

# NATIONAL HEALTH REFORM AGREEMENT

Council of  
Australian  
Governments

An agreement between

- the Commonwealth of Australia and
- the States and Territories, being:
  - ◆ the State of New South Wales;
  - ◆ the State of Victoria;
  - ◆ the State of Queensland;
  - ◆ the State of Western Australia;
  - ◆ the State of South Australia;
  - ◆ the State of Tasmania;
  - ◆ the Australian Capital Territory; and
  - ◆ the Northern Territory of Australia.

The objective of this Agreement is to improve health outcomes for all Australians and the sustainability of the Australian health system.

This Agreement sets out the architecture of National Health Reform, which will deliver major structural reforms to establish the foundations of Australia's future health system.

In particular, this Agreement provides for more sustainable funding arrangements for Australia's health system.

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# National Health Reform Agreement

## PRELIMINARIES, SYSTEM WIDE OBJECTIVES AND ROLES AND RESPONSIBILITIES

### Preliminaries

1. This Agreement:
  - a. sets out the shared intention of the Commonwealth, State and Territory (the States) governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system;
  - b. introduces new financial and governance arrangements for Australian public hospital services and new governance arrangements for primary health care and aged care;
  - c. implements National Health Reform as agreed by the Council of Australian Governments (COAG) Heads of Agreement on National Health Reform in February 2011;
  - d. builds on and reaffirms the Medicare principles and high-level service delivery principles and objectives for the health system in the National Healthcare Agreement (agreed by COAG in 2008 and amended in July 2011);
  - e. supersedes the National Health and Hospitals Network Agreement and the Heads of Agreement on National Health Reform;
  - f. recognises that:
    - i. the States are the system managers of the public hospital system; and
    - ii. the Commonwealth has full funding and program responsibility for aged care (except where otherwise agreed) and has lead responsibility for GP and primary health care;
  - g. builds on and complements the policy and reform directions and outcomes, progress measures and outputs outlined in the National Healthcare Agreement (NHA). This Agreement should be read in conjunction with the NHA; and
  - h. is subject to the Intergovernmental Agreement on Federal Financial Relations (IGA FFR) and should be read in conjunction with that Agreement and subsidiary schedules.
2. Included at Appendix A is a list of definitions for words and phrases used in this Agreement.

### Objectives of this Agreement

3. The Commonwealth and the States will work in partnership to implement new arrangements for a nationally unified and locally controlled health system which will:

- a. improve patient access to services and public hospital efficiency through the use of activity based funding (ABF) based on a national efficient price (Schedule A);
  - b. ensure the sustainability of funding for public hospitals by increasing the Commonwealth's share of public hospital funding through an increased contribution to the costs of growth (Schedule A);
  - c. improve the transparency of public hospital funding through a National Health Funding Pool and a nationally consistent approach to ABF (Schedule A and B);
  - d. improve standards of clinical care through the Australian Commission on Safety and Quality in Health Care (ACSQHC) (Schedule B);
  - e. improve performance reporting through the establishment of the National Health Performance Authority (NHPA) (Schedule B);
  - f. improve accountability through the Performance and Accountability Framework (Schedule C);
  - g. improve local accountability and responsiveness to the needs of communities through the establishment of Local Hospital Networks and Medicare Locals (Schedule D);
  - h. improve the provision of GP and primary health care services through the development of an integrated primary health care system and the establishment of Medicare Locals (Schedules D and E); and
  - i. improve aged care and disability services by clarifying responsibility for client groups (Schedule F).
4. States will provide health and emergency services through the public hospital system, based on the following Medicare principles:
- a. eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals;<sup>1</sup>
  - b. access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and
  - c. arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

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<sup>1</sup> This Agreement recognises that clinical practice and technology changes over time and that this will impact on modes of service and methods of delivery. These principles should be considered in conjunction with the definition of public hospital services set out at clauses A10 to A26.

5. More specifically, under this Agreement, the States reaffirm their commitment to the following as provided in the NHA:
  - a. provide public patients with access to all services provided to private patients in public hospitals;
  - b. plan and deliver teaching and training and support research provided through public hospitals;
  - c. ensure that eligible persons who have elected to be treated as private patients have done so on the basis of informed financial consent;
  - d. provide and fund pharmaceuticals for public and private admitted patients and for public non-admitted patients in public hospitals (except where Pharmaceutical Reform Arrangements are in place); and
  - e. maintain a Public Patients Hospital Charter and an independent complaints body and ensure that patients are aware of how to access these provisions.
6. This Agreement acknowledges the Commonwealth's lead role in funding and delivering GP and primary health care and aged care, and that the Commonwealth will work in partnership with the States to enable patients to receive the care they need when and where they need it – and in doing so, taking pressure off public hospitals.

## Roles and Responsibilities

7. Under this Agreement the Commonwealth and the States will be jointly responsible for:
  - a. funding public hospital services, using ABF where practicable and block funding in other cases;
  - b. funding growth in public hospital services and the increasing cost of public hospital services;
  - c. establishing and maintaining nationally consistent standards for healthcare and reporting to the community on the performance of health services;
  - d. giving effect to the new Commonwealth-State governance arrangements including the establishment of relevant national bodies; and
  - e. collecting and providing data to support the objectives of comparability and transparency, and to ensure that data is shared between relevant participants in national health care arrangements to promote better health outcomes.
8. Under this Agreement, the States will be responsible for:
  - a. system management of public hospitals, including:
    - i. establishment of the legislative basis and governance arrangements of public hospital services, including the establishment of Local Hospital Networks;
    - ii. system-wide public hospital service planning and performance;
    - iii. purchasing of public hospital services and monitoring of delivery of services purchased;

- iv. planning, funding and delivering capital;
  - v. planning, funding (with the Commonwealth) and delivering teaching, training and research;
  - vi. managing Local Hospital Network performance; and
  - vii. state-wide public hospital industrial relations functions, including negotiation of enterprise bargaining agreements and establishment of remuneration and employment terms and conditions to be adopted by Local Hospital Networks;
- b. taking a lead role in managing public health; and
  - c. sole management of the relationship with Local Hospital Networks to ensure a single point of accountability in each State for public hospital performance, performance management and planning.
9. In providing these services States will adhere to the Business Rules and other requirements set out in Schedule G.
10. Under this Agreement, the Commonwealth will be responsible for:
- a. system management, policy and funding for GP and primary health care services;
  - b. establishing Medicare Locals to promote coordinated GP and primary health care service delivery;
  - c. working with each State on system-wide policy and state-wide planning for GP and primary health care;
  - d. promoting equitable and timely access to GP and primary health care services; and
  - e. planning, funding, policy, management and delivery of the national aged care system noting that there will be different arrangements in Western Australia and Victoria under this Agreement (clause F4 refers).

## Implementation of the Agreement

11. This Agreement will be implemented through the following mechanisms:
- a. COAG will provide overall leadership, in consultation with Standing Council on Health and Treasurers;
  - b. the Standing Council on Health will take the leadership role in implementation of National Health Reform, including by:
    - i. ensuring outstanding implementation and policy matters are on track for resolution, and escalating them to COAG when required; and
    - ii. considering the progress of implementation of key milestones under this Agreement six months before commencement timeframes, and providing advice to COAG if necessary;
  - c. Treasurers will provide advice to COAG on Commonwealth-State financial aspects of the reform agenda, including jurisdictions' performance against the mechanisms to ensure maintenance of effort through to 2014-15; and

- d. COAG Senior Officials will monitor implementation of this Agreement against the implementation plan at Schedule H and will escalate implementation issues to COAG when required.
12. The Commonwealth and States will implement public hospital governance and financing arrangements as set out by this Agreement in line with the timeframes identified in this Agreement. In recognition of the implementation by the States of these reforms, the Commonwealth will provide at least an additional \$16.4 billion in growth funding between 2014-15 and 2019-20 through meeting 45 per cent of efficient growth between 2014-15 and 2016-17 and 50 per cent of efficient growth from 2017-18 onwards; in the event the additional growth funding is less than \$16.4 billion, the Commonwealth will provide the remainder to States as top-up funding.
  13. This Agreement affirms that the following implementation principles should underpin National Health Reform:
    - a. governments agree that an effective health system that meets the health needs of the community requires coordination between hospital, GP and primary health care and aged care to minimise service duplication and fragmentation;
    - b. Australians should be able to access transparent and nationally comparable performance data and information on hospitals, GPs and primary health care, aged care services and other health services;
    - c. governments should continue to support diversity and innovation in the health system as a crucial mechanism to achieve better outcomes;
    - d. all Australians should have equitable access to high quality health care, including those living in regional and remote areas; and
    - e. governments agree that Australia's health system should promote social inclusion and reduce disadvantage, especially for Indigenous Australians.
  14. The Commonwealth and States commit to meeting the following critical milestones under this Agreement:
    - a. the establishment of national bodies as outlined in Schedule B, including the passing of legislation by the following timeframes:
      - i. Commonwealth and State legislation establishing the National Health Funding arrangements no later than 1 April 2012;
      - ii. Commonwealth legislation establishing the Independent Hospital Pricing Authority (IHPA) no later than 31 December 2011; and
      - iii. Commonwealth legislation establishing the National Health Performance Authority (NHPA) no later than 31 December 2011;
    - b. the commencement of Local Hospital Networks no later than 1 July 2012, as outlined in Schedule D;
    - c. the establishment of Medicare Locals no later than 1 July 2012, as outlined in Schedule D;

- d. Commonwealth and each State's activity based hospital funding being paid into and out of the National Health Funding Pool from 1 July 2012, as outlined in Schedule B;
  - e. the implementation of a nationally consistent ABF system for:
    - i. admitted acute services, emergency department services and non-admitted patient services (initially using the Tier 2 outpatient clinics list) commencing on 1 July 2012; and
    - ii. other non-admitted services, mental health and sub-acute services commencing on 1 July 2013; and
  - f. the Home and Community Care (HACC) transfer taking effect on 1 July 2012 (with the exception of Victoria and Western Australia).
15. All States will receive additional Commonwealth funding for public hospitals, relative to the former National Healthcare Specific Purpose Payment (SPP), as a result of this Agreement and:
- a. no State will be worse off in the short or long term, because they will continue to receive at least the amount of funding they would have received under the former National Healthcare SPP and their share of the \$3.4 billion in funding available through the National Partnership Agreement on Improving Public Hospital Services (subject to the terms of that Agreement);
  - b. the Commonwealth's ongoing contribution to efficient growth funding from 1 July 2014 into the future will ensure all State governments will be better-off in the long term, relative to existing payment arrangements; and
  - c. as an initial commitment, the Commonwealth guarantees that it will provide at least \$16.4 billion in additional funding over the 2014-15 to 2019-20 period.
16. The Commonwealth, States and the national bodies established by this Agreement will comply with applicable privacy legislation and principles during the implementation of this Agreement and will consult with relevant stakeholders during implementation.
17. The arrangements outlined in this Agreement should be delivered with no net increase in bureaucracy across Commonwealth and State governments as a proportion of the ongoing health workforce.

## Review of the Agreement

18. A review of this Agreement will be commissioned by COAG and undertaken by a panel of reviewers agreed by COAG. The first review will occur in 2015-16, or later if agreed by COAG, and will be set against the objectives in this Agreement outlined in clause 3, including consideration of the following matters:
- a. whether the implementation of the new national governance, financial and other arrangements in this Agreement give effect to the policy intent of this Agreement;
  - b. the impact of the new GP and primary health care arrangements outlined in this Agreement on the demand for hospital services;
  - c. whether any unintended consequences such as cost-shifting, perverse incentives or other inefficiencies have arisen as a result of the new national governance, financial and other arrangements in this Agreement; and

- d. other matters as agreed by COAG.

### **Process for Amending the Agreement**

- 19. Subject to clause 20, this Agreement may be amended at any time in writing with the agreement of all parties and with terms and conditions as agreed by all the parties.
- 20. To provide greater certainty and security to the States, the Commonwealth commits to put in place legislation requiring a process to be followed, should the Commonwealth seek to vary this Agreement. The process will involve the Commonwealth taking the following steps:
  - a. providing three months notice of the proposed variation to all governments prior to consideration by COAG, unless all governments agree otherwise; and
  - b. gaining COAG's agreement to the variation.

### **Dispute Resolution**

- 21. Any party may give notice to other parties of a dispute under this Agreement.
- 22. Officials of relevant parties will attempt to resolve any dispute in the first instance. If a dispute cannot be resolved by officials it may be escalated to the relevant Ministers, and if necessary, the relevant COAG Council.
- 23. If a dispute cannot be resolved by the relevant Ministers, it may be referred to COAG for consideration.

The Parties have confirmed their commitment to this Agreement as follows:

<p><i>Signed for and on behalf of the Commonwealth of Australia by</i></p> <hr/> <p><b>The Honourable Julia Gillard MP</b> Prime Minister of the Commonwealth of Australia</p> <p>July 2011</p>	
<p><i>Signed for and on behalf of the State of New South Wales by</i></p> <hr/> <p><b>The Honourable Barry O’Farrell MP</b> Premier of the State of New South Wales</p> <p>July 2011</p>	<p><i>Signed for and on behalf of the State of Victoria by</i></p> <hr/> <p><b>The Honourable Ted Baillieu MP</b> Premier of the State of Victoria</p> <p>July 2011</p>
<p><i>Signed for and on behalf of the State of Queensland by</i></p> <hr/> <p><b>The Honourable Anna Bligh MP</b> Premier of the State of Queensland</p> <p>July 2011</p>	<p><i>Signed for and on behalf of the State of Western Australia by</i></p> <hr/> <p><b>The Honourable Colin Barnett MLA</b> Premier of the State of Western Australia</p> <p>July 2011</p>

<p><b>Signed</b> for and on behalf of the State of South Australia by</p> <hr/> <p><b>The Honourable Mike Rann MP</b> Premier of the State of South Australia</p> <p>July 2011</p>	<p><b>Signed</b> for and on behalf of the State of Tasmania by</p> <hr/> <p><b>The Honourable Lara Giddings MP</b> Premier of the State of Tasmania</p> <p>July 2011</p>
<p><b>Signed</b> for and on behalf of the Australian Capital Territory by</p> <hr/> <p><b>Ms Katy Gallagher MLA</b> Chief Minister of the Australian Capital Territory</p> <p>July 2011</p>	<p><b>Signed</b> for and on behalf of the Northern Territory by</p> <hr/> <p><b>The Honourable Paul Henderson MLA</b> Chief Minister of the Northern Territory of Australia</p> <p>July 2011</p>

## SCHEDULE A – SUSTAINABILITY OF FUNDING FOR PUBLIC HOSPITAL SERVICES

### Commonwealth Funding

- A1. Under this Agreement, Commonwealth National Health Reform funding will replace the National Healthcare SPP in Schedule D of the IGA FFR from 1 July 2012. The Commonwealth will fund:
- a. hospital services provided to public patients in a range of settings and funded on an activity basis;
  - b. hospital services provided to eligible private patients in public hospitals;
  - c. hospital services provided to patients in public hospitals better funded through block grants, including relevant services in rural and regional communities;
  - d. teaching and training functions funded by States undertaken in public hospitals or other organisations (such as universities and training providers);
  - e. research funded by States undertaken in public hospitals; and
  - f. public health activities managed by States.
- A2. From 1 July 2012, funding will be provided on the basis of activity through ABF wherever practicable.
- A3. From 1 July 2014, the Commonwealth will fund 45 per cent of efficient growth of activity based services, increasing to 50 per cent from 1 July 2017. Efficient growth consists of:
- a. the national efficient price for any changes in the volume of services provided (the role of the national efficient price and how it will be determined is set out in Schedule B); and
  - b. the growth in the national efficient price of providing the existing volume of services.
- A4. Where services or functions are more appropriately funded through block grants and for teaching, training and research, the Commonwealth will fund 45 per cent of growth in the efficient cost of providing the services or performing the functions from 1 July 2014, increasing to 50 per cent from 1 July 2017. The efficient cost will be determined annually by the IHPA, taking account of changes in utilisation, the scope of services provided and the cost of those services to ensure the Local Hospital Network has the appropriate capacity to deliver the relevant block funded services and functions.
- A5. The Commonwealth will provide at least \$16.4 billion in additional funding through these revised funding arrangements between 2014-15 and 2019-20, compared with the funding that would have been provided through the former National Healthcare SPP.
- A6. The Commonwealth will also continue to support private health services through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and Private Health Insurance Rebate. Subject to any exceptions specifically made in this Agreement or through variation to this Agreement, the Commonwealth will not fund patient services through this Agreement if the same service, or any part of the same service, is funded through any of these benefit programs or any other Commonwealth program.

- A7. The parties agree that the following Commonwealth benefits constitute exceptions to the principle outlined at clause A6:
- a. MBS payments covered by a determination made by the Commonwealth Health Minister, or a delegate of the Minister, under s19(2) of the *Health Insurance Act 1973*;
  - b. MBS payments relating to services provided to eligible admitted private patients in public hospitals;
  - c. PBS benefits dispensed under Pharmaceutical Reform Arrangements agreed between the Commonwealth and the relevant State; and
  - d. the default bed day rate (or equivalent payment) supported through the private health insurance rebate.
- A8. Commonwealth funding for public hospital services and functions under this Agreement is dependent on the provision of data requested by the National Bodies outlined in Schedule B, including in relation to services to patients, information identifying the patient to whom the services were provided, the public or private status of the patient, the nature of the service and the facility providing the service.

## Hospital Services and Functions eligible for Commonwealth Funding on an Activity Basis or Block Funded Basis

### Scope of 'Public Hospital Services'

- A9. States will provide health and emergency services through the public hospital system, based on the Medicare principles set out at clause 4 and interpreted consistently with this section (clauses A10-A26).
- A10. Unless a State chooses to reach bilateral agreement with the Commonwealth under clauses A18 to A22 on this matter, the scope of public hospital services funded on an activity or block grant basis that are eligible for a Commonwealth funding contribution will include:
- a. all admitted services, including hospital in the home programs;
  - b. all emergency department services provided by a recognised emergency department service; and
  - c. other outpatient, mental health, subacute services and other services that could reasonably be considered a public hospital service in accordance with clauses A11 to A17.
- A11. States will provide the IHPA with recommendations for other services that could reasonably be considered to be a public hospital service and which are not captured by clause A10(a) and A10(b) that they consider should be eligible for a Commonwealth funding contribution.
- A12. The IHPA will develop and publish criteria for assessing services for inclusion on a general list of hospital services eligible for Commonwealth growth funding. The IHPA will consider each State's recommendations against the published criteria and establish a general list of other services eligible for a Commonwealth funding contribution.

- A13. The Standing Council on Health may then:
- a) until 30 June 2013, direct the IHPA with regard to specific inclusions or exclusions of services to or from the general list; and
  - b) request the IHPA to reconsider its determination of services included on or excluded from the general list. If the IHPA considers the service should continue to be included or excluded, it will publicly release its determination and the basis of that determination.
- A14. The IHPA may update the criteria and will update the general list based on any updated criteria, or as required to reflect innovations in clinical pathways. States may request the IHPA to update the list or to assess specific services against the criteria for inclusion on the general list.
- A15. In establishing the published criteria a primary consideration will be whether the service could reasonably be considered to be a public hospital service during 2010.
- A16. Services named on the general list will attract a Commonwealth funding contribution if provided by any Local Hospital Network as agreed between the State and that Local Hospital Network.
- A17. A service not already captured within the general list and which is not eligible for Commonwealth funding under clause A10 will be eligible for Commonwealth funding for a specific hospital if that service was purchased or provided by that hospital during 2010. States will provide the IHPA with a list of such services provided by each hospital during 2010. This may include services, if not captured by the general list, provided by hospitals in rural and remote areas, hospital avoidance programs, particular existing services provided by outpatient clinics, and existing outreach services such as renal dialysis, chemotherapy, palliative care, rehabilitation and mental health crisis intervention teams. The IHPA may request additional information to confirm the services were provided during 2010.
- A18. A State Health Minister and Treasurer and the Commonwealth Health Minister and Treasurer may enter into a bilateral agreement to determine the scope of public hospital services funded on an activity or block grant basis that are eligible for a Commonwealth funding contribution.
- A19. The scope of public hospital services under a bilateral agreement will include:
- a. all admitted services, including hospital in the home programs;
  - b. all emergency department services provided by a recognised emergency department service;
  - c. all other services agreed between Ministers as being provided or purchased by a public hospital within the State during 2010; and
  - d. any other services, agreed between Ministers, provided or purchased by public hospitals in Australia.
- A20. Unless otherwise agreed by Ministers, the bilateral agreement will include lists of services which will be funded by the Commonwealth if provided by individual hospitals, and lists of services which will be funded by the Commonwealth if provided at any hospital in the State, or by types of hospital in the State.

- A21. If the State Ministers and the Commonwealth Ministers have not reached a bilateral agreement by 1 May 2012, the scope of public hospital services within the State which will be eligible for a Commonwealth funding contribution will be determined using the process in clauses A10 to A17.
- A22. A bilateral agreement will be reviewed every two years to reflect changing patterns of service delivery, and may be varied at any other time by mutual consent.
- A23. Public hospital services which attract a Commonwealth funding contribution will continue to be eligible for Commonwealth funding, even if they are subsequently provided outside a hospital in response to changes in clinical pathways.
- A24. States agree they will not change the management, delivery and funding of health and related services for the dominant purpose of making that service eligible for Commonwealth funding.
- A25. Should the IHPA identify anomalies in service volumes or other data which suggest that services have been transferred from the community to public hospitals, the IHPA will analyse those services. In performing the analysis the IHPA will consult with the relevant State, Medicare Local, and other stakeholders. Following an appropriate consultation period, the IHPA may determine that those particular services provided by that hospital have been transferred for the dominant purpose of making that service eligible for Commonwealth funding and those particular services provided by that hospital will be no longer be eligible for Commonwealth funding.
- A26. The Commonwealth agrees that it will not change the management, delivery and funding of health and related services for the dominant purpose of directing services from the community into the hospital setting.

## Block Funding

- A27. From 2013-14, the process for determining the discrete amounts for block funding is set out below:
- a. the IHPA, in consultation with jurisdictions, develops Block Funding Criteria and identifies whether hospital services and functions are eligible for block funding only or mixed ABF and block funding;
  - b. States, during the consultation period, assess their hospital functions and services against the Block Funding Criteria and, if necessary, provide advice to the IHPA on the potential impact of the criteria;
  - c. the IHPA provides the Block Funding Criteria to COAG for endorsement; and
  - d. COAG considers the Block Funding Criteria proposed by the IHPA and either:
    - i. endorses the recommendation; or
    - ii. requests the IHPA to refine the Block Funding Criteria and bring it back to COAG.
- A28. States provide advice to the IHPA on how their hospital services and functions meet the Block Funding Criteria on an annual basis. For small rural and small regional hospitals, this advice can be provided once every six years, or more frequently at the discretion of the State.

- A29. On the basis of this advice, the IHPA will determine which hospital services and functions are eligible for Commonwealth funding on a block grant basis.
- A30. Using the IHPA's determination the Administrator of the National Health Funding Pool (the Administrator) will then calculate the Commonwealth's funding contribution for block funded services and functions.
- A31. In 2015-16 and every three years thereafter, COAG will reconsider those aspects of the IHPA's Block Funding Criteria that require revision and reapply the process detailed in clause A27.

### **Transition from the National Healthcare SPP (2012-13 and 2013-14)**

- A32. For 2012-13, the Commonwealth will provide funding equivalent to the amount that would otherwise have been payable through the National Healthcare SPP. This amount will be divided into the following funding streams:
- a. an amount for public health activities calculated as the sum of amounts identified under the NHA relating to national public health, youth health services and essential vaccines (service delivery) in 2008-09 (\$244.0 million), indexed by the former National Healthcare SPP growth factor;
  - b. a proportion of the total amount for hospital services to patients in public hospitals better funded through block grants and in respect of teaching, training and research functions funded by States undertaken in public hospitals, with the distribution of funds between these block funded elements based on State advice;
    - i. the proportion will be agreed between the Commonwealth Health Minister and each State Health Minister by 31 December 2011, to ensure that where it is possible to do so Commonwealth funding is provided on an ABF basis, taking into account the overall policy objective of funding on an activity basis wherever practicable;
  - c. the residual amount will be divided between the following interim ABF service categories based on State advice:
    - i. acute admitted public patients;
    - ii. eligible private patients;
    - iii. emergency department services; and
    - iv. eligible non-admitted patient services.
      - 1. The amounts referred to in clause A32(c) will be divided by the total volume of weighted services for the relevant ABF service category specified in the Service Agreements within each State multiplied by the national efficient price to derive the provisional Commonwealth percentage funding contribution rate for each ABF service category in 2012-13. The final Commonwealth percentage funding contribution rate will be recalculated once actual service volumes are known.
- A33. For 2013-14, the Commonwealth will provide funding equivalent to the amount that would otherwise have been payable through the National Healthcare SPP. This amount will be divided into the following funding streams:

- a. the amount for public health activities in 2012-13 indexed by the former National Healthcare SPP growth factor;
- b. discrete amounts, calculated by the Administrator based on the IHPA's determination at clause A27, as agreed by COAG for:
  - i. block funded public hospital services provided at each relevant Local Hospital Network;
  - ii. teaching and training functions performed at each relevant Local Hospital Network or other organisations (such as universities and training providers); and
  - iii. research functions performed at each relevant Local Hospital Network;
- c. the residual amount will be divided between the following ABF service categories based on advice from the IHPA:
  - i. acute admitted public patients;
  - ii. eligible private patients;
  - iii. emergency department services;
  - iv. mental health services (not already captured by clause A33(c)(i));
  - v. eligible non-admitted patient services; and
  - vi. sub-acute admitted public patients.
    - 1. The amounts referred to in clause A33(c) will be divided by the volume of weighted services for the relevant ABF service categories specified in the Service Agreements within each State multiplied by the national efficient price to derive the provisional Commonwealth percentage funding contribution rate for each ABF service category in 2013-14. The final Commonwealth percentage funding contribution rate will be recalculated once actual service volumes are known.

## Payments for Services Funded on an Activity Basis

A34. In 2014-15, 2015-16 and 2016-17, the Commonwealth's funding for each ABF service category will be calculated individually for each State by summing:

- a. *previous year amount*: the Commonwealth's percentage funding rate for the relevant State in the previous year multiplied by the volume of weighted services provided in the previous year multiplied by the national efficient price in the previous year;
- b. *price adjustment*: the volume of weighted services provided in the previous year multiplied by the change in the national efficient price relative to the previous year multiplied by 45 per cent; and
- c. *volume adjustment*: the net change in volume of weighted services to be provided in the relevant State (relative to the volume of weighted services provided in the previous year) multiplied by the national efficient price multiplied by 45 per cent.

- A35. The Commonwealth percentage funding rate for each ABF service category in each State will be calculated by dividing the sum of clause A34 by the relevant year's total volume of weighted services multiplied by the national efficient price.
- A36. The Administrator will provide the Commonwealth and States with a formal forecast of the Commonwealth's funding contribution for each ABF service category before the start of each financial year. The formal forecast will be provided within 14 calendar days of receipt of both:
- a. service volume information for all Local Hospital Networks within a State, as provided in Service Agreements; and
  - b. the forecast national efficient price from the IHPA.
- A37. The Administrator will also provide informal estimates of the Commonwealth's funding contribution to States where requested, should a State provide estimated service volume information for all Local Hospital Networks within that State.
- A38. For 2017-18 and later years, the Commonwealth's funding for each ABF service category will be calculated as per clause A34 but replacing the 45 per cent rate specified in clauses A34(b) and A34(c) with 50 per cent.
- A39. The methodologies set out in clauses A34, A35 and A38 relate to the calculation of preliminary payment entitlements. Final payment entitlements will be made after the reconciliation adjustments specified in clause B59-61 have been completed.
- A40. If the IHPA makes any significant changes to the ABF classification systems or costing methodologies, the effect of such changes must be back-cast to the year prior to their implementation for the purpose of the calculations set out in clauses A34, A35 and A38. The IHPA will consider transitional arrangements when developing new ABF classification systems or costing methodologies.
- A41. ABF payments for eligible private patients must utilise the same ABF classification system as for public patients with the cost weights for private patients being calculated by excluding or reducing, as appropriate, the components of the service for that patient which are covered by:
- a. Commonwealth funding sources other than ABF;
  - b. patient charges including:
    - i. prostheses; and
    - ii. accommodation and nursing related components/charge equivalent to the private health insurance default bed day rate (or other equivalent payment).
- A42. ABF will be implemented through a phased approach:
- a. the implementation of nationally consistent ABF approaches for acute admitted services, emergency department services and non-admitted patient services (initially using the Tier 2 outpatient clinics list) will commence on 1 July 2012; and
  - b. the implementation of nationally consistent ABF approaches for any remaining non-admitted services, mental health and sub-acute services will commence on 1 July 2013.

## Public Health Activities

- A43. Payments for public health activities for 2014-15 will be equal to the previous year's payment indexed by the former National Healthcare SPP growth factor.
- A44. Unless otherwise agreed, beyond 2014-15 the Commonwealth's commitment to public health will continue to grow by the former National Healthcare SPP growth factor.
- A45. States will have full discretion over the application of public health funding to the outcomes set out in the NHA.
- A46. The mechanism for delivering Commonwealth funding for public health activities to States in 2015-16 and future years will be re-considered by the Commonwealth and States in the context of a review of the National Partnership Agreement on Preventive Health, which expires in 2014-15.

## Teaching, Training and Research

- A47. Payments for 2014-15, 2015-16 and 2016-17 will consist of the previous year's payment plus 45 per cent of the growth in the efficient cost of providing the relevant function calculated in accordance with clause A4.
- A48. Payments for 2017-18 and later years will consist of the previous year's payment plus 50 per cent of the growth in the efficient cost of providing the relevant function, calculated in accordance with clause A4.
- A49. The IHPA will provide advice to the Standing Council on Health on the feasibility of transitioning funding for teaching, training and research to ABF or other appropriate arrangements reflecting the volumes of activities carried out under these functions by no later than 30 June 2018.

## Block Funded Services

- A50. Payments for 2014-15, 2015-16 and 2016-17 will consist of the previous year's payment plus 45 per cent of the growth in the efficient cost of providing the services, adjusted for the addition or removal of block services as provided in clauses A27-A30 (calculated in accordance with clause A4).
- A51. Payments for 2017-18 and later years will consist of the previous year's payment plus 50 per cent of the growth in the efficient cost of providing the services, adjusted for the addition or removal of block services as provided in clauses A27-A30 (calculated in accordance with clause A4).

## Private or Not-For Profit Provision of Public Hospital Services

- A52. Where a State contracts with a private or not-for-profit provider to operate a public hospital, that hospital will be treated as a public hospital for the purposes of this Agreement, and may be, or form part of, a Local Hospital Network in accordance with clause D23(c). This arrangement will apply to existing contracts and contracts entered into after the Agreement commences.
- A53. Hospitals owned by charitable organisations which are recognised as public hospitals, whether by legislation or by other arrangements, will be treated as a public hospital for the purposes of this Agreement, and may be, or form part of, a Local Hospital Network in accordance with clause D23(c).

- A54. Other public hospital services provided by the private or not-for-profit sector can be contracted for in the following ways:
- a. the State contracts centrally and establishes a notional 'contracted services Local Hospital Network' which is not required to meet the governance arrangements set out in clauses D11 to D21. All other clauses will apply to this Local Hospital Network; or
  - b. Local Hospital Networks may enter into individual contracts with the private or not-for-profit sectors.
- A55. For any notional contracted services Local Hospital Network, the State will provide information on forecast and actual contracted activity to the Administrator, and this will include the same type, level and specificity of data on the contracted activity as required of other Local Hospital Networks under this Agreement.
- A56. The Commonwealth will provide funding in respect of the contracted activity through the National Health Funding Pool to the State. IHPA determined loadings will apply in respect of patient characteristics, and service location.
- A57. Public hospital services provided under contract by the State with the private sector or not-for-profit sector will be treated as being provided by public hospitals and will be treated consistently with the approach in clauses A10 to A17 to determine eligibility for a Commonwealth funding contribution.

## Veteran Entitlements

- A58. Arrangements for funding and provision of health care for entitled veterans are the subject of a separate Commonwealth-State agreement. Nothing in any separate agreement will interfere with the rights of entitled veterans to access public hospital services as public patients.

## Determining the State Funding Contribution

- A59. The State contribution to the funding of public hospital services and functions will be calculated on an activity basis or provided as block funding in accordance with the process outlined above in the eligibility clauses A10-A17.
- A60. States will determine the amount they pay for public hospital services and functions and the mix of those services and functions, and will meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution.
- A61. Variations in the State funding contribution in respect of individual Local Hospital Networks for services and functions funded under this Agreement may be required to enable States to play their role of system managers of the public hospital system. States may use their own proportion of public hospital funding, or Commonwealth block funding paid to the States (other than funding for teaching, training or research), to retain some funding from Local Hospital Networks and use it to adjust service levels across the State, and to respond to unforeseen events and other contingencies as set out at clause B55.
- A62. This Agreement does not preclude exploration and trial of new and innovative approaches to public hospital funding on a limited basis, to improve efficiency and health outcomes. Under the exploration and trial, a State would need to notify the Commonwealth in advance and continue to acquit and report Commonwealth funding on an ABF or a block funded basis as appropriate, as provided for in this Agreement. The outcomes would be provided to IHPA and discussed between the Standing Council on Health.

- A63. State funding paid on an activity basis to Local Hospital Networks will be based for each service category on:
- a. the price set by that State (which will be reported in Service Agreements); and
  - b. the volume of weighted services as set out in Service Agreements.
- A64. It is expected that these arrangements will create incentives for Local Hospital Network efficiency. If a Local Hospital Network is able to operate more efficiently than the level of funding set by the State under the Local Hospital Network Service Agreement, the Local Hospital Network will be able to retain and reinvest the benefits accruing from efficiency in service delivery and in accordance with State policy and practice, as guided by the Service Agreement.
- A65. There will be no requirement for Local Hospital Networks to be paid the full national efficient price if the State considers that a lower payment is appropriate, having regard to the actual cost of service delivery and the Local Hospital Network's capacity to generate revenue from other sources.
- A66. To improve transparency and national comparability, States will provide to the Administrator and the IHPA:
- a. the price per weighted service they determine;
  - b. the volume of weighted services as set out by the national ABF classification scheme; and
  - c. any variations to service loadings from the national ABF classification schemes.

## Funding Guarantee

- A67. No State will be worse off in the short or long term, as set out in clause 15.
- A68. Consistent with this guarantee, if a State's funding entitlement calculated in accordance with clauses A1-A57 for a particular year is less than the amount of funding the State would have received under the former National Healthcare SPP for that year, the Commonwealth will provide top-up funding to ensure that the State receives at least the amount of the funding it would have received under the former National SPP.
- A69. The Commonwealth also guarantees that its increased contribution to efficient growth funding (defined as the amount paid in excess of what the States in aggregate would have received under the former National Healthcare SPP) will be no less than \$16.4 billion between 2014-15 and 2019-20.
- A70. The Commonwealth will provide top-up funding to meet any shortfall against the \$16.4 billion guarantee.
- A71. The States may use top-up funding for any health service that will assist in ameliorating the growth in demand for hospital services, including chronic disease management programs; preventive health programs; mental health programs; hospital admission avoidance programs; hospital early discharge programs; or other health services as jointly agreed by the Commonwealth and the relevant State.

## Calculation of the Funding Guarantee

A72. A proportion of the \$16.4 billion guarantee will be guaranteed on a state-specific basis as outlined in the following table:

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
State specific guarantee amounts (\$m)	575	1,225	1,500	2,000	2,000	2,200
Projected annual growth funding amounts (\$m)	574	1,231	1,983	3,012	4,161	5,433
Percentage of projected growth funding amounts guaranteed	100%	100%	76%	66%	48%	40%

A73. The state-specific guaranteed amount will be allocated among the States on an equal per capita (EPC) basis to provide each State with a specific guarantee (in addition to the amount it would have received under the National Healthcare SPP).

A74. Any top-up funding required under the state-specific guaranteed amount will be paid annually, but retrospectively, after reconciliation to actual activity levels for the relevant year and will be required to be used for the purposes specified in clause A71.

A75. By July 2017, Heads of Treasuries will review the need for further top-up funding against the national \$16.4 billion guarantee. Where Heads of Treasuries agree that top-up funding is likely to be required in order to meet the \$16.4 billion guarantee, it will recommend instalments to be advanced in addition to any top-up funding paid under the state-specific guarantees.

A76. Heads of Treasuries will then consider the need for continued instalments of top-up funding against the national guarantee on an annual basis each year until the end of the guarantee period.

A77. Top-up funding under the national guarantee will be distributed amongst the States on an EPC basis. Any over-payments of instalments advanced against the national guarantee will be repaid to the Commonwealth once final growth funding entitlements are determined after the end of 2019-20, or earlier if mutually agreed between the relevant parties.

A78. Any top-up funding provided under the state-specific guaranteed amounts will count toward the \$16.4 billion national guarantee.

A79. If a State plans for activity lower than the state-specific guarantee and invests potential gap payments elsewhere, the State accepts the risk of additional activity up to the level of the state-specific guarantee. Activity above the state-specific guarantee is funded by the Commonwealth according to the principles of efficient growth funding.

## Maintenance of Effort

A80. The maintenance of effort mechanisms for State expenditure will operate as follows:

- a. the benchmarks for assessing maintenance of effort will:

- i. for 2011-12 and 2012-13, be based on previously budgeted forward estimates of State recurrent health expenditure in place prior to the National Health and Hospitals Network Agreement; and
  - ii. for 2013-14, grow by at least 5.25 per cent in 2013-14 relative to the outcome in 2012-13 for recurrent expenditure.
- b. States will provide to Heads of Treasuries:
  - i. data in respect of the benchmarks in clause A80(a)(i); and
  - ii. within four months of the end of the financial year, report on expenditure undertaken in the financial year against these benchmarks and provide an explanation for any failure to achieve the benchmarks;
- c. Heads of Treasuries will assess the information provided by the States and provide a report for consideration by the Standing Council on Federal Financial Relations (SCFFR); and
- d. the SCFFR will provide advice to the Commonwealth on:
  - i. whether an adjustment should be made to the baseline against which future growth funding entitlements will be calculated, having regard to any explanation for failure to achieve the benchmarks; and
  - ii. a decision by a jurisdiction to constrain general growth in government expenditure would be an acceptable reason for failure to achieve the benchmarks, provided that the slowing in expenditure growth is not specific to the health system and that any slower growth in health expenditure is sustained beyond the end of the transition period.

A81. Heads of Treasuries will also consider and report to the SCFFR on the extent to which the Commonwealth has maintained its overall level of health expenditure over the same period (2011-12 to 2013-14).

### **Treatment of National Partnership Funding for Calculation of Growth**

A82. The review of the National Partnership Agreement on Improving Public Hospital Services will be completed with decision by COAG by December 2013. This timing reflects the need for certainty of arrangements for the States given the current expiry of funding by the end of 2013-14.

A83. COAG, through the Heads of Treasuries, has agreed a process for the consideration of National Partnerships, and this will frame the review of the National Partnership Agreement on Improving Public Hospital Services.

A84. Key features of the review process include:

- a. State Treasurers being able to advise the Commonwealth Treasurer of their views in terms of whether funding should continue, for consideration in the Commonwealth Budget process;
- b. the SCFFR being able to make recommendations to COAG, which may include recommendations on the form and scope of proposed ongoing funding, including assessing whether the National Partnership Agreement on Improving Public Hospital

Services should be incorporated into the growth funding base, continued or terminated;

- i. The SCFFR does not itself have the authority to make funding decisions and the recommendations made by the SCFFR to COAG must be supported by funding decisions made as part of the Commonwealth Budget process.

A85. Criteria considered in framing recommendations will draw on those agreed by COAG, including:

- a. the success of the National Partnership Agreement on Improving Public Hospital Services in achieving its objectives, outcomes and outputs and consideration as to whether ongoing funding is required to maintain the outcomes;
- b. whether funding, objectives or outcomes are 'ongoing' in nature because they support longstanding services or because the National Partnership Agreement on Improving Public Hospital Services has been used to lift standards that the Commonwealth and States agree should be maintained; and
- c. in considering the merits of rolling the National Partnership Agreement on Improving Public Hospital Services into the funding base, whether the expiring Agreement falls within the policy objectives of the NHA.

A86. In considering such issues, the review will identify:

- a. the impact on the level of activity (including but not limited to beds, services, and staffing) which may have arisen from the funding;
- b. the projected impact on the health system and patient care of any discontinuation of funding; and
- c. the baseline activity levels against which future service growth should be measured for the purpose of calculating Commonwealth growth funding, should the National Partnership funding be discontinued.

A87. Where the review identifies evidence of increased activity levels attributable to the National Partnership Agreement on Improving Public Hospital Services under clauses A86(a) and A86(b), the Commonwealth agrees in principle to making an appropriate baseline adjustment to reflect the share of the ongoing cost of those additional services. The baseline adjustment will have regard to the actual volume of additional services provided in the relevant State, and the level of Commonwealth operational funding for services provided in the original National Partnership Agreement on Improving Public Hospital Services.

## Cross-border Arrangements

A88. The treatment of cross-border hospital activities will be governed by the following principles:

- a. the State where a patient would normally reside should meet the cost of services (exclusive of the Commonwealth contribution discussed below) where its resident receives hospital treatment in another jurisdiction;
- b. payment flows (both Commonwealth and State) associated with cross-border services should be administratively simple, and where possible consistent with the broader arrangements of this Agreement;

- c. the cross-border payment arrangements should not result in any adverse GST distribution effects;
- d. States recognise their commitment under the Medicare principles which require medical treatment to be prioritised on the basis of clinical need;
- e. both States should have the opportunity to engage in the setting of cross-border activity estimates and variations, in the context that this would not involve shifting of risk; and
- f. there should be transparency of cross-border flows.

## Funding Flows

- A89. Commonwealth funding contributions will flow to the provider jurisdiction through the National Health Funding Pool. Steps will be taken to prevent Commonwealth payments made in accordance with these arrangements being subject to equalisation by the Commonwealth Grants Commission to avoid financially disadvantaging one State.
- A90. Funding contributions by the resident State will be made to the provider State through the National Health Funding Pool, either:
- a. on a regular basis throughout the year, reflecting activity estimates between the parties as scheduled through a Cross-border Agreement with subsequent reconciliation for activity; or
  - b. on an ad-hoc basis reflecting actual activity.

## Agreement around Activity

- A91. Cross-border Agreements will be developed between jurisdictions which experience significant cross-border flows, where one of the parties requests a Cross-border Agreement be in place.
- A92. Cross-border Agreements will set out estimated activity levels providing the capacity for both parties to contribute to planning of cross-border activity.
- A93. Cross-border Agreement disputes will be dealt with as part of the IHPA dispute resolution process.

## Pricing

- A94. Prices will be set at the national efficient price, as determined by the IHPA including adjustments for any loadings for the provider Local Hospital Network, unless otherwise agreed by the parties to the Cross-border Agreement.
- A95. Capital will not be explicitly priced by the IHPA, however cross-border dispute resolution can include disputes in relation to the resident State's contribution to capital funding.
- A96. The Commonwealth and States agree that they will accept and implement any recommendations made by the IHPA in relation to cross-border disputes under clause B3(k), and will provide additional funding to the other party in a dispute if this is required.
- A97. If, three months after the IHPA has made a recommendation under clause B3(k), a State has not complied with any element of the recommendation requiring it to make payments to

another State, the IHPA may at the request of the second State, advise the Commonwealth Treasurer of any adjustments to Commonwealth payments to the National Health Funding Pool required to give effect to the recommendation. States agree to fund from their own resources any reduction in Commonwealth payments to Local Hospital Networks.

## Nationally Funded Centres

A98. These arrangements may have an impact on nationally funded centres. This will be considered further by the Standing Council on Health.

## Cost-shifting

A99. Jurisdictions may make submissions to the IHPA requesting it advise whether a party to this Agreement has shifted costs onto another jurisdiction in a manner which is contrary to the intent of this Agreement.

A100. The IHPA will provide the other party a copy of the submission and request a responding submission to be provided within 60 days. The IHPA will provide this response to the initiating jurisdiction.

A101. The IHPA will then assess the submissions, consult further with affected jurisdictions and publicly release its assessment should it consider that cost-shifting has occurred.

## SCHEDULE B – ESTABLISHMENT OF NATIONAL BODIES

### Independent Hospital Pricing Authority

- B1. The IHPA will be established as soon as possible as an independent Commonwealth statutory authority under the *Financial Management and Accountability Act 1997* (FMA Act) with:
- a. a Chairperson appointed by the Commonwealth;
  - b. a Deputy Chairperson appointed by the States; and
  - c. five members to be agreed by COAG, with at least one member having regional and rural expertise.
- B2. The costs associated with the establishment and ongoing functioning of the IHPA will be borne by the Commonwealth.
- B3. The IHPA has the following determinative functions:
- a. developing and specifying the national classifications to be used to classify activity in public hospitals for the purposes of ABF;
  - b. subject to clause B86, determining the supporting data requirements and data standards to apply to data to be provided by States, including:
    - i. data and coding standards to support uniform provision of data; and
    - ii. patient demographic characteristics and other information that is relevant to classifying, costing and paying for public hospital functions;
  - c. subject to clause B86, specifying costing data, methods and standards to be used in studies of the costs of delivering public hospital services, and to collect such data from Local Hospital Networks, through the States, to enable it to calculate the national efficient price and loadings;
  - d. determining the national efficient price for services provided on an activity basis in public hospitals through empirical analysis of data on actual activity and costs in public hospitals, taking account of any time lag and the cost weights to be applied to specific types of services;
  - e. determining the national efficient cost of services provided on a block funded basis in public hospitals through empirical analysis of data on actual activity and costs in Australian public hospitals, taking account of any time lag;
  - f. developing, refining and maintaining such systems as are necessary to calculate the national efficient price, including determining classifications, costing, data elements and data collections;
  - g. determining adjustments ('loadings') to the national efficient price required to take account of legitimate and unavoidable variations in the costs of service delivery, including those driven by hospital size, type and location;
  - h. developing projections of the national efficient price for a four year period, updated on an annual basis and providing confidential reports on these projections to the Commonwealth and States;

- i. determining what other services provided by public hospitals are eligible for a Commonwealth funding contribution (clause A10-A26 refers);
  - j. determining the Block Funded Criteria to be applied to agreed hospitals, functions and services that would be better funded in that way, in 2012-13 (for application in 2013-14) and every three years thereafter. Before this determination can be made the Block Funding Criteria must have been endorsed by COAG (clause A27 refers);
  - k. resolving disputes on cross-border issues, where parties are unable to reach bilateral agreement and either party seeks a determination from the IHPA; and
  - l. determining the national efficient price that will apply to eligible private patients receiving public hospital services:
    - i. the IHPA's determination will be informed by advice from Heads of Treasuries, produced in cooperation with health departments, regarding current funding arrangements and incentives for private patients in public hospitals. Heads of Treasuries will provide this advice by the end of calendar year 2011.
- B4. The Standing Council on Health may direct the IHPA to refine the determination of public hospital services eligible for a Commonwealth funding contribution (clause B3(i) refers).
- B5. The IHPA has the following advisory functions:
- a. advising COAG on a nationally consistent definition and typology of public hospitals eligible for:
    - i. block funding only (including small rural and regional hospitals better funded in that way); and
    - ii. mixed ABF and block funding;
  - b. making recommendations to the Treasurer to adjust Commonwealth contributions to implement cross-border recommendations under clause A97;
  - c. advising the Standing Council on Health on the feasibility of transitioning funding for teaching, training and research to ABF or other appropriate arrangements (clause A49 refers) by no later than 30 June 2018; and
  - d. making an assessment in relation to cost-shifting in line with clauses A99-A101.
- B6. The IHPA will improve transparency by publicly reporting on:
- a. ABF, including release of nationally consistent classifications, costing methods and data and efficient prices;
  - b. its advice in respect of block funding and the basis of that advice; and
  - c. its findings and supporting analysis on cost-shifting and cross-border issues raised by parties to the Agreement, following consultation with the relevant jurisdictions.
- B7. The IHPA will provide all governments with draft copies of its reports before they are released publicly. All governments will have 45 calendar days in which to comment on the reports.

- B8. The IHPA may undertake data collection and research, including by commissioning others to undertake specified studies and research.
- B9. In carrying out its functions, the IHPA will:
- a. publicly call for submissions from interested parties annually;
  - b. have regard to any submissions from governments regardless of when they are made; and
  - c. draw on relevant expertise and best practice within Australia and internationally.
- B10. Should the IHPA, in carrying out its functions, identify significant anomalies in service provision or pricing which potentially suggest activity contrary to the intent of this Agreement, the IHPA may consult with the relevant jurisdiction. If the matter is unresolved following consultation with the relevant jurisdiction, the IHPA may confidentially provide information to all jurisdictions about the matter. Should a jurisdiction consider this information evidence of cost-shifting, they can make a submission to the IHPA as set out in clause A99.

## Principles for Determining the National Efficient Price

- B11. The role of the national efficient price is to:
- a. form the basis for the calculation of the Commonwealth funding contribution; and
  - b. provide a relevant price signal to States and Local Hospital Networks.
- B12. In determining the national efficient price, the IHPA must:
- a. have regard to ensuring reasonable access to public hospital services, clinical safety and quality, efficiency and effectiveness and financial sustainability of the public hospital system;
  - b. consider the actual cost of delivery of public hospital services in as wide a range of hospitals as practicable;
  - c. consider the expected changes in costs from year to year when making projections;
  - d. have regard to the need for continuity and predictability in prices;
  - e. have regard to any input costs funded through other Commonwealth programs, such as pharmaceuticals supplied under arrangements pursuant to section 100 of the *National Health Act 1953* and magnetic resonance imaging services funded through MBS bulk-billing arrangements; and
  - f. develop methods which allow consideration of reasonable and likely growth in cost inputs, so that the national efficient price can be projected into the future in a predictable and transparent manner.
- B13. In determining adjustments to the national efficient price, the IHPA must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including:
- a. hospital type and size;

- b. hospital location, including regional and remote status; and
- c. patient complexity, including Indigenous status.

B14. While these adjustments to the national efficient price should provide a relevant price signal to States and Local Hospital Networks, the IHPA should not seek to duplicate the work of the Commonwealth Grants Commission in determining relativities.

### Establishment of an Interim Independent Hospital Pricing Authority

- B15. Prior to the statutory establishment of the IHPA, the Commonwealth will establish an interim IHPA as an executive agency, separate from any Commonwealth government department.
- B16. The arrangements for the interim IHPA will be consistent with all relevant clauses of this Agreement (except clause B1). The Commonwealth will not direct the interim IHPA in a way that is inconsistent with this Agreement while it has capacity to do so, ensuring its independence during the interim arrangements.
- B17. If the permanent IHPA has not been established by 31 December 2011, COAG will review the arrangements in place for the interim IHPA.

### National Health Funding Pool and National Health Funding Body

#### National Health Funding Pool

- B18. A single National Health Funding Pool will be established, comprising a Reserve Bank of Australia account for each State, for the purposes of receiving all Commonwealth and activity-based State public hospital funding.
- B19. The existence and operation of the Pool in relation to a particular State owes its authority to the enabling legislation passed by both the Commonwealth Parliament and the Parliament of that State.
- B20. Pool accounts will be audited, have complete transparency in reporting and accounting, and will meet all other transparency requirements established by COAG and relevant legislation.
- B21. There will be complete transparency and line-of-sight of respective contributions into and out of Pool accounts to Local Hospital Networks, discrete State managed funds, or to State health departments in relation to public health funding and any top-up funding, and of the basis on which the contributions are calculated. There will also be complete transparency and line-of-sight of respective contributions out of State managed funds to Local Hospital Networks.
- B22. Additional streams of funding may be incorporated into the National Health Funding Pool, once agreed by COAG, with the aim of optimising transparency and efficiency of all public hospital funding flows.

#### Governance

- B23. To give effect to this COAG agreement, the Administrator will be an independent statutory office holder, distinct from Commonwealth and State departments, to be jointly established by the legislation of the Commonwealth and all States by 1 July 2012.

- B24. The Chair of the Standing Council on Health will seek nominations from all Health Ministers for the position of Administrator. The Chair will then seek agreement of all Health Ministers to the proposed appointment. The Administrator will be appointed by written instrument by all Health Ministers in accordance with the advice provided by the Chair of the Standing Council on Health. The same individual will be appointed the Administrator by all jurisdictions.
- B25. The Commonwealth and State legislation will detail the collaborative process between all jurisdictions to select the Administrator, will establish the position of the Administrator, and will provide for his or her appointment.
- B26. Commonwealth legislation will provide for the Administrator to perform the following functions:
- a. calculating and advising the Commonwealth Treasurer of the Commonwealth contribution to the National Health Funding Pool under this Agreement;
  - b. overseeing payment of Commonwealth funding determined under this Agreement into State accounts established at the Reserve Bank of Australia under State legislation;
  - c. reconciling estimated and actual volume of service delivery, informed by the results of data checking activities conducted by other bodies on behalf of the Administrator, and incorporating the result of this reconciliation into the calculation of the Commonwealth contribution to the National Health Funding Pool;
  - d. publicly reporting on:
    - i. funding received into the National Health Funding Pool from the Commonwealth;
    - ii. payments made from the National Health Funding Pool to Local Hospital Networks and State managed funds, and the basis on which these payments are made;
    - iii. payments made, and the basis on which these payments are made, from the State managed funds to Local Hospital Networks and other providers, based on information provided by States;
    - iv. payments made by the Commonwealth through the National Health Funding Pool to the States for the provision of public health services;
    - v. top-up payments made by the Commonwealth through the National Health Funding Pool to the States;
    - vi. the volume of public hospital services provided by Local Hospital Networks; and
    - vii. the delivery of other public hospital functions funded by the National Health Funding Pool; and
  - e. other functions conferred by State legislation in accordance with this Agreement.
- B27. States will pass legislation that will provide for the Administrator to perform the following functions:

- a. maintaining accounts (established by each State) with the Reserve Bank of Australia in the name of each State, collectively known as the National Health Funding Pool;
- b. overseeing payments into Pool accounts of State funding provided under this Agreement;
- c. paying State funding from Pool accounts to Local Hospital Networks and other recipients in accordance with the direction of the relevant State Health Minister; and
- d. publicly reporting on:
  - i. funding received into the National Health Funding Pool from the States;
  - ii. payments made from the National Health Funding Pool to Local Hospital Networks and State managed funds, and the basis on which these payments are made;
  - iii. payments made from the State managed funds to Local Hospital Networks and other providers, and the basis on which these payments are made;
  - iv. the volume of public hospital services provided by Local Hospital Networks; and
  - v. the delivery of other public hospital functions funded by the National Health Funding Pool and State managed funds.

B28. States will also pass legislation:

- a. establishing an account at the Reserve Bank of Australia in the name of each State for the purpose of receiving relevant funds under this Agreement from the Commonwealth and States;
- b. establishing discrete State managed funds for the purposes of receiving funding for block grants, teaching, training and research;
- c. ensuring State funding is paid into Pool accounts and State managed funds in accordance with this Agreement;
- d. recognising any funds contained in the State Pool account as being part of the State revenue fund;
- e. providing that funds held within Pool accounts may only be used to fund public hospital functions or public health activities, and only in accordance with this Agreement;
- f. providing that the Commonwealth funding contribution to a Pool account will be distributed in accordance with the distribution provided by the Administrator to the Commonwealth Treasurer;
- g. disapplying all relevant and applicable State law, including financial management and accountability legislation, from applying to the functions of the Administrator;
- h. adjusting any provision of State privacy legislation required to give effect to the flows of data necessary under this Agreement, subject to suitable safeguards being established to protect personal information and rights; and

- i. providing for a copy of all financial statements and audit reports issued by the States to be made available to the Commonwealth Health Minister.
- B29. Commonwealth legislation will contain a provision that disapplies the requirements of the *FMA Act 1997* (FMA Act) (Commonwealth) from applying to the functions of the Administrator.
- B30. The legislation of the Commonwealth and all States will contain a set of provisions, to be agreed by all jurisdictions, detailing the financial management and accountability arrangements pertaining to the functions of the Administrator. These provisions will specify that the Administrator is to comply with a request by any Health Minister to provide such reports, documents and information in relation to the performance of the functions of the Administrator as the Health Minister requires.
- B31. Subject to clause B36 and any necessary modifications required to enact this Agreement, the Commonwealth's administrative law arrangements will apply to the Administrator and the National Health Funding Body. All relevant and applicable Commonwealth administrative legislation, such as the *Administrative Appeals Tribunal Act 1975*, the *Administrative Decisions (Judicial Review) Act 1977*, the *Legislative Instruments Act 2003*, the *Ombudsman Act 1976*, the *Freedom of Information Act 1982*, the *Australian Information Commissioner Act 2010*, and the *Privacy Act 1988*, will therefore apply to the functions of the Administrator detailed in the legislation of the Commonwealth and the States.
- B32. Commonwealth legislation will not allow any Commonwealth Minister to direct the Administrator in the performance of any function detailed in this Agreement.
- B33. The Standing Council on Health will agree a list of persons who may act in the role of the Administrator from time to time as required.
- B34. The Chair of the Standing Council on Health is to advise all Health Ministers if:
  - a. any State Health Minister, with the support of two or more additional State Health Ministers, has requested the suspension of the Administrator; or
  - b. the Commonwealth Health Minister has requested the suspension of the Administrator.

All Health Ministers will then suspend the Administrator, agree the same individual to be the acting Administrator and then appoint the acting Administrator.
- B35. All Health Ministers are to terminate the appointment of the Administrator if such an action is agreed by a simple majority of members of the Standing Council on Health.
- B36. State legislation may provide for the Administrator to be subject to state-specific anti-corruption legislation.
- B37. Any delay in the passage of State legislation establishing the State account in the National Health Funding Pool or the position of the Administrator for a specific State will not, in any way, affect the operation of the Pool in relation to the other States once the Commonwealth legislation has been enacted.
- B38. For avoidance of doubt, any jurisdiction that enacts or amends legislation that is inconsistent with the provisions of this Agreement relating to the new National Health Reform funding arrangements, including the establishment, appointment, powers and functions of the Administrator, will be in breach of this Agreement.

- B39. The Commonwealth and States will seek COAG agreement to any proposed amendments to legislation establishing the position and functions of the Administrator and the operation of the National Health Funding Pool.
- B40. A single annual report and accompanying financial statement on the operation of the National Health Funding Pool will be provided to the Commonwealth parliament and each State parliament. The Commonwealth will formally request the Commonwealth Auditor-General and the States will formally request the Auditor-General of each State to consider how best to achieve this outcome.
- B41. The Commonwealth will formally request the Commonwealth Auditor-General and the States will formally request the Auditor-General of each State to consider the appropriate arrangements in relation to financial audits of the National Health Funding Pool and performance audits of the administration of the National Health Funding Pool.
- B42. Commonwealth legislation will also establish a prescribed agency, to be known as the National Health Funding Body. The sole function of the National Health Funding Body is to assist the Administrator in carrying out his or her functions under Commonwealth and State legislation.
- B43. The Commonwealth will prescribe the National Health Funding Body as 'inter-jurisdictional' under part 6A of the FMA Act to ensure State Health Ministers will be given access to information available to the Commonwealth Health Minister.
- B44. The National Health Funding Body will be staffed under the *Public Service Act 1999* (Commonwealth) and may include staff seconded from the States. The staff of the National Health Funding Body would not be subject to direction from any Commonwealth Minister while undertaking duties as directed by the Administrator.
- B45. The Commonwealth Auditor-General will undertake financial audits and may undertake performance audits of the operations of the National Health Funding Body.

#### Payments into the National Health Funding Pool and State Managed Funds

- B46. Commonwealth payments into the pool will be made monthly, calculated as 1/12th of the estimated annual payment. Commonwealth payments will be made into the National Health Funding Pool in accordance with Schedule D of the IGA FFR.
- B47. States will determine when State payments are made into the Pool and State managed funds.

#### Payments from the National Health Funding Pool and State Managed Funds

- B48. Payments will be made from the Pool accounts to Local Hospital Networks and State managed funds in accordance with Service Agreements to be agreed between the States and Local Hospital Networks.
- B49. Payments may be made out of the Pool accounts directly to other parties on the behalf of Local Hospital Networks for the provision of shared services, as detailed in a Service Agreement between a Local Hospital Network and a State. Any subsequent reference to payments made to Local Hospital Networks in this Agreement includes a reference to payments made to other parties for the provision of shared services.

- B50. States and Local Hospital Networks can agree amendments to Service Agreements in order to adjust service volumes or pricing to take account of such matters as changing health needs, variations in actual service delivery and hospital performance.
- B51. States, as the system manager of public hospitals, can determine the frequency of alterations to Service Agreements. States will notify the Administrator, within 28 calendar days, of agreed variations to a Service Agreement.
- B52. The payment arrangements for Commonwealth funding are as follows:
- a. ABF will flow directly to Local Hospital Networks through Pool accounts;
  - b. funding for block grants will flow through Pool accounts to State managed funds and from there to Local Hospital Networks;
  - c. funding for teaching, training and research will flow through Pool accounts to State managed funds and from there to Local Hospital Networks or other organisations (such as universities and training providers) depending upon the specific funding arrangements established in each State for the provision of those services; and
  - d. public health funding and any top-up funding will flow through Pool accounts to State health departments.
- B53. The payment arrangements for States' funding are as follows:
- a. ABF will flow directly through Pool accounts to Local Hospital Networks;
  - b. funding for block grants will flow through State managed funds to Local Hospital Networks; and
  - c. funding for teaching, training and research will flow through State managed funds to Local Hospital Networks or other organisations (such as universities and training providers) depending upon the specific funding arrangements established in each State for the provision of those services.
- B54. States will direct the disbursement of State funding from Pool accounts and State managed funds to Local Hospital Networks. The frequency of State payments to Local Hospital Networks will be in accordance with Service Agreements, agreed between the State and Local Hospital Network.
- B55. States are able to make exceptional payments through a Pool account or a State managed fund to Local Hospital Networks at any time.
- B56. States will direct the timing of Commonwealth payments from Pool accounts and State managed funds to Local Hospital Networks. However, States will not redirect Commonwealth payments:
- a. between Local Hospital Networks;
  - b. between funding streams (for example from ABF to block funding); or
  - c. to adjust the payment calculations underpinning the Commonwealth's funding.
- B57. States can cause Commonwealth payments to be modified by changing the relevant Service Agreements, if they wish, and by notifying the Administrator of an agreed variation, in

accordance with clause B51. These changes to Commonwealth funding will take effect in the next payment period.

- B58. To ensure that payments flowing out of the National Health Funding Pool are correct, no payment will flow from the Pool until the respective State has validated the schedule of payment and instructed the Administrator to make payment on the State's behalf.

## Adjustments to the Commonwealth's Contribution to Local Hospital Networks Funding

- B59. There will be two levels of adjustments to the Commonwealth's funding contribution to Local Hospital Networks:
- a. a six-monthly adjustment, and
  - b. an annual adjustment.
- B60. The six-monthly adjustment will be conducted in arrears and will arise from the reconciliation conducted to determine the actual volume for services provided by the Local Hospital Networks for Commonwealth payment purposes. Any State may request that the Commonwealth conduct this reconciliation more frequently. Having regard to technological and operational improvements, States will consider moving to more frequent reconciliation and adjustment arrangements.
- B61. The annual adjustment will be conducted in arrears once actual volumes have been validated by the service volume reconciliations to ensure the Commonwealth meets its agreed contribution to the funding of efficient growth and to effect any payment arising from the funding guarantee, as detailed in clauses A67-A79.
- B62. Any variation to Commonwealth payments arising from the adjustments will be spread equally across payments for a subsequent quarter.
- B63. States will provide to the Administrator, within at least three months (with a preference to reducing the period over time) of the end of each reconciliation period, gross volume and patient identified data regarding actual services delivered for those public hospital functions funded by the Commonwealth on an activity basis to enable reconciliations to be undertaken in accordance with clause B60. Variations for the service volume reconciliation will include, but not be limited to, the reconciliation of general transcription errors, including the incorrect coding of services provided and duplicate entries, and the exclusion of services paid for by the Commonwealth via other funding streams, the exclusion of services for which data has not been provided, and the exclusion of services with incomplete data.
- B64. In order to attract a Commonwealth funding contribution for each public hospital service provided on an activity basis, States must ensure that all data relevant to the funding of that service has been provided. In order to attract a Commonwealth funding contribution for each public hospital service funded on a block grant basis or function, States must ensure that all data relevant to that service or function has been provided.

## Reporting by the Administrator

- B65. The Administrator will provide a monthly report to the Commonwealth and States detailing the following at the Local Hospital Network level:
- a. the basis for the amount of Commonwealth funding flowing into Pool accounts;

- b. the basis for the amount of State funding flowing into Pool accounts and State managed funds;
- c. the number of public hospital services funded and provided as a running yearly total, in accordance with the national system of ABF; and
- d. the delivery of other public hospital functions funded by the National Health Funding Pool and State managed funds as a running yearly total.

B66. The same transparency arrangements that apply to the National Health Funding Pool will also apply to the State managed funds. States will provide data to the Administrator in accordance with the timeframe and format specified in the Administrator's data plan on the:

- a. flow of Commonwealth and State funds into and out of State managed funds; and
- b. provision of public hospital services by Local Hospital Networks.

B67. All reports produced by the Administrator will be publicly available.

B68. Reporting undertaken by the Administrator will be structured to avoid duplication and overlap with the reporting undertaken by other bodies detailed in this Agreement.

## Auditing

B69. Financial audits will be undertaken at least annually, at the completion of each financial year. Performance audits may be undertaken at any time.

## Establishment and Recurrent Costs of the Administrator and the National Health Funding Body

B70. The costs associated with the establishment and ongoing functioning of the Administrator and the National Health Funding Body will be borne by the Commonwealth.

## Notification of the Data Requirements of the Administrator

B71. By January 2012, or as soon as possible thereafter, in advance of the data plans detailed in clause B85, the Administrator will determine the minimum level of data required to calculate the Commonwealth's contribution of the national efficient price, conduct reconciliation activities and ensure national comparability. From 2013-14 onwards, the data plan developed by the Administrator will determine the minimum level of data required.

B72. The minimum level of data required in the data plans, as detailed in clause B71, may be included in Service Agreements or provided as an attachment to the Service Agreement. This attachment will be made publicly available by the State. Where a reference is made to a Service Agreement elsewhere in this Agreement, the reference also includes this attachment.

## Provision of Service Level Data and Service Agreements to the Administrator

B73. States will provide the Administrator with a confidential estimate of weighted service volumes for a financial year, as an aggregated total, by the end of March in the preceding financial year.

B74. States will provide the Administrator with confirmed aggregate weighted service volumes for a financial year, and estimated service volumes for each Local Hospital Network, by the end

of May in the preceding financial year. The estimated weighted service volumes provided are to incorporate the level of disaggregation required by the Administrator in order to calculate the Commonwealth's funding contribution, in accordance with clause B26a.

B75. States will provide the Administrator with a copy of the Service Agreement for each Local Hospital Network once agreed between the State and the Local Hospital Network.

### **National Health Performance Authority**

B76. The NHPA will be established as soon as possible as an independent Commonwealth statutory authority under the FMA Act, with the following governance structure:

- a. a Chairperson appointed by the Commonwealth;
- b. a Deputy Chairperson appointed by the States; and
- c. five members to be agreed by COAG, with at least one member having regional and rural expertise.

B77. The costs associated with the establishment and ongoing functioning of the NHPA will be borne by the Commonwealth.

B78. The NHPA, in accordance with the Performance and Accountability Framework, will:

- a. provide clear and transparent quarterly public reporting of the performance of every Local Hospital Network, the hospitals within it, every private hospital and every Medicare Local, through the new Hospital Performance Reports and Healthy Communities Reports, as outlined in clauses C2(c) and C6-C9;
- b. monitor the performance of Local Hospital Networks, Medicare Locals and hospitals against these performance measures and standards in order to identify:
  - i. high-performing Local Hospital Networks, Medicare Locals and hospitals and facilitate sharing of innovative and effective practices; and
  - ii. poorly performing Local Hospital Networks and Medicare Locals, to assist with performance management activities;
- c. develop additional performance indicators as appropriate, when asked by the Commonwealth Health Minister at the request of COAG; and
- d. maintain the MyHospitals website (clause C11 refers).

B79. In undertaking its work, the NHPA will provide comparative analysis across Local Hospital Networks and Medicare Locals and identify best practice.

### **Australian Commission on Safety and Quality in Health Care**

B80. The role of the ACSQHC is to:

- a. lead and coordinate improvements in safety and quality in health care in Australia by identifying issues and policy directions, and recommending priorities for action;
- b. disseminate knowledge and advocate for safety and quality;

- c. report publicly on the state of safety and quality including performance against national standards;
- d. recommend national data sets for safety and quality, working within current multilateral governmental arrangements for data development, standards, collection and reporting;
- e. provide strategic advice to the Standing Council on Health on best practice thinking to drive quality improvement, including implementation strategies; and
- f. recommend nationally agreed standards for safety and quality improvement.

B81. The ACSQHC will expand its role of developing national clinical standards and strengthened clinical governance. These arrangements will be further developed in consultation with States.

B82. The ACSQHC will:

- a. formulate and monitor safety and quality standards and work with clinicians to identify best practice clinical care, to ensure the appropriateness of services being delivered in a particular health care setting; and
- b. provide advice to the Standing Council on Health about which of the standards are suitable for implementation as national clinical standards.

B83. The ACSQHC does not have regulatory functions.

## Governance arrangements

B84. The Commonwealth has established the ACSQHC as a permanent, independent statutory authority under the *Commonwealth Authorities and Companies Act 1997*.

## Data Provision

B85. The national bodies outlined at clauses B1-B79 will develop rolling three year data plans indicating their future data needs.

B86. In determining data requirements, each body must:

- a. seek to meet its data requirements through existing national data collections, where practical;
- b. conform with national data development principles and wherever practical use existing data development governance processes and structures, except where to do so would compromise the performance of its statutory functions;
- c. allow for a reasonable, clearly defined, timeframe to incorporate standardised data collection methods across all jurisdictions;
- d. support the concept of 'single provision, multiple use' of information to maximise efficiency of data provision and validation where practical, in accordance with privacy requirements;
- e. balance the national benefits of access to the requested data against the impact on jurisdictions providing that data; and

f. consult with the Commonwealth and States when determining its requirements.

B87. Privacy of individual healthcare users is paramount and will be protected at all times. The agencies referred to in clause B97 will collect, secure and use information in accordance with relevant legislation and National Privacy Principles, ethical guidelines and practices in order to protect the privacy of individuals. To give effect to this commitment, the Commonwealth will consult with relevant privacy stakeholders on Commonwealth-related data aspects of this Agreement.

B88. The national bodies will develop rolling three year data plans each year, in line with the following process:

- a. each national body will develop a data plan that takes into account the objectives of this Agreement and the requirements in clause B86; and
- b. each national body will provide its data plan to the Standing Council on Health. The plan will be considered final and complete 30 calendar days after release, unless the process referred to in clause B91 is invoked.

B89. The first data plans will be provided to the Standing Council on Health in early 2012, covering the 2013-14 to 2015-16 financial years.

B90. The national bodies will advise jurisdictions of their data requirements for the period between the commencement of this Agreement and 1 July 2012 (the interim period), following the requirements set out in clause B86.

B91. The Standing Council on Health may direct the national bodies in respect of specific elements of their data plans or interim data plans:

- a. if it determines that a plan does not meet the requirements set out at clause B86; and
- b. provided that such a direction would not diminish the achievement of transparency, comparability or other objectives of this Agreement or materially delay implementation.

B92. If a jurisdiction intends to request the Standing Council on Health to consider issuing a direction under clause B91, the following procedure will be used:

- a. within 45 calendar days of the release of the plan, the jurisdiction must lodge a submission with the Standing Council on Health, setting out its reasons for seeking the direction;
- b. the jurisdiction must provide the body that developed the data plan with a copy of the submission; and
- c. within 21 calendar days of receiving the submission, the Standing Council on Health will consider the matter out of session and agree its response.

B93. Subject to clauses B86 and B87, the Commonwealth and States will provide the national bodies outlined above with the data the national bodies determine is required to carry out their functions in accordance with their data plans. This data will be provided to each body as required, with the exception of patient identified data which will be provided to the Commonwealth Department of Human Services for the purpose of de-identifying the data (as set out in clause B94). This de-identified data will then be used by the IHPA in the

calculation of the national efficient price and ensure appropriate Commonwealth payments for public hospital services.

- B94. Where patient identified data is required, States will provide that data with patients identified by a Medicare Card Number to the Commonwealth Department of Human Services. The Department of Human Services will then de-identify that data and provide it to the relevant national body. Where patient identified data is required it will be subject to existing Commonwealth statutory protections of individuals' privacy.
- B95. The Commonwealth and the States will take responsibility for the data integrity within their systems and agree to establish appropriate independent oversight mechanisms for data integrity, to provide certainty to the Australian public about the actual performance of hospitals and other parts of the health system.
- B96. The parties agree that over time data should be streamlined and rationalised to reduce administrative overheads and facilitate data sharing. As part of this, the Standing Council on Health will investigate the feasibility, benefits and costs of moving towards a single national data repository.
- B97. As set out in clause B86(d), data provided to the national bodies may be shared between agencies as set out by the following principles:
- a. agencies created by this Agreement will be able to access data to allow them to meet their functions as set out by this Agreement;
  - b. the Australian Bureau of Statistics will be able to access relevant data required to meet its legislative and contractual reporting requirements;
  - c. the Australian Institute of Health and Welfare (AIHW) will be able to access relevant data to allow the AIHW to meet its statutory and contractual reporting requirements;
  - d. the COAG Reform Council will be able to access relevant data required to meet its obligations as agreed through the IGA FFR;
  - e. the Commonwealth Department of Human Services will be able to access data to perform its role of de-identifying patient level data to allow the NHPA and the Administrator to perform their functions; and
  - f. the Commonwealth Department of Health and Ageing, the Commonwealth Department of Veterans' Affairs, the Commonwealth Treasury, State health departments and State treasuries will be able to access all de-identified data for the purposes of policy analysis and planning.
- B98. To ensure that States are able to effectively fulfil their responsibilities in public hospital management and health planning, the Commonwealth will provide reasonable access to Local Hospital Network level and Medicare Local level health and ageing data about Commonwealth programs. The Standing Council on Health will agree appropriate protocols and procedures to govern the operation of this arrangement, including compliance with Commonwealth legislative obligations.
- B99. The Standing Council on Health will make provision in the National Health Information Agreement for bona fide researchers to access de-identified data for the purposes of research and analysis.

- B100. With regard to clause B97(f), those agencies will not publish, or use in any way publicly, received data without the express approval of the originating body, except where this data has been provided for the purposes of publication and is being used in that manner.
- B101. In using the data available, agencies listed in clause B97 will have regard to the caveats and limitations of the collected data.
- B102. Each body will publish details of Commonwealth and State compliance with the data requirements of the national bodies on a quarterly basis.
- B103. The Commonwealth and the States agree to enter into a National Health Information Agreement by January 2012 that reflects the objectives of this Agreement, and other matters.
- B104. The data standards and data development processes set out in the National Health Information Agreement must be consistent with the objectives and provisions of this Agreement. Where there is any inconsistency, the provisions of this Agreement shall have precedence over the National Health Information Agreement.

## SCHEDULE C – TRANSPARENCY AND PERFORMANCE

### Performance and Accountability Framework

- C1. The Commonwealth and the States will introduce clear and transparent performance reporting against the new Performance and Accountability Framework to provide Australians with information about the performance of their health and hospital services in a way that is nationally consistent and locally relevant.
- C2. The Performance and Accountability Framework will include:
- a. a subset of the national performance indicators already agreed by COAG through the NHA to report on national trends and the performance of all jurisdictions;
  - b. reference to national clinical quality and safety standards developed by the ACSQHC as approved by the Standing Council on Health; and
  - c. design principles for the new Hospital Performance Reports and Healthy Communities Reports which will provide clear and transparent reporting on the performance of every Local Hospital Network, the hospitals within it, every private hospital and every Medicare Local. These reports will reflect:
    - i. new service and financial performance standards developed by the NHPA;
    - ii. new national standards which will be agreed by COAG from time to time, to reflect selected short to medium term goals and priorities of national significance; and
    - iii. selected clinical quality and safety measures drawn from the quality and safety standards developed by the ACSQHC and agreed by the Standing Council on Health.
- C3. The Performance and Accountability Framework may be amended from time to time, as agreed by the Standing Council on Health.
- C4. The COAG Reform Council will continue its role of reviewing the national performance indicators at a State level and of publicly reporting on the performance of the Commonwealth and the States in achieving the jurisdictional level outcomes and performance benchmarks included in the NHA.
- C5. New national standards will be used over time to drive improved performance across the health system. New national standards have already been developed by COAG (in the National Partnership Agreement on Improving Public Hospital Services) in relation to:
- a. emergency departments; and
  - b. elective surgery.
- C6. The new national standards, Hospital Performance Reports, Healthy Communities Reports and national clinical and quality standards will report on access to services, quality of service delivery, financial responsibility, patient outcomes and patient experience. Performance measures will be few in number and supported by data which is timely, comparable, administratively simple, cost effective and accurate.

- C7. The NHPA will make regular assessments on the performance of Medicare Locals against the measures in the Performance and Accountability Framework and provide advice to the Commonwealth on both high and low performing Medicare Locals. The Commonwealth will be responsible for appropriate action to address any ongoing poor performance of Medicare Locals.
- C8. Through the Healthy Communities Reports, the NHPA will transparently and publicly report on GP and primary health care services and outcomes in the local community and region of each Medicare Local, including on local demography and health status, local services and health outcomes.
- C9. Through the Hospital Performance Reports the NHPA will transparently and publicly report on public hospital service staffing, financial resources and performance outcomes and standards.
- C10. The NHPA will make regular assessments of Local Hospital Network performance against the measures in the Performance and Accountability Framework and provide advice to the Commonwealth and State governments on poor performing Local Hospital Networks. States, as system managers of the public hospital system, will act in line with Health Ministers' agreed roles and responsibilities to remediate ongoing poor performance.
- C11. The MyHospitals website will become the online vehicle for the NHPA to report on the performance of individual hospitals and Local Hospital Networks, enabling patients to compare the services available at, and the performance of, different hospitals in their local area.
- C12. To support monitoring and reporting on Medicare Local and Local Hospital Network activity against the Performance and Accountability Framework, the Commonwealth (in regard to Medicare Locals) and the States (in regard to Local Hospital Networks) will provide the NHPA with patient-level and hospital-level service data, staffing information, financial payment and other financial information relating to the provision of public hospital, GP and primary health care services, according to a timetable determined by the NHPA and agreed by the Standing Council on Health.
- C13. In order to streamline the data reporting obligations of the States, private hospitals and Medicare Locals under the Performance and Accountability Framework, existing data sources and existing data supply pathways will be utilised as much as possible. The Standing Council on Health will continue to rationalise reporting required from the States, private hospitals and Medicare Locals.
- C14. The NHPA will determine appropriate performance reporting data to be provided by private hospitals, taking into account commercial confidentiality.

## SCHEDULE D – LOCAL GOVERNANCE

### Local Hospital Networks

- D1. Local Hospital Networks will be established by States by 1 July 2012.
- D2. The Commonwealth and the States agree that the establishment of Local Hospital Networks will decentralise public hospital management and increase local accountability to drive improvements in performance. Local Hospital Networks will be accountable for treatment outcomes and responsive to patients' needs and will make active decisions about the management of their own budget. They will have the flexibility to shape local service delivery according to local needs.
- D3. Local Hospital Networks will engage with the local community and local clinicians, incorporating their views into the day-to-day operational planning of hospitals, particularly in the areas of safety and quality of patient care.
- D4. Local Hospital Networks will directly manage public hospital services and functions and may at the discretion of States also have responsibility for delivery of other health services. Local Hospital Networks will work with Medicare Locals to integrate services and improve the health of local communities.

### Local Hospital Network Responsibilities

- D5. Local Hospital Networks will be responsible for:
  - a. managing their own budget, in accordance with State financial and audit requirements;
  - b. managing performance of functions and activities specified in Service Agreements;
  - c. receiving Commonwealth and State funding contributions for delivery of services as agreed under the Service Agreement entered into with the State government;
  - d. local implementation of national clinical standards to be agreed between the Commonwealth and States on the advice of the ACSQHC;
  - e. local clinical governance arrangements;
  - f. providing information to States at their request, for the purpose of enabling the relevant State to provide information and data to the national bodies and the Commonwealth;
  - g. maintaining accountability under, and subject to, State financial accountability and audit frameworks; and
  - h. collaborating with Medicare Locals and private providers to meet the health needs of the community and minimise service duplication and fragmentation.
- D6. Local Hospital Networks will assist States through:
  - a. contributing expertise, local knowledge and other relevant information to State-managed capital and service planning arrangements; and
  - b. the implementation and local planning of capital infrastructure.

- D7. Local Hospital Networks will engage with the following stakeholders to enable their views to be considered when making decisions on service delivery at the local level, or service and capital planning at the state level:
- a. other Local Hospital Networks to collaborate on matters of mutual interest;
  - b. local primary health care providers, Medicare Locals and aged care services; and
  - c. the local community and local clinicians, particularly in the area of safety and quality of patient care.

## Service Agreements

- D8. The Local Hospital Network Service Agreement will include at a minimum:
- a. the number and broad mix of services to be provided by the Local Hospital Network, so as to inform the community of the expected outputs from the Local Hospital Network and allow the Administrator to calculate the Commonwealth's funding contribution (clause B26a refers);
  - b. the quality and service standards that apply to services delivered by the Local Hospital Network, including the Performance and Accountability Framework;
  - c. the level of funding to be provided to the Local Hospital Networks under the Service Agreement, through ABF, reported on the basis of the national efficient price, and block funding; and
  - d. the teaching, training and research functions to be undertaken at the Local Hospital Network level.
- D9. Service Agreements will be publicly released by States within fourteen calendar days of finalisation or amendment and will then also be made available through relevant national bodies. States may agree additional matters with Local Hospital Networks (such as the delivery of additional programs).
- D10. The Commonwealth will not be a party to Local Hospital Network Service Agreements and will have no role, directly or indirectly, in the negotiation or implementation of Local Hospital Network Service Agreements.

## Local Hospital Network Governance

- D11. States will establish Local Hospital Networks as separate legal entities under State legislation to devolve operational management for public hospitals and accountability for local delivery to the local level.
- D12. States will be accountable for financial management and audit of Local Hospital Networks and will ensure that stringent independent oversight and financial accountability is put in place.
- D13. Local Hospital Networks will have separate bank accounts, will be able to receive funding from the National Health Funding Pool independent of State treasuries or health departments and will be audited as separate entities.

- D14. Local Hospital Networks will have a professional Governing Council and Chief Executive Officer, responsible for:
- a. delivering agreed services and performance standards within an agreed budget, based on annual strategic and operating plans, to give effect to the Local Hospital Network Service Agreement;
  - b. ensuring accountable and efficient provision of services and producing annual reports, subject to State financial accountability and audit frameworks;
  - c. monitoring Local Hospital Network performance against the agreed performance monitoring measures in the Local Hospital Network Service Agreement, including the Performance and Accountability Framework outlined in Schedule C;
  - d. improving local patient outcomes and responding to system-wide issues; and
  - e. maintaining effective communication with the State and relevant local stakeholders, including clinicians and the community.
- D15. Local Hospital Network Governing Councils will be responsible for:
- a. negotiating and agreeing with the relevant State government a Local Hospital Network Service Agreement and any necessary adjustments; and
  - b. developing a strategic plan for the Local Hospital Network, and implementing an operational plan to guide the delivery of the services, within the budget agreed under the Local Hospital Network Service Agreement.
- D16. Local Hospital Network Governing Councils will comprise members with an appropriate mix of skills and expertise to oversee and provide guidance to large and complex organisations, including:
- a. health management, business management and financial management;
  - b. clinical expertise, including expertise external to the Local Hospital Network wherever practicable;
  - c. cross-membership with Medicare Locals wherever possible;
  - d. where appropriate, people from universities, clinical schools and research centres; and
  - e. where appropriate, people with other skills and experience.
- D17. The overall makeup of Local Hospital Network Governing Councils will be determined taking into account the need to ensure local community knowledge and understanding.
- D18. Local Hospital Network Governing Councils will be recruited through a process conducted publicly, transparently and in accordance with due process principles, and will be remunerated at rates determined by the relevant State.
- D19. Local Hospital Network Governing Council members will be appointed under State legislation by State Health Ministers. Each Local Hospital Network's Chief Executive Officer (CEO) will be appointed by the Governing Council, with the approval of the State Health Minister or their delegate, and will be accountable to the Governing Council.

- D20. After two years, Senior Officials will provide advice to COAG on the alignment between the actual composition of Local Hospital Network Governing Councils and the appointment criteria outlined in clauses D16 to D19. Based on the initial advice, COAG will decide whether such advice is required on an ongoing basis.
- D21. Local Hospital Network Governing Councils will establish a formal engagement protocol with local Medicare Locals.

## Local Hospital Network Structure

- D22. Local Hospital Networks will comprise single or small groups of public hospitals with a geographic or functional connection, large enough to operate efficiently and to provide a reasonable range of hospital services and small enough to enable the Local Hospital Networks to be effectively managed to deliver high quality services.
- D23. Types of Local Hospital Networks will include:
- a. metropolitan Local Hospital Networks, which will comprise at least one hospital, but could comprise a small group of hospitals, and should be built around principal referral hospitals or specialist hospitals;
  - b. specialist Local Hospital Networks, which will have a functional focus without any particular geographic focus and will operate with whole-of-State coverage, for example specialist hospitals or the largest most complex tertiary hospitals; and
  - c. other Local Hospital Networks, bringing together an individual or groups of hospitals operated by third parties as public hospitals, including those operated by religious orders.
- D24. In regional Australia, a flexible approach will be adopted to determine the regional, rural and remote Local Hospital Network structure that best meets the needs of these communities and best takes into account the challenges of managing multiple small hospitals.
- D25. If over time States identify that significant changes are needed to roles and structures for Local Hospital Networks, they will work with Local Hospital Networks to deliver the adjustments necessary to respond to these changes, including the number and location of staff.
- D26. States will work cooperatively with the Commonwealth to ensure, wherever possible, common geographic boundaries with Medicare Local boundaries, including where States introduce arrangements for cross-border Local Hospital Networks.
- D27. In respect of performance assessment, reporting and management of Local Hospital Networks:
- a. the Standing Council on Health will agree a system which:
    - i. defines guidelines and determines a process for assessing different levels of performance; and
    - ii. outlines the roles and responsibilities of jurisdictions in response to persistent, unaddressed poor performance;

- b. States, as system managers of the public hospital system, will agree and adopt the Performance and Accountability Framework as outlined in Schedule C, and will be responsible for ensuring Local Hospital Network performance in accordance with this framework;
- c. The NHPA will assess and report on Local Hospital Network performance against the measures in the Performance and Accountability Framework and provide advice to States on poor performing Local Hospital Networks; and
- d. States, as system managers of the public hospital system, will decide on the nature and timing of actions to remediate ongoing poor performance.

## Australian Capital Territory and Northern Territory Arrangements

D28. The Australian Capital Territory and the Northern Territory will agree parallel arrangements with the Commonwealth, designed to replicate the Local Hospital Network general model so far as is practical.

## Medicare Locals

- D29. Medicare Locals will be established by the Commonwealth by 1 July 2012.
- D30. The Commonwealth will work with States, primary health care providers and other relevant groups to establish Medicare Locals as primary health care organisations across Australia.
- D31. Medicare Locals will be the GP and primary health care partners of Local Hospital Networks, responsible for supporting and enabling better integrated and responsive local GP and primary health care services to meet the needs and priorities of patients and communities.
- D32. Medicare Locals and State-funded health and community services will cooperate to achieve these objectives.
- D33. The strategic objectives for Medicare Locals are:
- a. improving the patient journey through developing integrated and coordinated services;
  - b. providing support to clinicians and service providers to improve patient care;
  - c. identifying the health needs of their local areas and development of locally focused and responsive services;
  - d. facilitating the implementation of primary health care initiatives and programs; and
  - e. being efficient and accountable with strong governance and effective management.
- D34. Medicare Locals will, among other functions, have responsibility for assessing the health needs of the population in their region, for identifying gaps in GP and primary health care services and putting in place strategies to address these gaps.
- D35. Medicare Locals will be independent legal entities (not government bodies) with strong links to local communities, health professionals and service providers, including GPs, allied health professionals and Aboriginal Medical Services. Medicare Locals will reflect their local communities and health care services in their governance arrangements.

- D36. As set out in Schedule E, the Commonwealth and States will work together on system-wide policy and state-wide planning for GP and primary health care. The Commonwealth will consult with States to ensure that:
- a. Medicare Locals are taken into account in system-wide policy and state-wide planning for primary health care; and
  - b. plans required to be developed by Medicare Locals take account of state-wide plans.
- D37. Medicare Locals and Local Hospital Networks will be expected to share some common membership of governance bodies where possible. Medicare Locals will be expected to work closely, and establish a formal engagement protocol, with Local Hospital Networks.
- D38. Medicare Locals will be subject to the performance monitoring and reporting requirements of the Performance and Accountability Framework outlined in Schedule C. The Commonwealth will be responsible for ensuring Medicare Local performance in accordance with this framework, where it applies.
- D39. The Commonwealth will establish performance management arrangements for Medicare Locals, and will ensure that the States have opportunities to access performance information as part of these arrangements. The NHPA will develop and produce reports on the performance of Medicare Locals and will provide confidential advice to the Commonwealth on poor performing Medicare Locals where ongoing poor performance has been identified. The Commonwealth will decide on the nature and timing of actions to remediate ongoing poor performance. Where the NHPA finds poor performance by a Medicare Local that plans and coordinates primary care services provided by a State, the relevant State will be consulted before the NHPA issues its final performance report.
- D40. States will not establish duplicate GP or primary health care planning and integration organisations. To the extent that such organisations already exist, the Commonwealth and the relevant State will work together to agree a transition plan, including timing, for the organisation then to become part of Medicare Local arrangements.
- D41. The Commonwealth and States will work together to create linkages and coordination mechanisms, where appropriate, between Medicare Locals and other State services that interact with the health system, for example services for children at risk, people with serious mental illness and homeless Australians.
- D42. In establishing Medicare Locals, the Commonwealth will work co-operatively with States to ensure, wherever possible, common geographic boundaries with Local Hospital Networks. These boundaries may be reviewed over time by the Commonwealth in consultation with States.
- D43. Medicare Locals will engage with the following stakeholders to enable their views to be considered when making decisions on service delivery at the local level, or service and capital planning at the State level:
- a. other Medicare Locals to collaborate on matters of mutual interest;
  - b. Local Hospital Networks; and
  - c. the local community and local clinicians, particularly in the area of safety and quality of patient care.

## SCHEDULE E – GP AND PRIMARY HEALTH CARE

### Commonwealth and State Engagement on System-wide Policy and State-wide Planning

- E1. GP and primary health care services are integral to an effective and efficient Australian health system. The Commonwealth will renew its efforts to improve GP and primary health care services in the community in order to improve care for patients. The Commonwealth will take lead responsibility for the system management, funding and policy development of GP and primary health care with the objective of delivering a GP and primary health care system that meets the health care needs of Australians, keeps people healthy, prevents disease and reduces demand for hospital services.
- E2. The Commonwealth and the States will work together on system-wide policy and state-wide planning for GP and primary health care given their impact on the efficient use of hospitals and other State funded services, and because of the need for effective integration across Commonwealth and State-funded health care services.
- E3. The Commonwealth will develop by December 2012 a national strategic framework to set out agreed future policy directions and priority areas for GP and primary health care, informed by bilateral work on state-specific plans for GP and primary health care, with state-specific plans to be completed by July 2013.
- E4. As part of its lead role in the delivery of GP and primary health care reform, the Commonwealth has a range of initiatives and reforms to Australia's GP and primary health care system under way or in the process of implementation, including Medicare Locals, GP Super Clinics and infrastructure grants, the practice nurse incentive, after hours arrangements, and additional GP and allied health professional training. These programs are currently being implemented and the Commonwealth will release implementation details for these programs, and consult the States in their development, as appropriate.
- E5. States will work cooperatively with the Commonwealth in the implementation and ongoing operation of the Commonwealth's primary health care initiatives.

## SCHEDULE F – AGED CARE AND DISABILITY SERVICES

- F1. This schedule clarifies the roles and responsibilities of governments in relation to basic community care services currently delivered through the Home and Community Care (HACC) program, Commonwealth funded and managed community and residential aged care, and certain specialist disability services provided under the National Disability Agreement and managed by States.
- F2. These changes to roles and responsibilities will enable the creation of a national aged care system and national disability services system and should be read together with the broader roles and responsibilities of governments detailed in the National Disability Agreement.
- F3. It is not intended that the split of responsibilities according to the age of clients be carried through into programs outside those mentioned in this Schedule.
- F4. Until otherwise agreed, the changes outlined below to roles and responsibilities for basic community care, aged care and disability services and the reconciliation arrangements referred to in clause F21 do not apply to Victoria and Western Australia. In these States, basic community care services will continue to be delivered under HACC as a joint Commonwealth-State funded program. The Commonwealth and these States will maintain bilateral agreements for that purpose. The review to be conducted in 2012 under existing agreements will deal only with business processes.

### Commonwealth Responsibilities

- F5. The Commonwealth will take full funding, policy, management and delivery responsibility for a consistent and unified aged care system covering basic home care through to residential care.
- F6. Specifically, the Commonwealth will be responsible for:
  - a. regulating packaged community and residential aged care delivered under Commonwealth aged care programs;
  - b. funding packaged community and residential aged care delivered under Commonwealth aged care programs for people aged 65 years and over (50 years and over for Indigenous Australians);
  - c. funding and regulating basic community care services for people aged 65 years and over (50 years and over for Indigenous Australians); and
  - d. funding specialist disability services delivered by the States in accordance with their responsibilities under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians).
- F7. In giving effect to these responsibilities, the Commonwealth will assume:
  - a. from 1 July 2011, funding and policy responsibility, and from 1 July 2012, operational responsibility for basic community care services for people aged 65 years and over (50 years and over for Indigenous Australians); and
  - b. funding responsibility from 1 July 2011 for specialist disability services delivered by the States in accordance with their responsibilities under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians).

- F8. The Commonwealth will continue to contribute funding to States for specialist disability services through the National Disability SPP and support effective national leadership in disability policy through the National Disability Agreement.
- F9. Current arrangements for access to Commonwealth aged care services for people under the age of 65 years will remain unchanged.

## State Responsibilities

- F10. States will be responsible for:
- a. regulating specialist disability services delivered under the National Disability Agreement;
  - b. funding and regulating basic community care services for people under the age of 65 years in line with their principal responsibility for delivery of other disability services by the States in accordance with their responsibilities under the National Disability Agreement, except Indigenous Australians aged 50 years and over for whom the cost of care will be met by the Commonwealth; and
  - c. funding packaged community and residential aged care delivered under Commonwealth aged care programs for people under the age of 65 years, except Indigenous Australians aged 50 years and over.
- F11. In giving effect to these responsibilities, the States will assume:
- a. funding and program responsibility from 1 July 2011 for basic community care services for people under the age of 65 years (under the age of 50 for Indigenous Australians); and
  - b. funding responsibility from 1 July 2011 for packaged community care and residential care delivered through the Commonwealth aged care program to people under the age of 65 years (under the age of 50 years for Indigenous Australians).
- F12. Current arrangements for access to disability services by States in accordance with their responsibilities under the National Disability Agreement for people 65 years and over (50 years and over for Indigenous Australians) will remain unchanged.
- F13. The roles and responsibilities, performance indicators and annual reporting provisions of the National Disability Agreement will reflect the changes to roles and responsibilities under this Agreement, including coverage of former HACC services for people under the age of 65 years (under the age of 50 years for Indigenous Australians).

## Shared Responsibilities

- F14. The Commonwealth and States will share responsibility for providing continuity of care across health services, aged care and disability services to ensure smooth client transitions.
- F15. Each level of government will continue to deliver basic community care services for the client groups under its responsibility.
- F16. The Commonwealth and States will share program responsibility for community care and residential care services for Indigenous Australian clients aged 50 to 64 years, who will be eligible to receive services from an appropriate provider under programs of either level of government. This will ensure that there will be no 'wrong door' for Indigenous Australians in

this age group seeking community or residential care services. Where care services are provided under a State funded program to an Indigenous person aged 50 years or older the Commonwealth will meet the cost of the service.

## Transition Arrangements

- F17. The implementation of the new arrangements for basic community care maintenance and support services will be carefully managed to ensure continuity of care for clients.
- F18. It is expected that basic level community care services will continue to be delivered through a mix of local government, State agency and non-government providers, and that individual providers will continue to be able to deliver both community disability and community aged care services during the implementation period and beyond.
- F19. The changes in roles and responsibilities for the provision of aged care and disability services detailed in this schedule will be budget neutral over the period 2011-12 to 2013-14. Budget neutrality will be achieved through adjustments to the National Disability SPP.
- a. Beyond 2013-14 an adjustment will continue to be made to the National Disability SPP held constant as a per capita share of the National Disability SPP based on the adjustment made in 2013-14.
- F20. The Commonwealth will work with States to effect the new funding arrangements with a smooth transfer to Commonwealth operational responsibility for HACC aged care services from 1 July 2012. The Commonwealth will fund service providers no earlier than 1 July 2012, and will not substantially alter service delivery mechanisms before 1 July 2015. There is no requirement for services to be delivered under competitive tender processes.
- F21. The process for reconciliation of State funding of packaged community and residential aged care services to people under the age of 65 years (under 50 years for Indigenous Australians), and Commonwealth funding of specialist disability services by States in accordance with their responsibilities under the National Disability Agreement for people 65 years and over (50 years and over for Indigenous Australians) will, during the transition period, involve transfers of resources between levels of government. These arrangements will have little or no direct impact on service providers and clients.

## SCHEDULE G - BUSINESS RULES FOR THE NATIONAL HEALTH REFORM AGREEMENT

*The following Business Rules are for service providers required to operate under the National Health Reform Agreement. These rules may be amended at any time with agreement in writing by all the parties or on behalf of the parties by the Commonwealth, State and Territory Health Ministers.*

### Public Patient Charges

- G1. Where an eligible person receives public hospital services as a public patient no charges will be raised, except for the following services provided to non-admitted patients and, in relation to (f) only, to admitted patients upon separation:
- a. dental services;
  - b. spectacles and hearing aids;
  - c. surgical supplies;
  - d. prostheses – however, this does not include the following classes of prostheses, which must be provided free of charge:
    - i. artificial limbs; and
    - ii. prostheses which are surgically implanted, either permanently or temporarily or are directly related to a clinically necessary surgical procedure;
  - e. external breast prostheses funded by the National External Breast Prostheses Reimbursement Program;
  - f. pharmaceuticals at a level consistent with the PBS statutory co-payments;
  - g. aids, appliances and home modifications; and
  - h. other services as agreed between the Commonwealth and States.
- G2. States can charge public patients requiring nursing care and accommodation as an end in itself after the 35th day of stay in hospital providing they no longer need hospital level treatment, with the total daily amount charged being no more than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

### Charges for Patients other than Public Patients

- G3. Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by the State.
- G4. Notwithstanding clause G3, pharmaceutical services to private patients, while they receive services as admitted patients, will be provided free of charge and cannot be claimed against the PBS.

### Pharmaceutical Reform Arrangements

- G5. States which have signed bilateral agreements for Pharmaceutical Reform Arrangements may charge the PBS for pharmaceuticals for specific categories of patients as provided for in the Arrangements.

## Public Health Services

G6. States and the Commonwealth will deliver public health services in accordance with the objectives, principles, roles and responsibilities, and any applicable standards, agreed in relevant national strategies, programs or initiatives.

## Public Patients' Charter and Complaints Body

G7. States agree to:

- a. continue the commitment under the previous health care agreements to preparing and distributing a Public Patients' Hospital Charter (the Charter), in appropriate community languages to users of public hospital services; and
- b. maintaining complaints bodies independent of the public hospital system to resolve complaints made by eligible persons about the provision of public hospital services received by them.

## Public Patients' Hospital Charter

G8. States agree to:

- a. review and update the existing Charter to ensure its relevance to public hospital services. The review should be conducted with the ACSQHC;
- b. develop the Charter in appropriate community languages and forms to ensure it is accessible to people with disabilities and from non-English speaking backgrounds;
- c. develop and implement strategies for distributing the Charter to public hospital service users and carers; and
- d. adhere to the Charter.

G9. States agree to the following minimum standards:

- a. the Charter will be promoted and made publicly available whenever public hospital services are provided; and
- b. the Charter will set out:
  - i. how the principles included in this Agreement are to apply to the provision of public hospital services in States;
  - ii. the process by which eligible persons can lodge complaints about the provision of public hospital services to them;
  - iii. that complaints may be referred to an independent complaints body;
  - iv. a statement of the rights and responsibilities of consumers and public hospitals in the provision of public hospital services in States and the mechanisms available for user participation in public hospital services; and
  - v. a statement of consumers' rights to elect to be treated as either public or private patients within States' public hospitals, regardless of their private health insurance status.

## Independent Complaints Body

- G10. States agree to maintain an independent complaints body to resolve complaints made by eligible persons about the provision of public hospital services to them.
- G11. States agree to the following minimum standards:
- a. the complaints body must be independent of bodies providing public hospital services and State health departments;
  - b. the complaints body must be given powers to investigate, conciliate and/or adjudicate on complaints received by it; and
  - c. the complaints body must be given the power to recommend systemic and specific improvements to the delivery of public hospital services.
- G12. The Commonwealth and the States agree that the powers of the complaints body will not interfere with or override the operation of registration boards or disciplinary bodies in States and that the exercise of powers by the complaints body will not affect the rights that a person may have under common law or statute law.
- G13. To assist in making recommendations and taking action to improve the quality of public hospital services, States agree to implement a consistent national approach, agreed with the ACSQHC or any successor, to collecting and reporting health complaints data to improve services for patients.

## Patient Arrangements

- G14. Election by eligible patients to receive admitted public hospital services as a public or private patient will be exercised in writing before, at the time of, or as soon as possible after admission and must be made in accordance with the minimum standards set out in this Agreement.
- G15. In particular, private patients have a choice of doctor and all patients will make an election based on informed financial consent.
- G16. Where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient chooses to be treated as a public patient, regardless of whether it is provided at the hospital or in private rooms.
- G17. Services provided to public patients should not generate charges against the Commonwealth MBS:
- a. except where there is a third party payment arrangement with the hospital or the State, emergency department patients cannot be referred to an outpatient department to receive services from a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services;
  - b. referral pathways must not be controlled so as to deny access to free public hospital services; and
  - c. referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services.
- G18. An eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit. On admission, the patient will be given

the choice to elect to be a public or private patient in accordance with the National Standards for Public Hospital Admitted Patient Election processes (unless a third party has entered into an arrangement with the hospital or the State to pay for such services). If it is clinically appropriate, the hospital may provide information about alternative service providers, but must provide free treatment if the patient chooses to be treated at the hospital as a public patient. However:

- a. a choice to receive services from an alternative service provider will not be made until the patient or legal guardian is fully informed of the consequences of that choice; and
- b. hospital employees will not direct patients or their legal guardians towards a particular choice.

G19. An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

- a. there is a third party payment arrangement with the hospital or the State or Territory to pay for such services; or
- b. the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.

G20. Where a patient chooses to be treated as a public patient, components of the public hospital service (such as pathology and diagnostic imaging) will be regarded as a part of the patient's treatment and will be provided free of charge.

G21. In those hospitals that rely on GPs for the provision of medical services (normally small rural hospitals), eligible patients may obtain non-admitted patient services as private patients where they request treatment by their own GP, either as part of continuing care or by prior arrangement with the doctor.

G22. States which have signed a Memorandum of Understanding with the Commonwealth for the COAG initiative "Improving Access to Primary Care Services in Rural Areas" may bulk bill the MBS for eligible persons requiring primary health care services who present to approved facilities.

G23. In accordance with this Agreement, public hospital admitted patient election processes for eligible persons should conform to the national standards set out in this schedule.

## Public Hospital Admitted Patient Election Forms

G24. States agree that while admitted patient election forms can be tailored to meet individual State or public hospital needs, as a minimum, all forms will include:

- a. a statement that all eligible persons have the choice to be treated as either public or private patients. A private patient is a person who elects to be treated as a private patient and elects to be responsible for paying fees of the type referred to in clause G1 of this Agreement;
- b. a private patient may be treated by a doctor of his or her choice and may elect to occupy a bed in a single room. A person may make a valid private patient election in circumstances where only one doctor has private practice rights at the hospital. Further, single rooms are only available in some public hospitals, and cannot be made available if required by other patients for clinical reasons. Any patient who requests and receives single room accommodation must be admitted as a private patient (note: eligible veterans are subject to a separate agreement);

- c. a statement that a patient with private health insurance can elect to be treated as a public patient;
- d. a clear and unambiguous explanation of the consequences of public patient election. This explanation should include advice that admitted public patients (except for care and accommodation type patients as referred to in clause G2):
  - i. will not be charged for hospital accommodation, medical and diagnostic services, prostheses and most other relevant services; and
  - ii. are treated by the doctor(s) nominated by the hospital;
- e. a clear and unambiguous explanation of the consequences of private patient election. This explanation should include advice that private patients:
  - i. will be charged at the prevailing hospital rates for hospital accommodation (whether a shared ward or a single room), medical and diagnostic services, prostheses and any other relevant services;
  - ii. may not be fully covered by their private health insurance for the fees charged for their treatment and that they should seek advice from their doctor(s), the hospital and their health fund regarding likely medical, accommodation and other costs and the extent to which these costs are covered; and
  - iii. are able to choose their doctor(s), providing the doctor(s) has private practice rights with the hospital;
- f. evidence that the form was completed by the patient or legally authorised representative before, at the time of, or as soon as practicable after, admission. This could be achieved by the witnessing and dating of the properly completed election form by a health employee;
- g. a statement that patient election status after admission can only be changed in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to, the following:
  - i. patients who are admitted for a particular procedure but are found to have complications requiring additional procedures;
  - ii. patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health care professional; and
  - iii. patients whose social circumstances change while in hospital (for example, loss of job);
- h. in situations where a valid election is made, then changed at some later point in time because of unforeseen circumstances, the change in patient status is effective from the date of the change onwards, and should not be retrospectively backdated to the date of admission;
- i. it will not normally be sufficient for patients to change their status from private to public, merely because they have inadequate private health insurance cover, unless unforeseen circumstances such as those set out in this Schedule apply;
- j. a statement signed by the admitted patient or their legally authorised representative acknowledging that they have been fully informed of the consequences of their

election, understand those consequences and have not been directed by a hospital employee to a particular decision;

- k. a statement signed by admitted patients or their legally authorised representatives who elect to be private, authorising the hospital to release a copy of their admitted patient election form to their private health insurance fund, if so requested by the fund. Patients should be advised that failure to sign such a statement may result in the refusal of their health fund to provide benefits; and
- l. where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election, or actual election, these patients will be treated as public patients and the hospital will choose the doctor until such time as a valid election is made. When a valid election is made, that election can be considered to be for the whole episode of care, commencing from admission.

### **Multiple and Frequent Admissions Election Forms**

G25. A State or hospital may develop a form suitable for individuals who require multiple or frequent admissions. The form should be for a specified period, not exceeding six months, and nominate the unit where the treatment will be provided. Further, the form should be consistent with the national standards and provide patients with the same information and choices as a single admission election form.

### **Other Written Material Provided to Patients**

G26. Any other written material provided to patients that refers to the admitted patient election process must be consistent with the information included in the admitted patient election form. It may be useful to include a cross reference to the admitted patient election form in any such written material.

### **Verbal Advice Provided to Patients**

- G27. Any verbal advice provided to admitted patients or their legally authorised representatives that refers to the admitted patient election process must be consistent with the information provided in the admitted patient election form.
- G28. Admitted patients or their legally authorised representatives should be referred to the admitted patient election form for a written explanation of the consequences of election.
- G29. To the maximum extent practicable, appropriately trained staff should be on hand at the time of election, to answer any questions admitted patients or their legally authorised representatives may have.
- G30. Through the provision of translation/interpreting services, hospitals should ensure, where appropriate, that admitted patients, or their legally authorised representatives, from non-English speaking backgrounds are not disadvantaged in the election process.

## SCHEDULE H – IMPLEMENTATION PLAN

The implementation plan set out below reflects the tasks, processes, timing and role allocation outlined in the provisions of this Agreement.

Task	Process for resolution	Timing	By whom (indicative)
<b>Financing</b>			
Amendments to the <i>Federal Financial Relations Act 2009</i>	Amend the <i>Federal Financial Relations Act 2009</i> to reflect changes to the IGA FFR as agreed by COAG.	31 December 2011	Commonwealth
Agreement between the Commonwealth and each State on the Commonwealth contribution to block funding and teaching, training and research in 2012-13	The Commonwealth Health Minister and each State Health Minister to hold bilateral discussions to resolve.	31 December 2011	Commonwealth and States
Development of Block Funding Criteria	The IHPA, in consultation with jurisdictions, will develop Block Funding Criteria to determine what services are eligible for block funding.	As soon as possible	IHPA in consultation with the Commonwealth and the States
Review of Block Funding Criteria	COAG will reconsider those aspects of the Block Funding Criteria that require revision and reapply the process in clause A27.	2015-16 and every three years thereafter	COAG
Commonwealth contribution for efficient growth funding	The Commonwealth's ongoing contribution to efficient growth funding will commence from 1 July 2014 - the Commonwealth will fund 45 per cent of efficient growth of activity based services, increasing to 50 per cent from 1 July 2017.	From 1 July 2014	Commonwealth
Mechanism for public health funding from 2015-16 onwards	The Commonwealth and States will consider a mechanism for delivering Commonwealth funding for public health activities to States from 2015-16. This will be considered in the context of a review of the National Partnership Agreement on Preventive Health which expires in 2014-15.	During review of NP on Preventive Health, or before 30 June 2015	Commonwealth and States

Task	Process for resolution	Timing	By whom (indicative)
Feasibility of transitioning funding for teaching, training and research to ABF or other appropriate arrangements	The IHPA will provide advice to the Standing Council on Health on the feasibility of transitioning funding for teaching, training and research to ABF or other appropriate arrangements reflecting the volumes of activities carried out under these functions.	No later than 30 June 2018	IHPA
\$16.4 billion top up payment guarantee	Heads of Treasuries (HOTS) will review the need for payment of any top up funding against the national guarantee. The Commonwealth will provide top-up funding to meet any shortfall against the \$16.4 billion guarantee.	July 2017, July 2018 and July 2019  30 June 2021	Commonwealth
Maintenance of effort	Heads of Treasuries will provide a report for consideration by the Standing Council for Federal Financial Relations, including information provided by the States against the benchmarks in clause A80 and the extent to which the Commonwealth has maintained its overall level of health expenditure over the same period (2011-12 to 2012-13).	2013-14	Standing Council for Federal Financial Relations
<b>National Health Funding Pool, the Administrator of the National Health Funding Pool and the National Health Funding Body</b>			
Establishment of the National Health Funding Pool, the Administrator of the National Health Funding Pool and the National Health Funding Body	The Commonwealth and States will pass legislation to establish the National Health Funding Pool, the Administrator of the National Health Funding Pool and the National Health Funding Body, in line with the functions and responsibilities provided in Schedule B.	1 April 2012	Commonwealth and States
Flow of funding into the National Health Funding Pool and State managed funds	Commonwealth and State ABF funding will flow into the Pool. States will determine when State payments are made into the Pool and State managed funds.	1 July 2012	Commonwealth and States
<b>Independent Hospital Pricing Authority and Activity Based Funding</b>			
Establishment of the Interim IHPA	The Commonwealth will establish an Interim IHPA as an executive agency in line with the requirements provided in Schedule B.	As soon as possible	Commonwealth
Establishment of the IHPA	The Commonwealth will pass legislation to establish the IHPA, in line with the functions and responsibilities provided in Schedule B.	31 December 2011	Commonwealth

Task	Process for resolution	Timing	By whom (indicative)
ABF implementation	ABF will be implemented through a phased approach: <ul style="list-style-type: none"> <li>• the implementation of a nationally consistent ABF system for acute admitted services, emergency department services and non-admitted patient services (initially using the Tier 2 outpatient clinic list) will commence on 1 July 2012; and</li> <li>• the implementation of nationally consistent ABF approaches for any remaining non-admitted services, mental health and sub-acute services will commence on 1 July 2013.</li> </ul>	Phase 1 – 1 July 2012  Phase 2 – 1 July 2013	Commonwealth and States
<b>National Health Performance Authority and Performance and Accountability Framework</b>			
Establishment of the NHPA	The Commonwealth will pass legislation to establish the NHPA in line with the functions and responsibilities provided in Schedule B.	31 December 2011	Commonwealth
<b>Data provision</b>			
Development of data requirements for Service Agreements	The Administrator of the National Health Funding Pool will determine the minimum level of data required to allow it to calculate the Commonwealth's contribution of the national efficient price, conduct reconciliation activities and ensure national comparability (in advance of providing its first data plan)	31 January 2012	Administrator of the National Health Funding Pool
Development of data plans that set out the data requirements of the national bodies	The national bodies will develop rolling three year data plans indicating their future data needs.	No later than 1 July 2012 and ongoing	IHPA, NHPA, NHFB
Development of a National Health Information Agreement	The Commonwealth and the States will enter into a National Health Information Agreement by January 2012 that reflects the objectives of this Agreement and other matters.	1 January 2012	Commonwealth and States

Task	Process for resolution	Timing	By whom (indicative)
<b>Local Hospital Networks</b>			
Establishment of LHNs	Establish Local Hospital Networks under State legislation in line with the requirements in Schedule D.	1 July 2012	States
Governing Council composition review	Review of the alignment between the actual composition of Governing Councils and the appointment criteria in clauses D16-19.	1 July 2014	SOM to provide advice to COAG.
Define and determine performance management systems for LHNs	Define guidelines and determine a process for assessing different levels of performance, and outline roles and responsibilities of jurisdictions in response to persistent, unaddressed poor performance.	1 July 2012	Standing Council on Health
<b>Medicare Locals</b>			
Establishment of Medicare Locals	The Commonwealth will work with States, primary health care providers and other relevant groups to establish Medicare Locals as primary health care organisations across Australia.	1 July 2012	Commonwealth
Establish performance management arrangements for Medicare Locals	Define performance management arrangements for Medicare Locals, ensuring that States have opportunities to assess performance information as part of these arrangements.	1 July 2012	Commonwealth
<b>GP and Primary Health Care</b>			
Development of a national strategic framework for GP and primary health care	The Commonwealth will develop a national strategic framework to set out agreed future policy directions and priority areas for GP and primary health care, informed by bilateral work on state-specific plans for GP and primary health care.	31 December 2012	Commonwealth and States
State-specific plans for GP and Primary Health Care	The Commonwealth and States will undertake bilateral work to develop state-specific plans for GP and primary health care.	31 July 2013	Commonwealth and States
<b>Aged Care and Disability Services</b>			
Home and Community Care (HACC) transfer	The HACC transfer in all States except Western Australia and Victoria.	1 July 2012	Commonwealth and States (except Victoria and Western Australia)

Task	Process for resolution	Timing	By whom (indicative)
Review of the Agreement			
COAG to commission a review of this Agreement	A review of this Agreement will be commissioned by COAG and undertaken by a panel of reviewers agreed by COAG. The review will be set against the objectives in this Agreement, outlined in clause 3.	The first review will occur in 2015-16, or later if agreed by SOM.	COAG

## APPENDIX A - DEFINITIONS

- A. A reference in this Agreement to the *Health Insurance Act 1973* or the *National Health Act 1953* is a reference to the Acts as at 1 July 2011 or as amended thereafter.
- B. Words and phrases which are not defined in this Agreement or defined in the *Health Insurance Act 1973* are to be given their natural meaning.
- C. In this Agreement, unless otherwise specified, words and phrases are to be interpreted as follows.

Activity Based Funding (ABF)	Refers to a system for funding public hospital services provided to individual patients using national classifications, cost weights and nationally efficient prices developed by the Independent Hospital Pricing Authority.
Administrator	Means the Administrator of the National Health Funding Pool, who is appointed in accordance with clause B24, and performs the functions set out in clauses B26-B27.
Admitted patient	Means “Admitted patient” as defined in the National Health Data Dictionary.
Australian Commission on Safety and Quality in Health Care	Means the authority performing the functions set out in Schedule B.
Block Funding	Means funding provided to support: <ul style="list-style-type: none"><li>• Public hospital functions other than patient services; and</li><li>• Public patient services provided by facilities that are not appropriately funded through ABF.</li></ul>
COAG	Refers to the Council of Australian Governments, being the peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association (ALGA).
COAG Senior Officials	Means the group comprising the chief executive officer of the Department of the Prime Minister and Cabinet, the Premier’s Department in each state and the Chief Minister’s Department in each Territory.
Compensable patient	Means an eligible person who is: <ul style="list-style-type: none"><li>• receiving public hospital services for an injury, illness or disease; and</li><li>• entitled to receive or has received a compensation payment in respect of an injury, illness or disease; or if the individual has died.</li></ul>
Complaints body	Means an independent entity established or commissioned to investigate complaints and/or grievances against providers of States’ public hospital

	services.
Default bed day rate	Means the rate set by the Commonwealth Minister under the <i>Private Health Insurance Act 2007</i> ,
Eligible admitted private patient	Means an eligible patient who is admitted and chooses to be treated as a private patient, and excludes compensable patients and other patients funded by third parties.
Eligible person	Means, as defined in subsection 3(1) (6) (6A) and (7) of the <i>Health Insurance Act 1973</i> , excluding compensable patients.
Emergency department	Means admission level three or above emergency service under the Australian College for Emergency Medicine guidelines, or as otherwise recommended by the IHPA and agreed by the Standing Council on Health.
Entitled veteran	Means a Department of Veterans' Affairs patient referred to in the <i>Veterans' Entitlements Act 1986</i> .
Implementation principles	Means the principles that should underpin National Health Reform as set out in clause 13.
Independent Hospital Pricing Authority (IHPA)	Means the authority established by Commonwealth legislation in accordance with clause B1 to perform the functions set out in clauses B3 to B8.
Ineligible person	Means any person who is not an eligible person.
Local Hospital Network	Means an organisation established in accordance with Schedule D and providing public hospital services.
Medicare Benefits Schedule (MBS)	Means the Commonwealth government's scheme to provide medical benefits to Australians established under part II, IIA, IIB and IIC of the <i>Health Insurance Act 1973</i> together with relevant Regulations made under the Act.
Medicare Locals	Means organisations funded by the Commonwealth to be the GP and primary health care partners of Local Hospital Networks in accordance with Schedule D of this Agreement.
Medicare Principles	Means the principles set out in clause 4 of this Agreement.
National efficient price	Means the base price(s) which will be determined by the IHPA and applied to those services funded on the basis of activity for the purpose of determining the amount of Commonwealth funding to be provided to Local Hospital Networks. The IHPA may determine that there are different base prices for discrete categories of treatment, for example admitted care, sub-acute care, non-admitted emergency department care and outpatient care. In the event that there are multiple national efficient

	prices, the IHPA will determine which national efficient price applies.
National Health Data Dictionary	Means the publication (in hard copy and/or the internet) containing the Australian National Standard of Data Definitions recommended for use in Australian health data collections; and the National Minimum Data Sets agreed for mandatory collection and reporting at a national level.
National Health Funding Body	Means the body established by Commonwealth legislation to assist the Administrator in carrying out his or her functions under Commonwealth and State legislation, in accordance with Schedule B of this Agreement.
National Health Funding Pool	Means the pool established by enabling Commonwealth and State legislation in accordance with Schedule B of this Agreement.
National Health Performance Authority (NHPA)	Means the authority established by Commonwealth legislation in accordance with clause B76 to perform the functions set out in clauses B78-B79.
Non-admitted patient services	Means services of the kind defined in the National Health Data Dictionary, under the data element “Non-Admitted Patient Service Type”.
Outpatient department	Means any part of a hospital (excluding the Emergency department) that provides non-admitted patient care.
Patient election status	Means the status of patients according to the National Standards for Public Hospital Admitted Patient Election Processes in Schedule G.
Performance and Accountability Framework	Means the framework established in accordance with Schedule C.
Pharmaceutical Benefits Scheme (PBS)	Means the Commonwealth government’s scheme to provide subsidised pharmaceuticals to Australians established under part VII of the <i>National Health Act 1953</i> (the Act) together with the National Health (Pharmaceutical Benefits) Regulation 1960 made under the Act.
Pharmaceutical Reform Arrangements	Means arrangements which provide for public hospitals that are Approved Hospital Authorities under Section 94 of the <i>National Health Act 1953</i> to supply pharmaceuticals funded by the PBS for specific categories of patients including: <ul style="list-style-type: none"> <li>• admitted patients on separation;</li> <li>• non-admitted patients; and</li> <li>• same day admitted patients for a range of drugs made available by specific delivery arrangements under Section 100 of the <i>National Health Act 1953</i>.</li> </ul>

Private Health Insurance Rebate	Means the Commonwealth government's scheme to provide private health insurance rebates established under the <i>Private Health Insurance Act 2007</i> together with relevant Regulations and rules made under that Act.
Public patient	Means an eligible person who receives or elects to receive a public hospital service free of charge.
Public patients' hospital charter	Means the document outlining how the principles of this Agreement are to be applied; the process by which eligible persons might lodge complaints about the provision of public hospital services; a statement of rights and responsibilities of consumers and public hospitals; and a statement of consumers' rights to elect to be treated as either public or private patients.
Service Agreement	Means an agreement between a state and a Local Hospital Network consistent with this Agreement.
Standing Council on Health	Means the forum established to facilitate provision of advice by Health Ministers to COAG.
State managed fund(s)	Means a fund(s) or account(s) established by State legislation for the purpose of receiving funding for block grants, teaching, training and research.
Weighted services	Means services of a particular ABF category where each service may count as more or less than one service as determined by the cost weight determined by the IHPA to be applicable to that service.