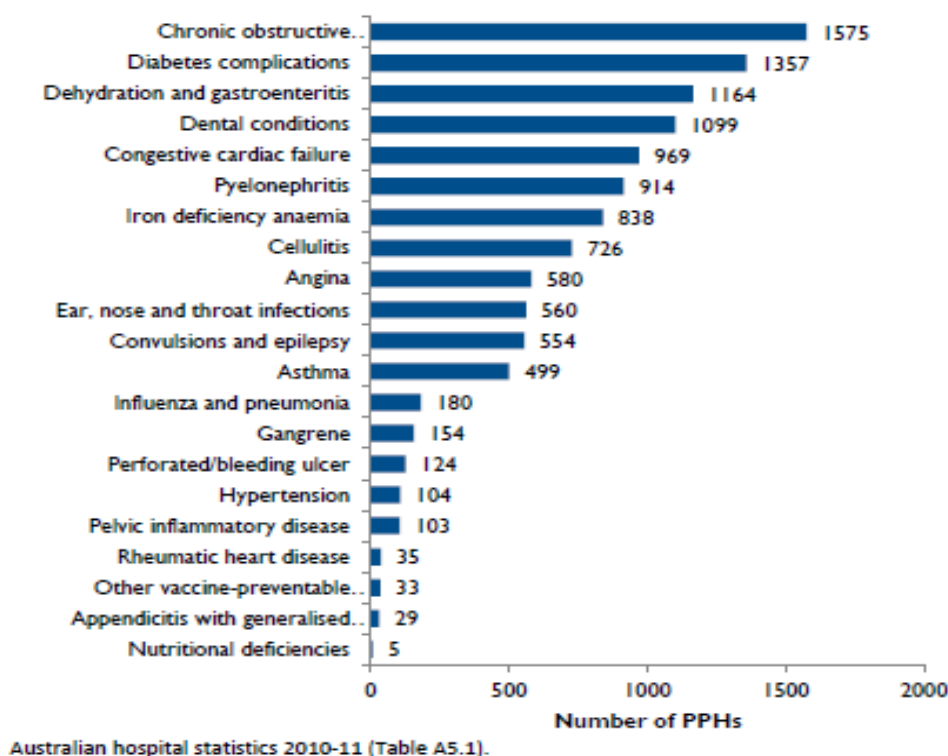


4.1.5 Potentially Preventable Hospitalisations (PPHs) (DHHS, 2013)

Broadly, the rates of PPHs are inversely related to SEIFA index and directly related to remoteness (AIHW, 2016). Tasmania's proportion of PPHs is 6.2%, equivalent to the national average of public and private hospital separations (AIHW, 2016).

In Tasmania, of all PPHs, 50.9% are related to chronic conditions, with 47.6% are related to acute conditions (DHHS, 2013). The conditions that contribute to our PPHs are ranked below:

PPH by type of condition, Tasmania 2010_11



4.2 Burden of Disease

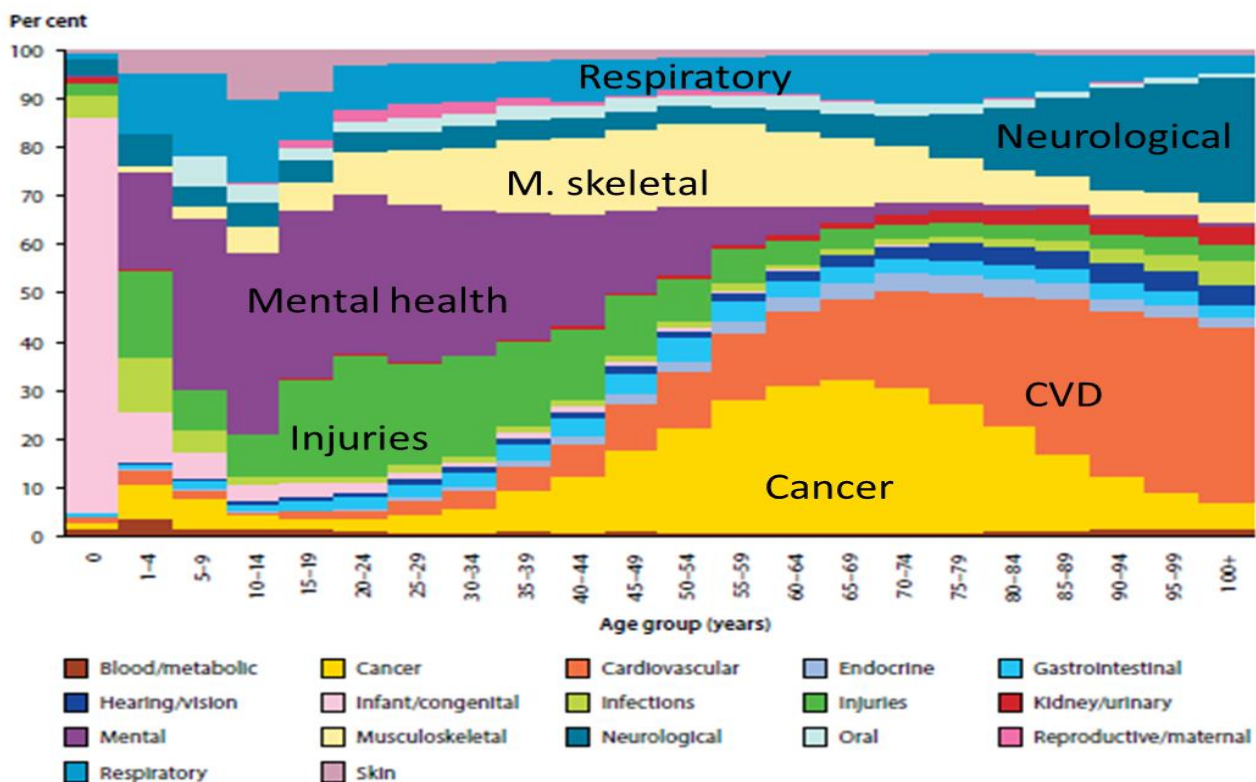
Burden of disease analysis enables comparison of the impact of different diseases, conditions or injuries at a population level. Information on the impact of various risk factors (such as smoking, physical inactivity or high blood pressure) on the health of the population can be used to measure the proportion of the burden of disease due to these risk factors. Burden of disease studies are useful for informing health policy and service planning (AIHW, 2011).

This impact can be broadly divided into non-fatal (living with disease) and fatal (dying from a disease). The data presented below also has a proportion of the burden attributed to risk factors.

The data presented below provides estimates of the total, fatal and non-fatal burdens for the Australian and Tasmanian populations for 2011. The previous study published in 2007 used data from 2003.

The primary utility of burden of disease data is to provide an independent and holistic view of the total burden of disease for Tasmania, as opposed to relying purely on hospital coded data. For the purposes of this document, we will focus on the Overall and Non-fatal burdens. *Appendix A: Disease and Injury list* provides a detailed breakdown of specific diseases within each of the disease groups.

The Total Burden of Disease for Australia, showing the relative contribution to the overall burden of disease nationally through the lifespan with specific diseases highlighted, appears below:



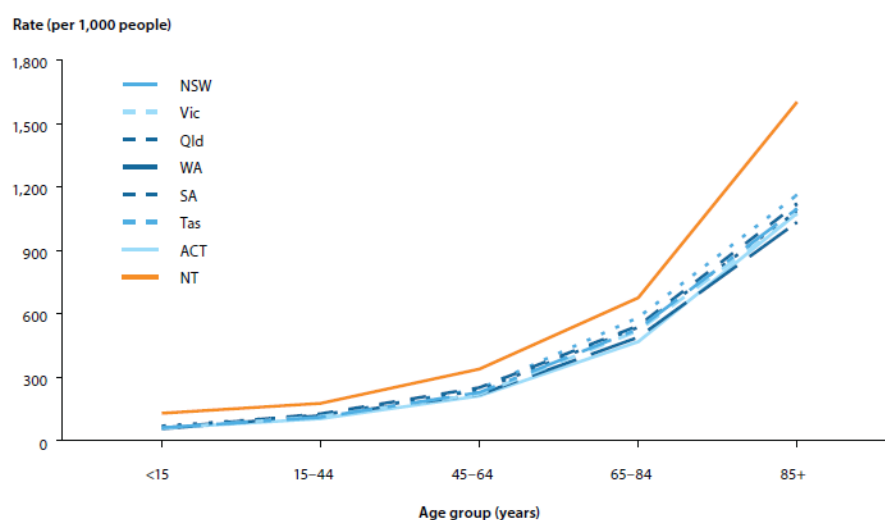
At least 31% of the total burden of disease is due to modifiable risk factors, and therefore potentially preventable. The risk factors contributing to the highest burden are:

- High body mass index (overweight and obesity)
- Tobacco use
- Alcohol use
- Physical inactivity, and
- High blood pressure.

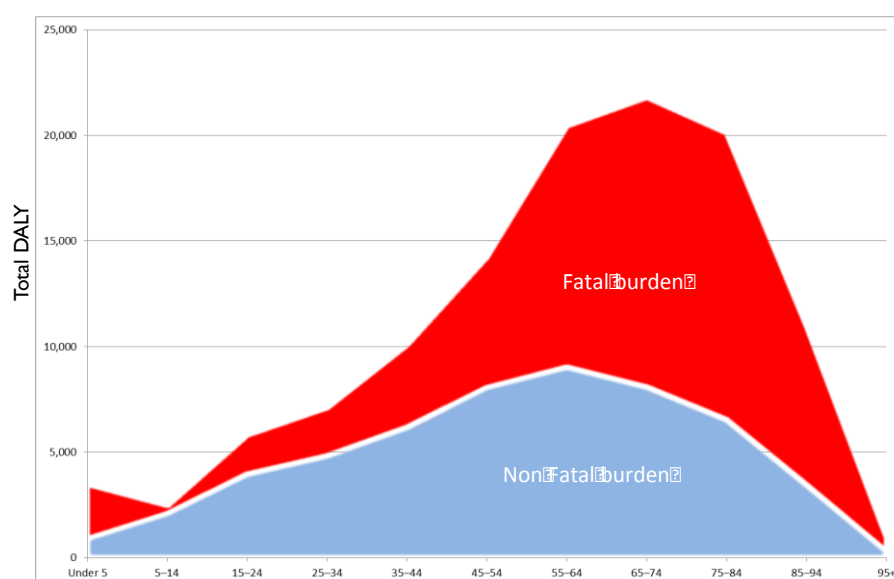
Socio-economic variability accounts for 21% of the differences in burden. In lower socio-economic groups, chronic disease and injuries dominate, with 80% of the national burden attributable to:

- Cancer
- Cardiovascular disease (CVD)
- Mental Health
- Musculoskeletal conditions
- Injuries
- Respiratory, and
- Neurological conditions.

In Tasmania, the rate of disease burden across the lifespan in Tasmania does not differ materially from the rest of the country, with the exception of the Northern Territory:



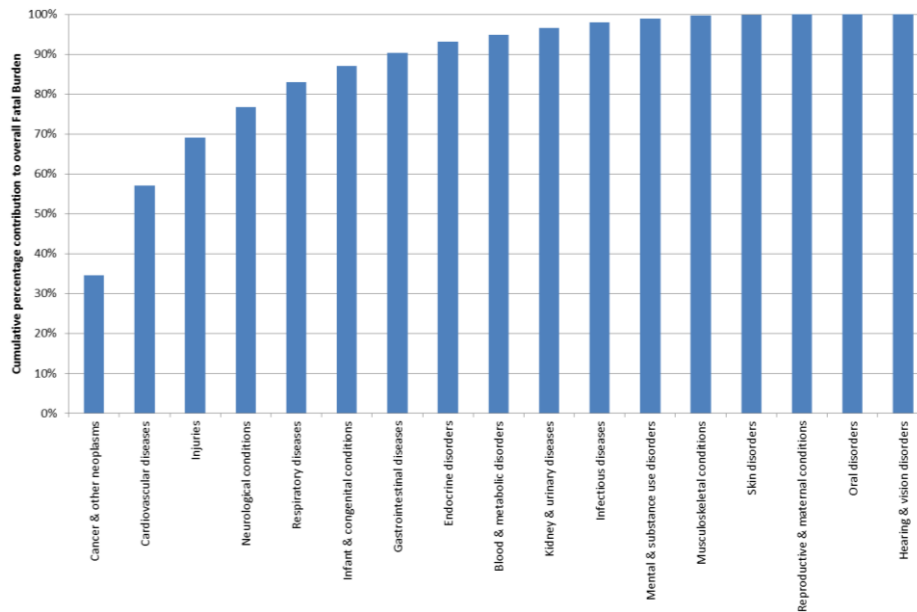
The total burden for Tasmania across the life span, with the Fatal / Non-Fatal disease burden separated, is shown below:



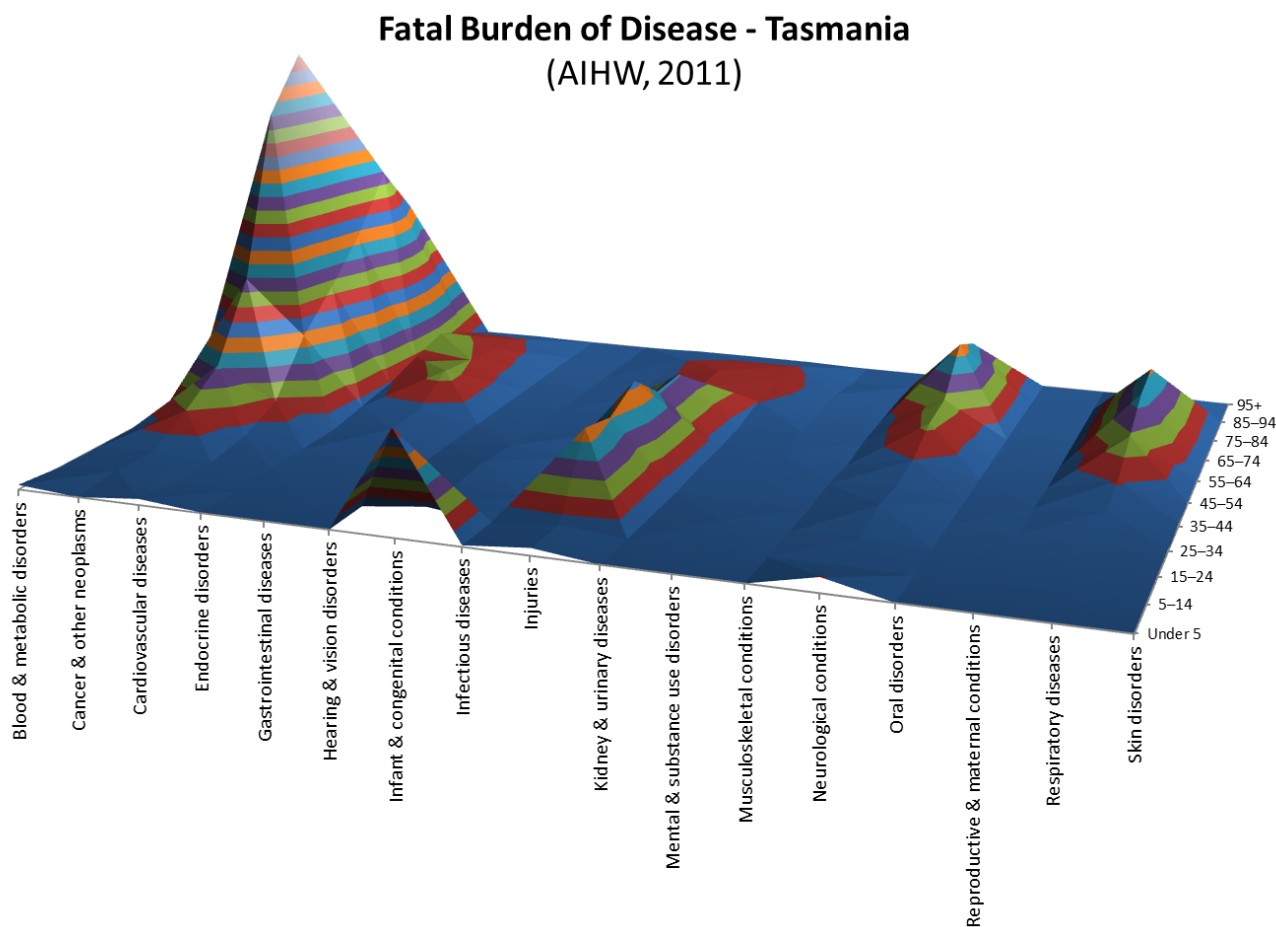
In Tasmania, the Non-Fatal burden increases significantly at the start of the working age and peaks at the end of this period when people are close to or at retirement age. The Fatal Burden peaks around retirement age.

4.2.1 Tasmanian Fatal Burden of Disease (AIHW, 2011)

The graph below shows the cumulative contribution for all conditions to the Total Fatal burden of Disease for Tasmania. The conditions that contribute to 80% of the Fatal Burden are Cancer, Cardiovascular Disease, Injuries, Neurological conditions and Rerspiratory disease.

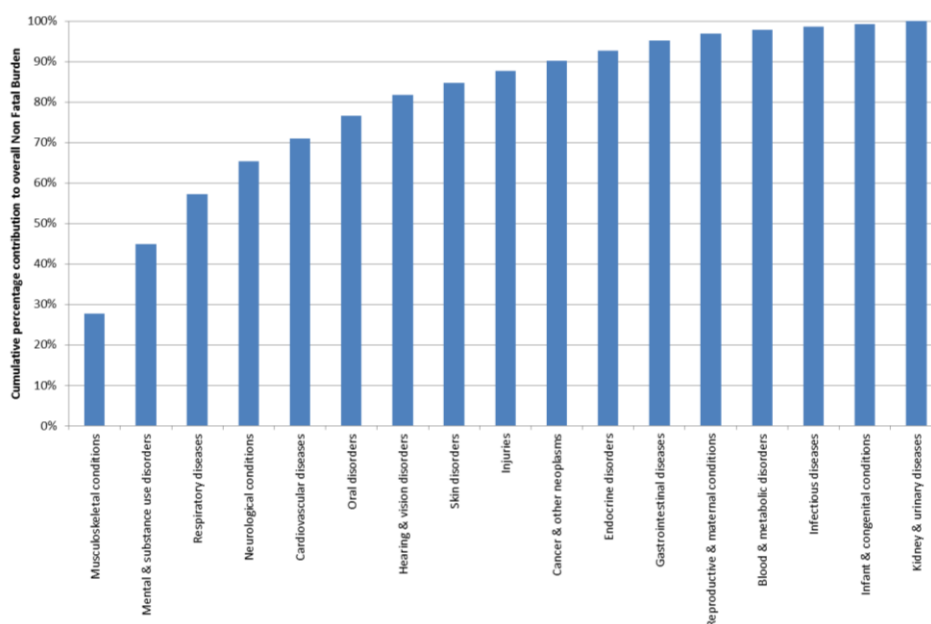


The same data illustrating the spread of burden and its impact at various stages across the lifespan for Tasmania is shown below:



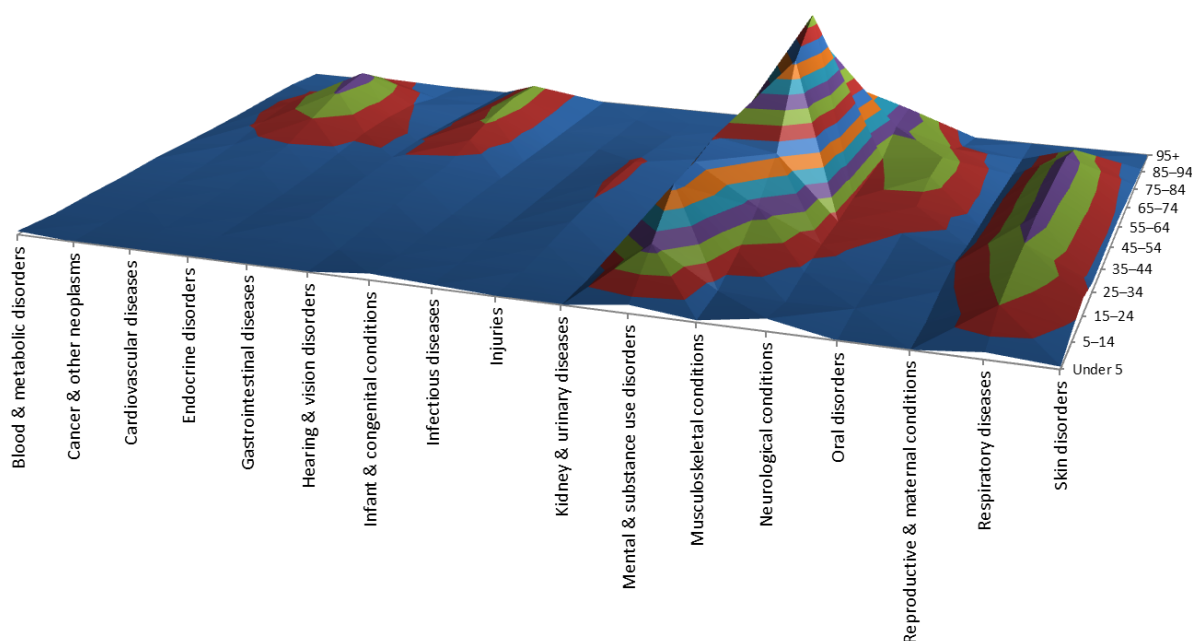
4.2.2 Tasmanian Non-Fatal Burden of Disease (AIHW, 2011)

The graph below shows the cumulative contribution for all conditions to the Total Non Fatal burden of Disease for Tasmania. The conditions that contribute to 80% of the Fatal Burden are Musculoskeletal, Mental Health, Respiratory, Cardiovascular, Oral disorders and Hearing and Vision disorders.



The same data illustrating the spread of burden and its impact at various stages across the lifespan for Tasmania is shown below:

Non-Fatal Burden of Disease - Tasmania
(AIHW, 2011)



4.3 Surgery

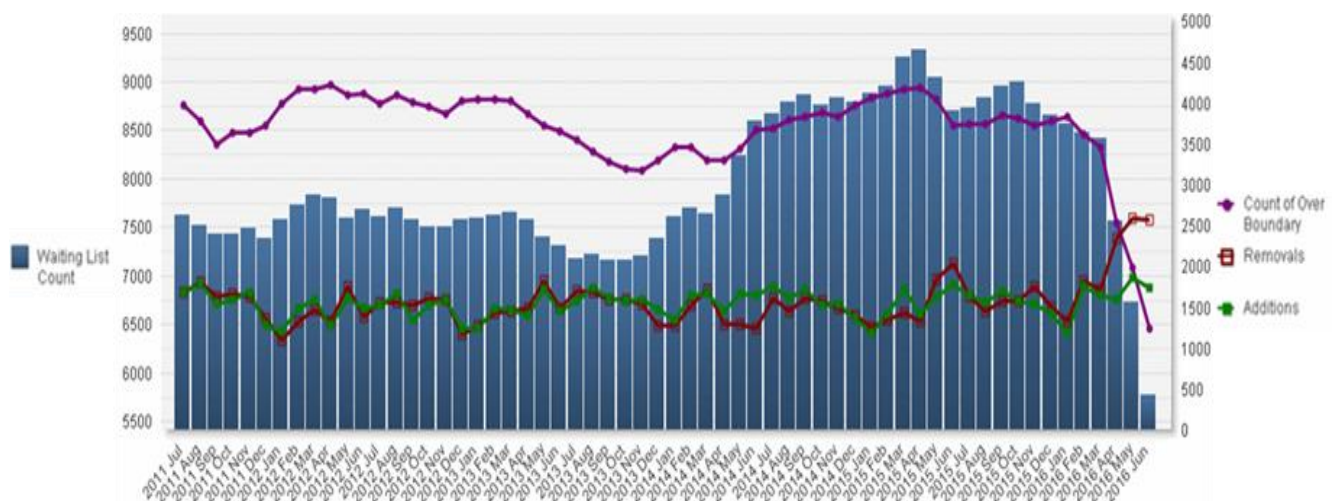
Tasmania faces a number of challenges with respect to elective and emergency surgery. For many years, Tasmanians have waited longer for surgery than residents of other states and territories, with many patients waiting significantly longer than the clinically recommended times. This has placed a great burden on the community and operational stress on the delivery of surgical services, and makes prioritisation of surgical cases difficult as mean wait times lengthen and pressure builds from the community.

While the elective surgery waiting list grew from 2014, over the last year targeted purchasing of elective surgery both from the THS and private providers has delivered not only record levels of activity, but also the lowest ever level of “over boundary” patients and the fewest patients on the Elective Surgery Waiting List (ESWL), since records have been available. This has been achieved by purchasing to treat those patients who have waited longest as a priority – a “treat in turn” approach. Over time, purchasing of elective surgery must also account for the mix of complexity of cases within the ESWL in order to allow for greater sophistication in our purchasing actions. This will assist in aligning with the provisions of the Tasmanian Role Delineation Framework (TRDF) and the Tasmanian Clinical Services Profile (TCSP). This work is planned for the 2018-19 SoPI.

Emergency surgery has not remained stable over time and a greater understanding of the drivers of emergency surgery is required. This work will be incorporated into the 2018-19 SoPI.

4.3.1 Elective Surgery

The demand for elective surgery is articulated via the ESWL and patient and procedure specific clinically recommended waiting times. Median waiting time for elective surgery in Tasmania was 55 days compared to the national average of 35 days (AIHW, 2016). From peak of 9331 in April 2015 (see below), the ESWL has fallen to less than 6000 in June 2016 – the lowest level recorded. While demand pressures and increasing disease burden mean that the ESWL is unlikely to remain at this low level in the longer term, what is more important is that the number of over boundary patients is also at its lowest ever level.



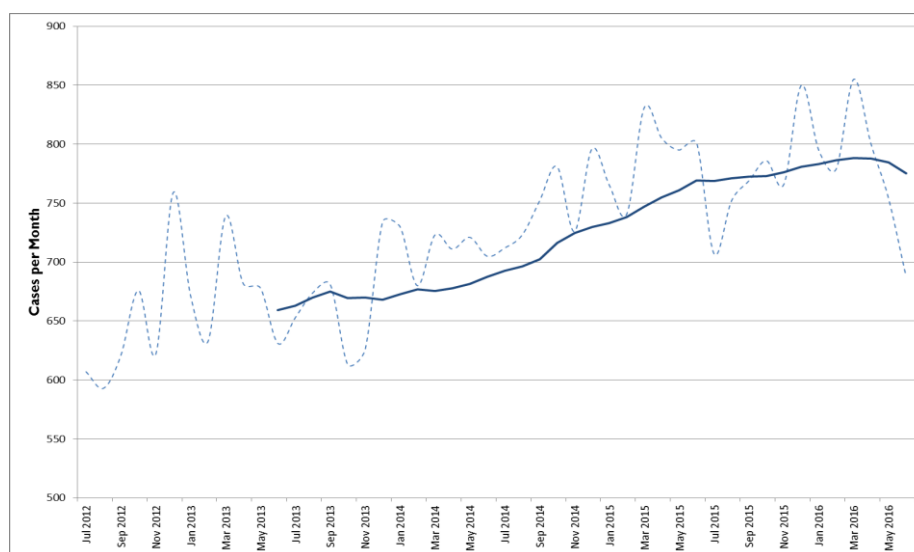
The use of Tasmanian Health Assistance Package (THAP) and Rebuilding Health Services Tasmania (RHST) funding to target long waiting patients has resulted in the observed drop in the count of over boundary patients. RHST funding will cease at the end of the 2017-18 financial year (30 June 2018). It would be unwise to assume that this type of funding would continue indefinitely, and hence an appropriate baseline level of elective surgery activity is required to maintain the waiting list in a long term balance, to ensure that the problem of long waits does not recur.

4.3.2 Emergency Surgery

Provision of Emergency Surgery services impacts on a service's capacity to provide Elective Surgery services to the community. The rate of emergency surgery in Tasmania is 12.0 admissions per 1 000 population compared to the national average of 11.2 per 1 000 population. By comparison, the Northern Territory has the highest rate at 20.7 and Queensland has the lowest rate at 10.1 admissions per 1 000 population. Tasmania thus does not have significantly higher rates of emergency surgery compared to the rest of the country.

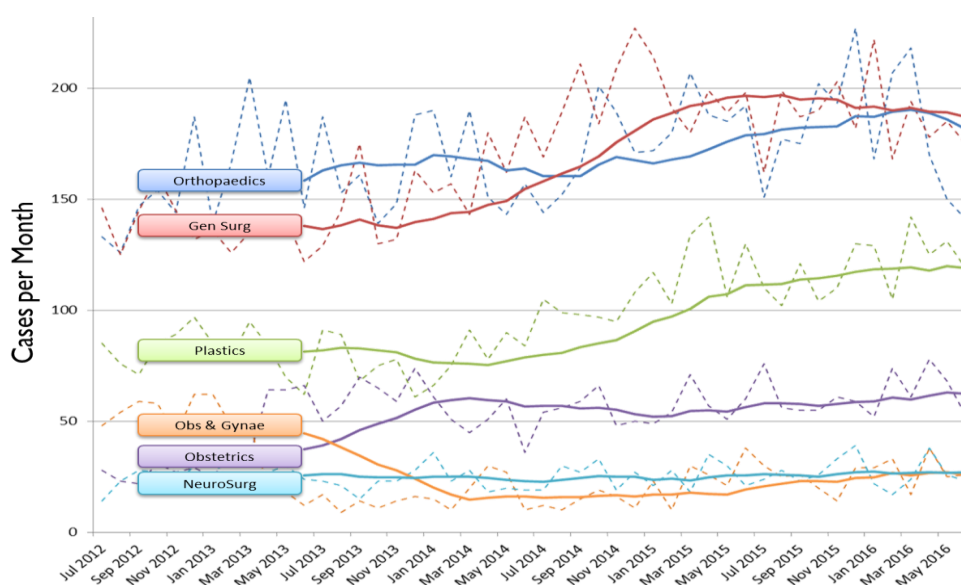
Nationally, there is a direct positive relationship between the degree of remoteness and emergency surgery rates. The same trend is true for socio-economic disadvantage. Given the regionality and socioeconomic status of the broader Tasmanian population, emergency surgery rates in Tasmania on a population basis are probably low given the context.

Emergency Surgery provision has increased across the State, especially during 2014. It has however started to plateau (see figure below with 12 month moving average).



Source: For Your Information (FYI), DHHS, August 2016

Individual specialities that are driving Emergency Surgery and their trends are shown below (trend lines are 12 month moving averages).



Source: For Your Information (FYI), DHHS, August 2016

4.3.3 Treat-in-Turn and Categorisation of urgency of procedures

Ensuring fairness of access is an important principle for the Purchaser. With this in mind it is the intent of the Purchaser to monitor both the Treat in Turn performance indicator of Providers, as well the urgency categorisation which work in concert to ensure fairness in the manner in which patients are selected off the ESWL for surgery.

It is acknowledged that this treatment algorithm cannot be applied one hundred percent of the time. Variation will occur due to a range of factors such as different patient requirements, efficient use of operating theatre time (procedure mix within each session) and training requirements in teaching hospitals. It has been agreed nationally that 60% of patients should be Treated in Turn (AIHW, 2012), providing 40% flexibility to allow for the insertion of training cases, maximising operational efficiency, and to accommodate individual patient needs.

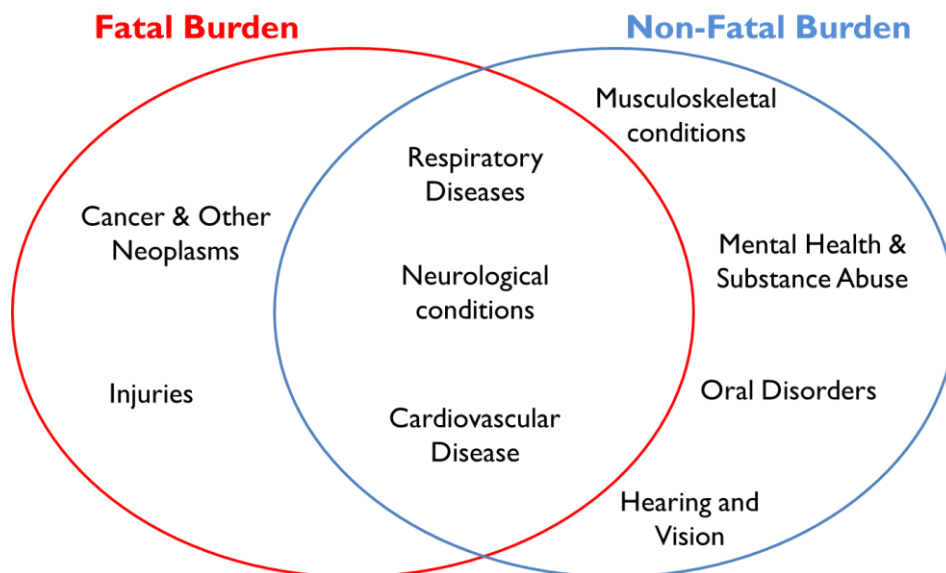
Correct categorisation of procedures not only facilitates an accurate ESWL urgency mix, but also ensures that the longest waiting patients are prioritised for treatment in a fair manner. Manipulation of urgency categories has the undesirable effect of placing unnecessary pressure on the delivery of services to meet appropriate timelines on urgency categories and artificially elevates the number of long wait cases.

5 Purchasing Priorities

5.1 Chronic Disease (Current & Future)

5.1.1 Chronic Disease Priorities (2017-18)

In order to focus purchasing priorities, an analysis was undertaken to understand the relative contribution of each disease that contributed to 80% of the burden in Tasmania for both Fatal and Non-Fatal burdens. The conditions that contribute to one or both are shown in the diagram below:



Respiratory diseases, neurological conditions and cardiovascular disease contribute significantly to both Fatal and Non-Fatal burdens of disease.

The One State, One Health System, Better Outcomes – ‘White Paper: Delivering Safe and Sustainable Clinical Services’ (June 2015) identified a number of services where key changes are required to ensure the state-wide delivery of evidence-based, quality and safe care.

The services identified below are addressed specifically in Section 6 – ‘Purchasing Actions 2017-18’ of this SoPI under the headings:

Chronic Conditions-

- Integrated Cancer Services
- Trauma and Critical Care Services (Injuries category)
- Mental Health Services.

Surgery -

- Integrated Surgical Services.

Future development -

- Subacute Services will be taken into consideration within future Sector Purchasing
- Burns Services - an independent ‘Review of the Tasmanian Burns Services’ conducted in October 2015 released a report on the findings and recommendations which are currently being implemented within the THS, and
- Maternity and Neonatal Services is under reconfiguration and consolidation, in particular the North West region, as a project initiative of the One State, One Health System, Better Outcomes – ‘White Paper: Delivering Safe and Sustainable Clinical Services’.

It is suggested that projection modelling for acute hospital demand be undertaken, focussing on these conditions with a view to purchasing activity specifically related to these conditions. The projection model recognises that growth in use of acute hospital services is determined by population growth, population ageing and changes in clinical practice. Each of these components must be projected to forecast future demand.

5.1.2 Chronic Disease Priorities (Future)

5.1.2.1 Diabetes and other risk factors

Diabetes

Endocrine disorders contribute 2.6% of the Total Burden of Disease in Tasmania (AIHW, 2011). The prevalence of Diabetes (self-reported) in Tasmania is 0.5% for Type I Diabetes and 4.0% for Type II Diabetes (DHHS, 2013). The AusDIAB Study (2000) reported that 8.75% of the Tasmanian population has Diabetes. It was the opinion of the authors of the Tasmanian Health Indicators Report (DHHS, 2013) that there may be Tasmanians living with Diabetes who are not aware they have the disease.

People with Diabetes, particularly those with complications, are likely to experience episodes of hospitalisation. Coding changes for acute episodes of care for Diabetes have rendered purchasing specifically for Diabetes difficult. It is more likely that a patient hospitalised with a complication due to Diabetes will be coded for the complication as the primary diagnosis rather than the Diabetes. Diabetes may (or may not) appear as a secondary diagnosis. Further work needs to be undertaken to understand the coded data environment before purchasing actions related to Diabetes can be formulated.

Risk Factors

Future iterations of the SoPI will address risk factors through purchasing activities in other sectors such as the Community and private sectors. Some examples of risk factors that will be addressed are:

- Smoking
- Overweight and obesity
- Alcohol consumption
- Nutritional status
- Physical inactivity, and
- Environmental risks.

Sector specific purchasing (c.f. Section 5.3) will enable the DHHS to improve purchasing actions for chronic disease risk factors.

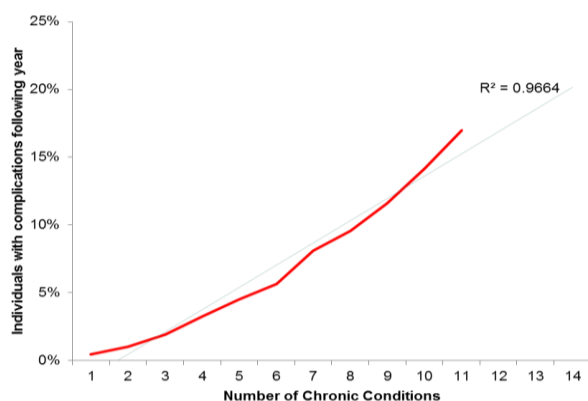
5.1.2.2 Multi-morbidity

Multi-morbidity is an issue that will require planning with a view to specific purchasing actions in the near future. Anecdotally, clinicians are discussing the rising problem of multi-morbidity and its impact on care delivery across the clinical spectrum, from operating theatres to emergency departments, and from outpatients to care in the community.

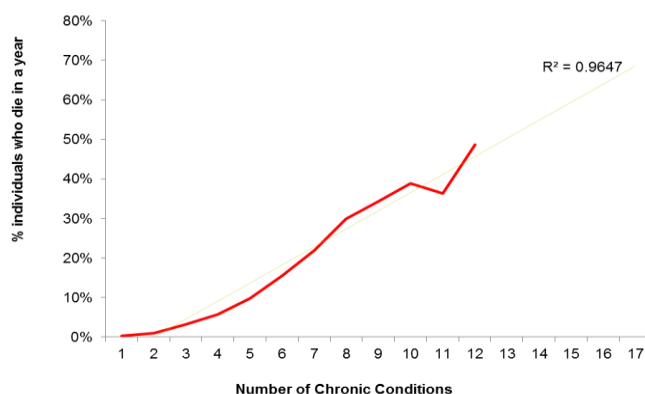
Between 1970 and 2010, Australian life expectancy increased from 71.02 years to 81.7 years (Bank, n.d.). Concurrent with this trend is an ageing population, an increase in chronic disease and multi-morbidity affecting more than half the elderly population (Marengoni, 2011) with 80% of the elderly population having three or more chronic conditions (Caughey, 2008). In the United States, multi-morbidity has been shown to increase progressively with age from a prevalence of 50% in those less than sixty five years of age to 81.5% in those aged over eighty five years (Salive, 2013).

Tasmania's high rates of lifestyle-related risk factors have contributed to Tasmania having higher rates of multi-morbidity (three or more self-reported chronic conditions) than any other jurisdiction, and this problem is worsening. 50.3% of Tasmanians had three or more chronic conditions in 2014–15, increasing from 41.8% in 2011–12 (One State, 2016).

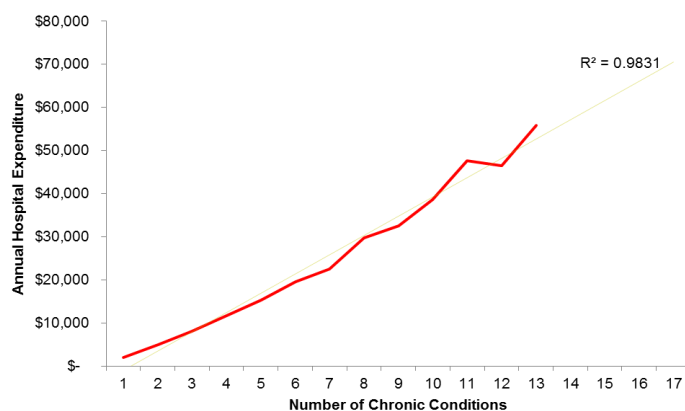
Multimorbid patients are at greater risk for further complications (Weir, 2015) and mortality (Corvoisier, 2015) (Prior, 2016). Furthermore, the cost of care required by multimorbid patients is also higher (Picco, 2016), (Navickas, 2016). These findings are also evident in Tasmanian acute admitted data (DHHS-PPP-MRA, 2015) as illustrated in the three graphs below:



Comorbidities vs Complications



Comorbidities vs Mortality



Comorbidities vs Cost

Multi-morbidity creates special challenges for health systems and the delivery of health care. People with multi-morbidity and complex healthcare needs often receive care that is fragmented, incomplete, inefficient and ineffective (Boyd, 2010).

5.2 Surgery (Current & Future)

5.2.1 Elective Surgery Priorities (2017-18)

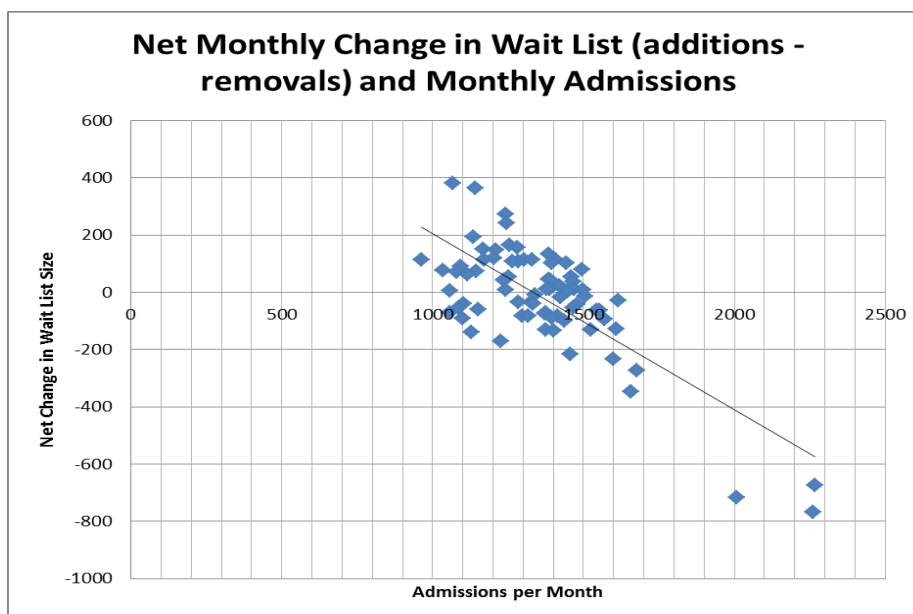
5.2.1.1 Continued removal of longest waiting patients from the ESWL

Significant progress has been made to remove the longest waiting patients from the waiting list using both THAP and RHST funding. By the time the Service Agreement to which this SoPI refers is in place, THAP funding will have ceased. There will however be remaining RHST funding during the 2017-18 financial year to allow for continued targeting of the longest waiting patients on the ESWL.

During 2017-18, the focus of elective surgery purchasing will therefore continue to be the elimination of over boundary waits and achievement of clinically recommended wait times through the successful implementation of Treat in Turn management of the waiting list.

5.2.1.2 Stable waiting list

In the longer term, it is estimated that approximately 1350 elective surgery cases will need to be performed per month (DHHS-PPP-MRA, 2015) (see figure below) in order to maintain an acceptable baseline level of activity.



This translates to 16 200 elective surgery cases needing to be performed across the state annually. Population growth will also need to be accounted for in the out years in order to maintain activity at baseline levels.

5.2.1.3 Treat in Turn

Treat in Turn rates will be monitored as a KPI, in order to ensure standardisation and fairness in the management of the ESWL. It is expected that 60% of patients will be Treated in Turn as per the National Definitions for Elective Surgery Urgency Categorisation (AIHW, 2012).

5.2.1.4 Urgency Categorisation

Variation in practice with regards to the distribution of categorisation will be monitored by the Purchaser.

5.2.2 Elective and Emergency Surgery Priorities (Future)

5.2.2.1 Elective Surgery

The Purchaser will develop a method (in the 2018-19 SoPI) of purchasing Elective Surgery cases based on the case / procedural / case urgency mix within the ESWL. The expectation is that this will not only acknowledge the complexity profile of the ESWL but also assist the provider(s) to plan surgical activity, and further support greater fairness for those patients on the waitlist with regards to Treat in Turn.

5.2.2.2 Emergency Surgery Volume

Specific case volumes of Emergency Surgery will be purchased in the 2017-18 SoPI.

5.2.2.3 Emergency Surgery drivers

A clear understanding of the drivers of Emergency Surgery needs to be gained, particularly as to which specialties are driving the need for Emergency Surgery.

5.3 Primary and Community Sector Purchasing (Future)

Health services provided in the primary and community sectors are essential to health care delivery in Tasmania. These services assist the well to remain so, prevent acute events, and, where possible, avoid or mitigate chronic health conditions.

Lack of integration between acute care and the primary and community sectors leads to duplication of services, impacting on the efficiency of the system. System efficiency is optimal when the allocation of resources aligns with and meets the legitimate health needs of the population. Continuity of care across the health system is important for patients, their families and carers, and health care providers. It is increasingly recognised that community engagement in health prevention can also be highly influential in improving the overall health of communities and, by extension, the individuals within those communities.

The Department has a responsibility to contribute to keeping Tasmanians healthy and out of hospital. In part, this is achieved through configuring the health system to provide better access to quality health care appropriate to individual needs, and fostering partnerships between the THS and service providers (Departmental, non-government and private sector). Partnering between GPs and other clinical providers is key to the sustainability and effective operation of both the primary and acute care sectors.

The activities that occur in the primary and community sectors impact upon the kinds and levels of demand experienced by the acute sector, and it is therefore important to understand and measure the needs of the community so that we can purchase the most appropriate services for the greatest positive effect.

In order to enable a greater degree of sophistication in purchasing activity into the future, the lower complexity service levels 3, 2 and 1 of the Tasmanian Clinical Services Profile (TCSP) should be described and delineated. This will create the opportunity for the Department to be more sophisticated in its purchasing intent and to articulate the purchase of community and primary care based services. It will provide the option of shifting service provision, where appropriate, away from acute service centres towards community based care or even care in the home.

5.4 Consumer Engagement (Future)

The Department is committed to strengthening the participation of consumers, carers and the community in healthcare planning, design, development, service delivery, research, monitoring and evaluation, in order to ensure a healthcare system that involves Tasmanians as active partners in building a healthy community.

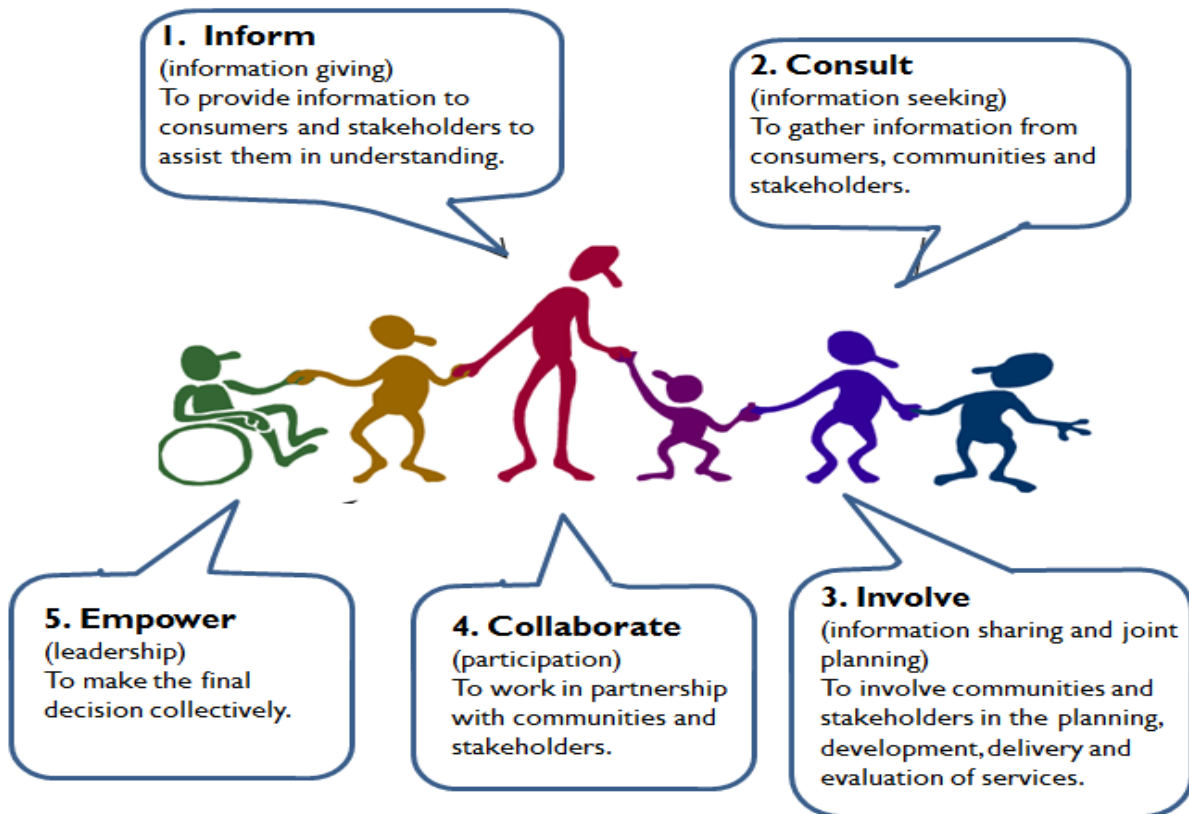
Consumer and community engagement practices will be developed further to ensure the voices of the Tasmanian community are central to health service planning and health care decisions, and to better meet the legitimate needs of the community.

In order to better support sector purchasing and reform, the Department will take a greater lead in consumer engagement with the people of Tasmania, to share responsibility and recognise their role as joint decision makers in service planning and delivery, to improve health outcomes.

To enhance the level of engagement it is essential to ensure that appropriate engagement measures are used. The below figure on the Spectrum of Stakeholder Engagement (Health, 2015) outlines the five levels of engagement and provides guidance on which level would be to ensure the most meaningful engagement in healthcare service planning and delivery.

Spectrum of Stakeholder Engagement

(increasing levels of impact)



**Referenced from Standard 2: Partnering with Consumers (ACSQHC, 2012)*

6 Purchasing Actions 2017-18

Chronic Disease

| | | | | |
|--|---|---------|---------|---------|
| 5.1.1 | <u>Purchaser intent:</u> Purchase activity (acute admitted RAW episodes – refer ‘Appendix B: Chronic Disease – Mapping’ definition) for the following chronic diseases that contribute to 80% of the burden in Tasmania. | | | |
| | Forecasting based on the projection modelling tool. For full mapping of SRGs refer ‘Appendix B: Chronic Disease – Mapping’. | | | |
| | <u>Provider obligation:</u> To provide acute admitted activity (episodes) as specified below: | | | |
| | | | | |
| Cardiovascular Disease | | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| 6149 | 6318 | 6486 | 6655 | 6823 |
| Neurological conditions | | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| 5418 | 5582 | 5745 | 5909 | 6072 |
| Respiratory Disease | | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| 5228 | 5392 | 5555 | 5719 | 5883 |
| Musculoskeletal conditions | | | | |
| <u>Additional Purchaser intent:</u> In accordance with TCSP/TRDF, increase Rheumatology services in the NW Region from a no level service to a Level 4 service. It is anticipated this service will be more cost effective, reduce waiting time and possibly eliminate the need for surgery. | | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| 3466 | 3523 | 3580 | 3637 | 3695 |
| Mental Health and Substance Abuse | | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| 3207 | 3244 | 3282 | 3319 | 3357 |
| Cancer and other Neoplasms | | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| 8603 | 8905 | 9207 | 9509 | 9810 |

| Injuries | | | | |
|--|--|-------------------------------------|--------------------------------------|--------------------------------------|
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| 1781 | 1840 | 1899 | 1959 | 2018 |
| Injuries - Deliberate Self Harm <u>Additional Purchaser intent:</u> Deliberate self-harm or suicide attempt patients, when discharged from the Acute Hospital (either Emergency Department or inpatient setting), are assessed and referred for follow up post discharge community care within 48 hours of discharge. | | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| Monitoring & Reporting | Monitoring & Reporting | Monitoring & Reporting | Monitoring & Reporting | Monitoring & Reporting |
| Injuries - Trauma <u>Additional Purchaser intent:</u> Provision of funding for resources to establish and implement a safe, high quality and evidence based state-wide Trauma Service and clinical governance framework, underpinned by major trauma criteria, guidelines and policies and supply of statewide training programs to build trauma capability along the full continuum of care for trauma patients. | | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| Resource Funding - \$165,000 (Capacity building) | Resource Funding - \$165,000 (Capacity Building) | Achieve RACS – Trauma Accreditation | Maintain RACS – Trauma Accreditation | Maintain RACS – Trauma Accreditation |
| Oral Disorders | | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| 451 | 456 | 462 | 468 | 473 |
| Hearing and Vision Disorders | | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| 212 | 221 | 229 | 238 | 247 |

Elective Surgery

| | | | | |
|---------|---|---------|---------|---------|
| 5.2.1.1 | Elective Surgery Waitlist | | | |
| | <u>Purchaser intent:</u> | | | |
| | Utilise remaining RHST funds to remove long waiting patients from the Elective Surgery Waitlist (ESWL). | | | |
| | <u>Provider obligation:</u> Remove the longest waiting patients from the ESWL either by clinical review or through providing treatment. | | | |
| | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
| | RHST funds (remaining) | n/a | n/a | n/a |

| | | | | |
|---------|---|---|-----------------------------------|-----------------------------------|
| 5.2.1.2 | Elective Surgery Volume | | | |
| | <u>Purchaser intent:</u> | | | |
| | Purchase sufficient Elective surgery activity volume to maintain a stable waiting list. | | | |
| | <u>Provider obligation:</u> Supply stated activity | | | |
| | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
| | 16 200 cases pa (Baseline) | 16 200 Baseline + Pop growth to be agreed | 2018_19 + Pop growth to be agreed | 2019_20 + Pop growth to be agreed |

| | | | | |
|--------------------|---|---------|---------|---------|
| 5.2.1.3 5.2.1.4 | Treat in Turn and Categorisation | | | |
| | <u>Purchaser intent:</u> | | | |
| | It is expected by the Purchaser that all patients on the Elective Surgery Waiting List will be categorised consistent with the National Elective Surgery Urgency Categorisation Guideline, and subsequently 60% of patients will be 'treated in turn' following the National Definitions for Elective Surgery Urgency Categories project 'treat in turn' principle. | | | |
| | The referenced Categorisation Guideline and Categorisation project were endorsed by AHMAC, RACS, 12 Australasian surgical colleges and the AIHW in 2015 and 2014 respectively.. | | | |
| | <u>Provider obligation:</u> Attain Treat in Turn KPI | | | |
| | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
| | 60% | 60% | 60% | 60% |

| | | | | |
|--------------------|---|--------------|--------------|--------------|
| 5.2.2.1 | Elective Surgery Waitlist (Future) - Purchase Activity | | | |
| | Future intent by the Purchaser, to purchase activity in a manner that accounts for case complexity within the ESWL. | | | |
| | <u>Provider obligation:</u> Supply stated activity mix | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| Policy Development | Activity tbc | Activity tbc | Activity tbc | Activity tbc |

Emergency Surgery

| | | | | |
|--------------------|--|--------------|--------------|--------------|
| 5.2.2.2 | Emergency Surgery Volume (Future) | | | |
| | Specify Emergency surgery volume. | | | |
| | <u>Provider obligation:</u> | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| Policy Development | Activity tbc | Activity tbc | Activity tbc | Activity tbc |

| | | | | |
|--------------------|--|--------------|--------------|--------------|
| 5.2.2.3 | Emergency Surgery Activity Mix (Future) | | | |
| | Specify speciality volume funding within Emergency Surgery volume. | | | |
| | <u>Provider obligation:</u> | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| Policy Development | Activity tbc | Activity tbc | Activity tbc | Activity tbc |

Sector Purchasing (Future)

| | | | | |
|--------------------|---|--------------|--------------|--------------|
| 5.3 | Connect our acute hospitals and health care services with the community by: | | | |
| | <ul style="list-style-type: none"> Supporting people with chronic conditions to manage their condition at home and in their community. Fostering coordinated care and chronic condition management through developed coordinated care models for people with chronic conditions. Reducing likelihood of developing a chronic condition, disease or disorder. | | | |
| | <u>Provider intent:</u> shifting service provision, where appropriate, away from acute service settings towards community based or even care in the home. | | | |
| 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
| Policy Development | TRDF/TCSP | Activity tbc | Activity tbc | Activity tbc |

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Appendix A: Disease and Injury List

Infectious diseases

Barmah Forest virus
Campylobacteriosis
Chlamydia
Dengue
Diphtheria
Gonorrhoea
HIV/AIDS
Haemophilus influenzae type-b
Hepatitis A
Hepatitis B (acute)
Hepatitis C (acute)
Influenza
Lower respiratory infections
Malaria
Measles
Meningococcal disease
Other gastrointestinal infections
Other infections
Other meningitis and encephalitis
Other sexually transmitted infections
Otitis media
Pertussis
Pneumococcal disease
Ross River virus
Rotavirus
Rubella
Salmonellosis
Syphilis
Tetanus
Trachoma
Tuberculosis
Upper respiratory infections
Varicella-zoster

Infant and congenital conditions

Birth trauma and asphyxia
Brain malformations
Cardiovascular defects
Cerebral palsy
Cleft lip and/or palate
Down syndrome
Gastrointestinal malformations
Neonatal infections

Infant and congenital conditions (continued)

Neural tube defects
Other chromosomal abnormalities
Other congenital conditions
Other disorders of infancy
Pre-term birth and low birthweight complications
Sudden infant death syndrome
Urogenital malformations

Cancer and other neoplasms

Benign and uncertain brain tumours
Bladder cancer
Bowel cancer
Brain and central nervous system cancer
Breast cancer
Cervical cancer
Ductal carcinoma in situ (breast)
Gallbladder cancer
Hodgkin lymphoma
Kidney cancer
Laryngeal cancer
Leukaemia
Liver cancer
Lung cancer
Melanoma of the skin
Mesothelioma
Mouth and pharyngeal cancer
Myeloma
Non-Hodgkin lymphoma
Non-melanoma skin cancer
Oesophageal cancer
Other benign, in situ and uncertain neoplasms
Other lymphohaematopoietic (blood) cancers
Other malignant neoplasms (cancers)
Ovarian cancer
Pancreatic cancer
Prostate cancer
Stomach cancer
Testicular cancer
Thyroid cancer
Unknown primary
Uterine cancer

Cardiovascular diseases

Aortic aneurysm
Atrial fibrillation and flutter
Cardiomyopathy
Coronary heart disease
Hypertensive heart disease
Inflammatory heart disease
Non-rheumatic valvular disease
Other cardiovascular diseases
Peripheral vascular disease
Rheumatic heart disease
Stroke

Respiratory diseases

Asthma
COPD
Interstitial lung disease
Other respiratory diseases
Pneumoconiosis
Sarcoidosis
Upper respiratory conditions

Gastrointestinal disorders

Abdominal wall hernia
Appendicitis
Chronic liver disease
Diverticulitis
Functional gastrointestinal disorders
Gallbladder and bile duct disease
Gastro oesophageal reflux disease
Gastroduodenal disorders
Inflammatory bowel disease
Intestinal obstruction (without hernia)
Other gastrointestinal diseases
Pancreatitis
Vascular disorders of intestine

Neurological conditions

Dementia
Epilepsy
Guillain-Barré syndrome
Migraine
Motor neurone disease
Multiple sclerosis
Other neurological conditions
Parkinson disease

Mental and substance use disorders

Alcohol use disorders
Anxiety disorders
Attention deficit hyperactivity disorder
Autism spectrum disorders
Bipolar affective disorder
Conduct disorder
Depressive disorders
Drug use disorders (excluding alcohol)
Eating disorders
Intellectual disability
Other mental and substance use disorders
Schizophrenia

Endocrine disorders

Diabetes
Other endocrine disorders

Kidney and urinary diseases

Chronic kidney disease
Enlarged prostate
Kidney stones
Other kidney and urinary diseases

Reproductive and maternal conditions

Early pregnancy loss
Endometriosis
Genital prolapse
Gestational diabetes
Hypertensive disorders of pregnancy
Infertility
Maternal haemorrhage
Maternal infections
Obstructed labour
Other maternal conditions
Other reproductive conditions
Polycystic ovarian syndrome
Uterine fibroids

Musculoskeletal conditions

Back pain and problems
Gout
Osteoarthritis
Other musculoskeletal
Rheumatoid arthritis

Hearing and vision disorders

Hearing loss
Other hearing and vestibular disorders
Other vision disorders
Vision loss

Skin disorders

Acne
Dermatitis and eczema
Other skin disorders
Psoriasis
Skin infections (including cellulitis)
Ulcers

Oral disorders

Dental caries
Other oral disorders
Periodontal disease
Severe tooth loss

Blood and metabolic disorders

Cystic fibrosis
Haemolytic anaemias
Haemophilia
Iron-deficiency anaemia
Other blood and metabolic disorders
Protein-energy deficiency

External causes of Injury

All other external causes of injury
Drowning
Falls
Fire, burns and scalds
Homicide and violence
Other land transport injuries
Other road traffic injuries
Other unintentional injuries
Poisoning
Road traffic injuries – motor vehicle occupants
Road traffic injuries – motorcyclists
Suicide and self-inflicted injuries

Nature of Injury

Burn injuries
Dislocations
Drowning and submersion injuries
Hip fracture
Humerus fracture
Internal and crush injury
Other fractures
Other injuries
Poisoning
Soft tissue injuries
Spinal cord injury
Tibia and ankle fracture
Traumatic brain injury

Appendix B: Chronic Disease – Mapping

| Chronic Disease | SRG | Relevant ESG |
|---|--------------------------------|---|
| <u>Cancer & Other Neoplasms</u> | 12 Haematology | 039 Red Blood Cell Disorders |
| | | 040 Lymphoma and Non-Acute Leukaemia |
| | | 041 Haematological Surgery |
| | | 042 Other Haematology |
| | 15 Medical Oncology | 050 Respiratory Neoplasms |
| | | 051 Digestive Malignancy |
| | | 052 Other Medical Oncology |
| | 16 Chemotherapy & Radiotherapy | 053 Chemotherapy |
| <u>Cardiovascular disease</u> | 01 Cardiology | 001 Chest Pain |
| | | 002 Unstable Angina |
| | | 003 Heart Failure and Shock |
| | | 004 AMI W/O Invasive Cardiac Inves Proc |
| | | 005 Other Cardiology |
| | 02 Interventional Cardiology | 006 Percutaneous Coronary Angioplasty W AMI |
| | | 007 Percutaneous Coronary Angioplasty W/O AMI |
| | | 008 Invasive Cardiac Inves Proc |
| | | 009 Other Interventional Cardiology |
| <u>Hearing & Vision disorders</u> | 14 Ophthalmology | 049 Non-procedural Ophthalmology |
| <u>Injuries</u> | 27 General Surgery | 090 OR Procedures for injuries |
| | | 091 Injuries - Non-surgical |
| | 35 Burns | 117 Extensive Burns, Medical |
| | | 118 Extensive Burns, Surgical |
| <u>Mental Health & Substance Abuse</u> | 36 Psychiatry | 119 Major Psychiatric Disorder |
| | | 120 Other Psychiatry |
| | 37 Drug & Alcohol | 121 Drug & Alcohol |
| <u>Musculoskeletal conditions</u> | 17 Rheumatology | 054 Rheumatology |
| | 23 Orthopaedics | 069 Non-surgical Back and Neck Problems |
| | | 070 Other Orthopaedics - Non-Surgical |

| Chronic Disease | SRG | Relevant ESRG |
|---------------------------------------|-------------------------|--|
| <u>Neurological conditions</u> | 07 Neurology | 023 Dementia, Delirium and Non-traumatic Stupor/Coma |
| | | 024 Stroke |
| | | 025 TIA |
| | | 026 Seizures |
| | | 027 Headache |
| | | 028 Other Neurology |
| <u>Oral disorders</u> | 20 Dentistry | 058 Dental Extractions and Restorations |
| | | 059 Dental and Oral Disease excluding Extractions |
| <u>Respiratory diseases</u> | 04 Respiratory Medicine | 012 Bronchitis and Asthma |
| | | 013 Chronic Obstructive Airways Disease |
| | | 014 Respiratory Infections/Inflammations |
| | | 015 Sleep Apnoea |
| | | 016 Other Respiratory Medicine |

Definition:

| | |
|--------------------------|------------------|
| Chargeable_Status | (All) |
| Age_Group | (All) |
| Stay_Type | (All) |
| ComplexSurg | (All) |
| Hospital_Type | Public |
| Place_of_Treatment | (RHH, LGH, NWRH) |
| ED_Flag | (All) |
| SSU_Flag | (All) |
| Multiple_Morbidity | (All) |
| Place_of_Residence (SA3) | (All) |