

NATIONAL HEALTH AND HOSPITALS NETWORK 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 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 and foundations of the National Health and Hospitals Network, which will deliver major structural reforms to establish the foundations of Australia's future health system.

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National Health and Hospitals Network Agreement

Preliminaries

1. This Agreement sets out the shared intention of the Commonwealth, State and Territory (the States) governments to implement a National Health and Hospitals Network for Australia.
2. The National Health and Hospitals Network will be a nationally unified and locally controlled health system that will ensure future generations of Australians enjoy world class, universally accessible health care, by:
 - a. establishing the Commonwealth Government as:
 - i. the majority funder of public hospital services;
 - ii. the level of government with full funding and policy responsibility for General Practice (GP) and primary health care as outlined in Schedule B; and
 - iii. the level of government with full funding, policy, management and delivery responsibility for a national aged care system; and
 - b. establishing the States as:
 - i. responsible for system-wide public hospital service planning and performance, purchasing of public hospital services and capital planning; and
 - ii. key partners supporting the Commonwealth's responsibility for system-wide GP and primary health care policy and service planning coordination as outlined in Schedule B.
3. This Agreement affirms the Medicare principles, high-level service delivery principles and objectives agreed by the Council of Australian Governments (COAG) in 2008, as shown in Appendix 1.

Key elements

Public hospitals and Local Hospital Networks

4. The Commonwealth Government will increase its funding contribution for public hospital services, as outlined in Schedule A, to provide:
 - a. 60 per cent of the national efficient price of every public hospital service provided to public patients;
 - b. 60 per cent of recurrent expenditure on research and training functions funded by States undertaken in public hospitals;

- c. 60 per cent of block funding paid against a COAG-agreed funding model, including for agreed functions and services and community service obligations required to support small regional and rural public hospitals;
 - d. 60 per cent of capital expenditure, on a 'user cost of capital' basis where possible; and
 - e. over time, up to 100 per cent of the national efficient price of 'primary health care equivalent' outpatient services provided to public patients.
5. States will be system managers for public hospitals, responsible for:
- a. purchasing services from Local Hospital Networks (LHNs) under a 'LHN Service Agreement' agreed between the LHN and the State;
 - b. system-wide public hospital service planning and policy;
 - c. system-wide public hospital capital planning and management, and capital planning and project management for hospital capital projects; and
 - d. in most cases, ownership of existing and new public hospital capital and assets, unless decided otherwise by the State.
6. LHNs will be established by State governments as separate legal entities under State legislation, in order to devolve operational management for public hospitals, and accountability for local delivery, to the local level. LHNs will be the direct managers of single or small groups of public hospital services and their budgets, and will be held directly accountable for hospital performance under the Performance and Accountability Framework outlined in Schedule D.
7. In respect of LHNs:
- a. State governments will be the single purchasers of all public hospital services through LHNs;
 - b. purchasing arrangements will be governed by a 'LHN Service Agreement' agreed between the State and each LHN;
 - c. funding contributions will be provided by both the Commonwealth and State governments, and Commonwealth funding will flow automatically in accordance with the levels of service set out in the LHN Service Agreement; and
 - d. the Commonwealth will not be a party to the LHN Service Agreement, and will have no role, directly or indirectly, in the negotiation or implementation of the LHN Service Agreement.

Primary health care and Primary Health Care Organisations

- 8. All governments agree that GP and primary health care services are integral to an effective and efficient Australian health system, meeting the health care needs of Australians in the community to keep people healthy and out of hospital.
- 9. The Commonwealth Government will take full funding and policy responsibility for Australia's GP and primary health care services outlined in Schedule B from 1 July 2011.

10. GP and primary health care will be defined for the purposes of this agreement as those services outlined in provision B10, subject to the other provisions of Schedule B.
11. To better deliver on these new Commonwealth responsibilities, alongside existing Commonwealth investment in GP and primary health care, States agree to transfer funding and policy responsibility to the Commonwealth for the GP and primary health care services outlined in Schedule B.
12. The Commonwealth and the States will work together on system-wide GP and primary health care policy, because it impacts 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.
13. Primary Health Care Organisations (PHCOs) will be created as independent organisations with strong links to local communities and health professionals. They will improve access to services and drive integration across GP and primary health care services by coordinating services and working closely with LHNs to identify and address local needs.

Financing

14. The reforms will be financed through a combination of:
 - a. funding as currently provided by the National Healthcare Specific Purpose Payment (Healthcare SPP);
 - b. dedication of an agreed amount of total GST revenue (all of which will continue to be provided to health and hospital services in each jurisdiction, as outlined in this Agreement); and
 - c. top-up funding to be an additional payment of no less than \$15.6 billion between 2014-15 and 2019-20 to be paid by the Commonwealth, reflecting the Commonwealth's greater responsibility for financing health and hospital expenditure growth under this Agreement.
15. The Commonwealth will establish an independent National Health and Hospitals Network Funding Authority (National Funding Authority) to oversee a National Health and Hospitals Network Fund and the distribution of the Commonwealth funding contribution through this fund, in line with Schedule C.
16. The Commonwealth Government will, through the National Health and Hospitals Network Fund:
 - a. pay 60 per cent of the national efficient price of every public hospital service provided to public patients under agreed LHN Service Agreements, including in respect of minor capital directly managed by LHNs, to National Health and Hospitals Network Funding Authorities (Funding Authorities) in each State, as outlined in provisions A8 and A9;
 - b. pay States:
 - i. into a discrete state-managed fund for:
 1. research;

2. training; and
 3. block funding paid against a COAG-agreed funding model, including for agreed functions and services and community service obligations required to support small regional and rural public hospitals;
- ii. for Commonwealth-funded GP and primary health care services (to the extent that they continue to provide relevant services on behalf of the Commonwealth); and
 - iii. a capital funding stream to be paid on a user cost of capital basis where possible, other than for minor capital directly managed by LHNs.
17. Under this Agreement, the National Health and Hospitals Network will be implemented so that no State government will be worse off in respect of Commonwealth transfers in the short-term and all will be better off in the long-term. To give effect to this commitment:
- a. the Commonwealth government will guarantee additional top-up funding paid to the States of no less than \$15.6 billion between 2014-15 and 2019-20, as outlined in provision C3(c); and
 - b. there will be a review of the level of GST to be dedicated once the system has transitioned to an efficient price, as outlined in provision C5(f).

Performance and Accountability Framework

18. The National Health and Hospitals Network will have a new Performance and Accountability Framework which will include:
- a. national performance indicators already agreed by COAG through the 2008 National Healthcare Agreement (NHA) to report on national trends and the performance of all jurisdictions;
 - b. national clinical quality and safety standards developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC); and
 - c. new Hospital Performance Reports and Healthy Communities Reports providing clear and transparent reporting on the performance of every LHN, the hospitals within it, every private hospital and every PHCO. Reports will reflect:
 - i. new service and financial performance standards (drawing on NHA performance indicators where possible);
 - 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.

National governance

19. The reforms will create new national governance functions including:
- a. an Independent Hospital Pricing Authority (IHPA), which will calculate and determine a national efficient price for the purposes of calculating the Commonwealth's payments for public hospital services, calculate and determine the Commonwealth's payments for block funding paid against a COAG-agreed funding model, and perform other functions as an integral part of the new system;
 - b. a National Performance Authority (NPA), which will report on the performance of every LHN, the hospitals within it, every private hospital and every PHCO, through the new Hospital Performance Reports and Healthy Communities Reports;
 - c. continuation of the role of the COAG Reform Council (CRC) in:
 - i. reporting on the performance of all jurisdictions against:
 1. the existing performance indicators set out in the NHA;
 2. the new National Standards; and
 3. the new national clinical quality and safety standards, as developed by the ACSQHC; and
 - ii. providing an independent assessment of whether predetermined performance benchmarks have been achieved prior to reward payments being made; and
 - d. continuation and expansion of the role of the ACSQHC to set national clinical standards for the delivery of health services.

Implementation

20. Roles and responsibilities for implementation under this Agreement will include the following:
- a. COAG will provide overall leadership, in consultation with Health Ministers and Treasurers;
 - b. Health Ministers will provide advice to COAG on health policy aspects of the reform plan, and take the leadership role in practical implementation of the National Health and Hospitals Network;
 - c. Treasurers will provide advice to COAG on Commonwealth-state financial aspects of the reform agenda, including:
 - i. the mechanisms to ensure that all States are better off in terms of Commonwealth transfers under the National Health and Hospitals Network reforms;
 - ii. the mechanisms to ensure maintenance of effort through the transition period;
 - iii. on the user cost of capital funding model as outlined in Schedule C; and

- iv. the mechanisms for GST dedication and Commonwealth Grants Commission (CGC) implications, as well as other future work associated with the financial implications of implementing the reforms;
 - d. Senior Officials will:
 - i. develop the future work plan in Appendix 4 and monitor implementation of the provisions in this Agreement, with regular reports back to COAG on progress and issues;
 - ii. ensure outstanding implementation and policy matters are on track for resolution, and escalate them to COAG when required; and
 - iii. provide leadership at the officials level; and
 - e. the CRC, Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics will play an important role in implementation, including providing data and analysis to inform the implementation of the National Health and Hospitals Network.
21. The current provisions of the Intergovernmental Agreement on Federal Financial Relations (IGA FFR), the NHA and any other relevant agreements will continue to apply until consequential changes to both documents are agreed by COAG, consistent with provision C16.
22. To provide greater certainty and security to States, the Commonwealth commits to exercising best endeavours to put in place the following:
- a. legislation that will prevent the Commonwealth from making any further changes to:
 - i. provision of all GST revenue – apart from the proportion of GST dedicated to health care – to States and Territories as untied general revenue assistance; and
 - ii. the amount of GST to be dedicated to health care;
 - b. legislation to insert a new provision in the *Federal Financial Relations Act 2009* (FFR Act), or other relevant legislation, requiring a three part process, should the Commonwealth seek to vary the NHHN Agreement in a way that involves substantial financial detriment to States. The three part process would involve the Commonwealth taking the following steps:
 - i. provide three months’ notice of the proposed variation to all governments prior to consideration by COAG, unless all governments agree otherwise;
 - ii. gain COAG’s agreement to the variation; and
 - iii. pass a resolution of each house of the Commonwealth Parliament approving the variation; and
 - c. legislation establishing as a special appropriation the Commonwealth’s top-up funding obligations under the NHHN Agreement, along with legislation making its top-up funding obligations under the NHHN Agreement mandatory on the Commonwealth.

23. This Agreement affirms that the following implementation principles should underpin the next stage of 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 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 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. reforms 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;
 - e. all Australians should have equitable access to high quality health care, including those living in regional and remote areas; and
 - f. governments agree that Australia's health system should promote social inclusion and reduce disadvantage, especially for Indigenous Australians.

<p>Signed for and on behalf of the Commonwealth of Australia by</p> <hr/> <p>The Honourable Kevin Rudd MP Prime Minister of the Commonwealth of Australia</p> <p>April 2010</p>	
<p>Signed for and on behalf of the State of New South Wales by</p> <hr/> <p>The Honourable Kristina Keneally MP Premier of the State of New South Wales</p> <p>April 2010</p>	<p>Signed for and on behalf of the State of Victoria by</p> <hr/> <p>The Honourable John Brumby MP Premier of the State of Victoria</p> <p>April 2010</p>
<p>Signed for and on behalf of the State of Queensland by</p> <hr/> <p>The Honourable Anna Bligh MP Premier of the State of Queensland</p> <p>April 2010</p>	<p>Signed for and on behalf of the State of South Australia by</p> <hr/> <p>The Honourable Mike Rann MP Premier of the State of South Australia</p> <p>April 2010</p>
<p>Signed for and on behalf of the State of Tasmania by</p> <hr/> <p>The Honourable David Bartlett MP Premier of the State of Tasmania</p> <p>April 2010</p>	<p>Signed for and on behalf of the Australian Capital Territory by</p> <hr/> <p>Jon Stanhope MLA Chief Minister of the Australian Capital Territory</p> <p>April 2010</p>
<p>Signed for and on behalf of the Northern Territory by</p> <hr/> <p>The Honourable Paul Henderson MLA Chief Minister of the Northern Territory of Australia</p> <p>April 2010</p>	

SCHEDULE A - PUBLIC HOSPITAL SERVICES AND LOCAL HOSPITAL NETWORKS

Objectives

- A1. The establishment of LHNs will decentralise public hospital management, increasing local accountability to drive improvements in performance. LHNs will be accountable for treatment outcomes and responsive to their patients' needs, and will make active decisions about the control of their own budget.
- A2. The implementation of a transparent and nationally consistent approach to public hospital funding will give LHNs the flexibility to shape local service delivery according to local needs. The Australian public will see hospitals become more accountable and responsive to local communities.
- A3. LHNs will provide an effective means of engaging with the local community and local clinicians to incorporate their views into the day-to-day operation of hospitals, especially regarding the quality and safety of patient care.

Local Hospital Network structure and governance

- A4. State governments will establish LHNs comprising 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 LHNs to be effectively managed to deliver high quality services.
- A5. LHNs will be the direct managers of public hospital services and may at the discretion of States also have responsibility for delivery of other health services.
- A6. LHNs will be consistent with the following broad characteristics:
 - a. LHNs in metropolitan areas 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. some LHNs will have a geographic focus with responsibility for particular areas;
 - c. other LHNs 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;
 - d. smaller metropolitan hospitals should be incorporated within LHNs on the basis of logical links to lead hospitals, whether through patient catchment or referral linkages;
 - e. in regional Australia, a flexible approach will be adopted to determine the regional, rural and remote network structure that best meets the needs of these

communities and best takes into account the challenges of managing multiple small hospitals; and

- f. noting the benefit of providing effective service models for 'communities of interest' that cross State borders, at the request of States, arrangements for cross-border LHNs may be agreed with the Commonwealth.

A7. In establishing LHNs:

- a. States will work cooperatively with the Commonwealth to ensure, wherever possible, common geographic boundaries with PHCO boundaries as outlined under provision B24;
- b. to build common geographic boundaries with PHCOs it is expected that in all States there will be at least as many LHNs as PHCOs. In many cases, due to the functionally focused LHNs outlined in provision A6(c), there will be more LHNs than PHCOs; and
- c. the final number and boundaries of LHNs will be primarily a matter for States to resolve. However:
 - i. as a transitional matter to establish the new system, the boundaries will be initially resolved bilaterally between First Ministers by 31 December 2010; and
 - ii. beyond this date, States will continue to consult with the Commonwealth on LHN structures and boundaries, as changes are made.

A8. Reflecting the funding partnership between the Commonwealth and the States, a Funding Authority will be established in each State as follows:

- a. the Funding Authorities will receive funding to pay for activity on the basis of activity based funding (ABF) from Commonwealth and State governments and make payments for activity on the basis of ABF to LHNs. These Funding Authorities will be called 'National Health and Hospital Network Funding Authority – [Name of State]';
- b. the Funding Authority in each State will be a joint intergovernmental authority which is State-based. Funding Authorities will have a board of supervisors – one from the State, one from the Commonwealth, and an independent chair chosen jointly between the parties;
- c. Commonwealth legislation will govern the Commonwealth payments to the relevant Funding Authority;
- d. State legislation will govern the State payments to the relevant Funding Authority;
- e. other matters concerning the establishment of the Funding Authorities will be agreed by COAG; and
- f. the objective of all Governments is to have total transparency about the funding flows and related services delivered through each Funding Authority. As such:
 - i. Funding Authorities will not be a constraint on information flows and reporting requirements outlined elsewhere in this Agreement; and
 - ii. Funding Authorities will provide reporting to the Commonwealth and the relevant State, with the timing and contents of reports to be agreed.

A9. Each Funding Authority will:

- a. receive funds:
 - i. from the National Health and Hospital Network Fund, automatically, as outlined in provision A21; and
 - ii. receive additional funding from the relevant State such as is required to meet the full cost of delivering ABF funded services in that State consistent with provisions A22 and A23;
- b. pay funds to LHNs, with funding by the Commonwealth to be paid as outlined in provision A21, and funding by the States to be paid in accordance with requirements to be determined by each State;
- c. not play any role whatsoever beyond the functions of receiving payments from Governments, and making payment to LHNs, according to this provision; and
- d. have such small administrative functions as are required to undertake the payment function described in this provision.

A10. LHNs will have the following governance structure:

- a. a professional Governing Council and Chief Executive Officer (CEO), responsible for:
 - i. delivering agreed services and performance standards within an agreed budget, based on annual strategic and operating plans, to give effect to the LHN Service Agreement;
 - ii. ensuring accountable and efficient provision of services and producing annual reports, subject to State financial accountability and audit frameworks;
 - iii. monitoring LHN performance against the agreed performance monitoring measures in the LHN Service Agreement, including the Performance and Accountability Framework outlined in Schedule D;
 - iv. improving local patient outcomes and responding to system-wide issues; and
 - v. maintaining effective communication with the State and relevant local stakeholders, including clinicians and the community.
- b. Governing Councils will comprise members with an appropriate mix of skills and expertise to oversee and provide guidance to large and complex organisations, including:
 - i. health management, business management and financial management;
 - ii. clinical expertise, external to the LHN wherever practical;
 - iii. cross-membership with local PHCOs wherever possible;
 - iv. where appropriate, representatives of universities, clinical schools and research centres; and
 - v. where appropriate, other skills and experience;

- c. the overall makeup of Governing Councils will be determined taking into account the need to ensure some local community knowledge and understanding; and
- d. 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.

- A11. Governing Council members will be appointed under State legislation by State Health Ministers. Each LHN's 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.
- A12. After 2 years, COAG will commission advice from the NPA on the alignment between the actual composition of Governing Councils and the appointment criteria outlined in provision A10(b). Based on the initial advice, COAG will decide whether such advice is required on an ongoing basis.
- A13. Governing Councils will establish a formal engagement protocol with local PHCOs.
- A14. In respect of performance management of LHNs:
- a. Health Ministers 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. State governments, as system managers, will agree and adopt the Performance and Accountability Framework as outlined in Schedule D, and will be responsible for ensuring LHN performance in accordance with this framework; and
 - c. the NPA will make regular assessments of LHN performance against the measures in the Performance and Accountability Framework and provide confidential advice to the Commonwealth, State governments on poor performing LHNs. States, as system managers, will act in line with Health Ministers' agreed guidelines, roles and responsibilities to remediate ongoing poor performance.
- A15. The Commonwealth and State governments, in establishing LHNs, will ensure there is no net increase in the number of ongoing health bureaucrats, as a proportion of the health workforce.
- A16. The Australian Capital Territory and the Northern Territory will enter into parallel arrangements with the Commonwealth, designed to replicate the general model so far as is practical.
- A17. All governments support the vital role played by non-government providers in providing health and public hospital services, including Catholic hospitals, and will work together, including with relevant stakeholders, to ensure this important contribution continues under the new arrangements.

Responsibilities of the States

A18. States will be responsible for:

- a. being the system manager and single purchaser of public hospital services, in order to ensure clear responsibility for day-to-day hospital system operation to deliver strong performance and patient outcomes;
- b. system-wide public hospital service planning and policy, including arrangements for providing highly specialised services and adjusting services between LHNs to meet changes in demand;
- c. system-wide public hospital capital planning and management, and capital planning and project management for hospital capital projects;
- d. in most cases, ownership of existing and new public hospital capital and assets, unless decided otherwise by the State; and
- e. managing LHN performance.

A19. States will be responsible for purchasing services from LHNs under a LHN Service Agreement, which will include:

- a. the number and broad mix of services to be provided by the LHN;
- b. the quality and service standards that apply to services delivered by the LHN, including the Performance and Accountability Framework;
- c. the level of funding to be provided to the LHN under the LHN Service Agreement, through ABF and block funding; and
- d. the teaching and research functions to be undertaken at the LHN level.

A20. States may agree with LHNs to renegotiate or amend LHN Service Agreements.

A21. The following process will occur for payment of State and Commonwealth funding to LHNs:

- a. in accordance with the levels of service and funding rules set out in the LHN Service Agreement then in force between the State and the LHN, each State will inform:
 - i. the Commonwealth of payments required to flow to the relevant Funding Authority from the National Health and Hospitals Fund; and
 - ii. the Funding Authority of payments to flow to LHNs;
- b. payments from the Commonwealth to the Funding Authorities and then to LHNs will be made automatically, so that States and LHNs will have budgeting certainty of the amount of Commonwealth funding for LHNs;
- c. payments from the Commonwealth to the Funding Authorities and then to LHNs will be made on a regular 'in advance' basis to be agreed, and at least monthly, to ensure that cash flow is maintained at the LHN level;
- d. States will notify the Commonwealth and the Funding Authorities, quarterly or as otherwise agreed, of any adjustments to the LHN Service Agreement agreed with the LHN that will affect the level of upcoming payments funded by the Commonwealth;

- e. LHNs will provide to States sufficient information regarding actual service levels delivered to enable them to inform the Commonwealth and the Funding Authority of the payments to be made in accordance with this provision; and
 - f. States will conduct reconciliation with actual service levels delivered at such frequency to be agreed, and communicate this to the Commonwealth and the Funding Authority to allow the adjustment of payments from the Commonwealth as required.
- A22. Consistent with E14, States will determine the amount they pay for public hospital services, and will meet residual costs of delivering public hospital services, including any costs over and above the Commonwealth's contribution to the national efficient price, as well as the remainder of teaching, research, capital costs and block funding.
- A23. States may use their own proportion of public hospital funding, or Commonwealth block funding paid to the States, to retain some funding from LHNs and use it to adjust service levels across the State, and to respond to unforeseen events and other contingencies.
- A24. States will be responsible for 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 LHNs.
- A25. States will identify significant changes needed to roles and structures between LHNs as circumstances evolve, and will work with LHNs to deliver the adjustments necessary to respond to these changes, including the number and location of staff.
- A26. States will be accountable for financial management and audit of LHNs and will ensure that stringent independent oversight and financial accountability is put in place.
- A27. The National Health and Hospitals Network Agreement commits the Commonwealth and all State governments to increased transparency and accountability, including in relation to the payment of funds. This includes:
- a. all funding paid to individual LHNs being independently audited and transparently and publicly reported, including the precise application of any funding provided by the Commonwealth or the States;
 - b. reporting required under this Agreement to be undertaken on a nationally consistent basis; and
 - c. LHNs transparently and publicly reporting on the expenditure of funds they have received.
- A28. For the purpose of calculating the national efficient price and state-specific prices, or executing other functions of the IHPA as outlined in Schedule E, States will provide the IHPA with hospital-level and patient-level data (consistent with the ABF classification and costing requirements to ensure national consistency) as required:
- a. on State funding contributions towards public hospital services provided by LHNs under LHN Service Agreements; and
 - b. other data necessary for the calculation of the national efficient and state-specific prices.

Responsibilities of the Commonwealth

A29. The Commonwealth Government will increase its funding contribution for public hospital services to:

- a. 60 per cent of the national efficient price of every public hospital service provided to public patients;
- b. 60 per cent of recurrent expenditure on research and training functions funded by States undertaken in public hospitals;
- c. 60 per cent of block funding paid against a COAG-agreed funding model, including for agreed functions and services and community service obligations required to support small regional and rural public hospitals;
- d. 60 per cent of capital expenditure, on a 'user cost of capital' basis where possible; and
- e. over time, up to 100 per cent of the national efficient price of 'primary health care equivalent' outpatient services provided to public patients.

A30. In providing funding in accordance with provision A29, the overall Commonwealth intention is to fund 60 per cent of total recurrent and capital government funding for public hospital services on an ongoing basis.

A31. The Commonwealth Government will be responsible for:

- a. paying 60 per cent of the national efficient price of every public hospital service provided to public patients under agreed LHN Service Agreements, including in respect of minor capital directly managed by LHNs, to Funding Authorities;
- b. paying States:
 - i. into a discrete State-managed fund for:
 1. research;
 2. training; and
 3. block funding paid against a COAG-agreed funding model, including for agreed functions and services and community service obligations required to support small regional and rural public hospitals;
 - ii. for Commonwealth-funded primary health care services (to the extent they continue to provide those services on behalf of the Commonwealth); and
 - iii. a capital funding stream to be paid on a user cost of capital basis where possible, other than for minor capital directly managed by LHNs.

A32. The Commonwealth's payments to the Funding Authorities will be made automatically in accordance with the levels of service set out in the LHN Service Agreement, on a regular 'in advance' basis, as outlined in provision A21.

A33. The Commonwealth will not intervene in matters concerning governance of LHNs or the negotiation and implementation of LHN Service Agreements.

Responsibilities of Local Hospital Networks

A34. LHNs will be responsible for:

- a. negotiating and agreeing with the relevant State government a LHN Service Agreement and any necessary adjustments, as outlined in provision A19;
- b. managing the LHN's budget as determined by the LHN Service Agreement;
- c. developing a strategic plan for the LHN, and implementing an operational plan to guide the delivery of the services, within the agreed budget under the LHN Service Agreement;
- d. providing to States sufficient information regarding actual service levels delivered to enable them to inform the Commonwealth of the payments to be made, as outlined in provision A21(e); and
- e. receiving Commonwealth funding for delivery of services from the Funding Authority in that State, as agreed under the LHN Service Agreement entered into with the State government.

A35. It is expected that these arrangements will create incentives for LHN efficiency. Based on this principle, if an LHN is able to operate more efficiently than the level of funding set by the State under the LHN Service Agreement, the LHN will be able to retain and reinvest the benefits accruing from efficiency in service delivery, in accordance with State policy and practice.

A36. LHNs will also be responsible for:

- a. employment of LHN staff in line with the remuneration and employment terms and conditions established by State governments in workplace relations agreements;
- b. local implementation of national clinical standards to be agreed between the Commonwealth and States on the advice of the ACSQHC;
- c. local clinical governance arrangements;
- d. providing information to States at their request, for the purpose of enabling the relevant State to provide information and data to the IHPA, as outlined in provision A28, and to the NPA, as outlined in provision D6; and
- e. maintaining accountability under and subject to State financial accountability and audit frameworks.

A37. LHNs 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.

A38. LHNs will engage with:

- a. other LHNs to collaborate on matters of mutual interest;
- b. local primary health care providers, PHCOs and aged care services; and

- c. the local community and local clinicians, 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 or territory level.

SCHEDULE B – PRIMARY HEALTH CARE AND PRIMARY HEALTH CARE ORGANISATIONS

Objectives

- B1. Locating responsibility for improving the GP and primary health care system with one level of government aims to:
- a. improve the efficiency of the health system and reduce pressure on hospital services;
 - b. reduce cost-shifting and blame-shifting; and
 - c. make it easier for patients to receive the services they need, improving patient outcomes and driving diversity and innovation in service provision.
- B2. The creation of PHCOs will improve the delivery of GP and primary health care services at the local level and ensure local GP and primary care is better integrated and more responsive to the needs and priorities of patients and communities. PHCOs will aim to do this by:
- a. improving the delivery of and access to GP and primary health care services at the local level to ensure there are fewer gaps in services, particularly for patients with chronic conditions and special needs;
 - b. working with local health care professionals, and engaging with the community, to ensure services work with each other so that patients will find it easier to navigate the local health system to find services they need; and
 - c. working with LHNs to assist with patients' transitions out of hospital, and where relevant into aged care, to ensure smoother transitions between service providers and greater coordination of services.

Primary health care transfer

- B3. In order to improve services in the community, address gaps in access to GP and primary care services and take pressure off hospitals, the Commonwealth Government will take full funding and policy responsibility for Australia's GP and primary health care services, as outlined in this Schedule, from 1 July 2011.
- B4. To better deliver on these new Commonwealth responsibilities, States agree to transfer funding and policy responsibility to the Commonwealth for the GP and primary health care services outlined in provision B10.
- B5. In addition, the Commonwealth will move over time to increase its funding contribution to up to 100 per cent of the national efficient price for GP and primary health care-equivalent outpatient services, as outlined in provision A29(e).

- B6. In formulating GP and primary health care policy, the Commonwealth recognises the need for ongoing engagement and collaboration with States. In particular:
- a. the Commonwealth and States will work together on system-wide GP and primary health care policy, because it impacts on the efficient delivery of hospital services and other State funded services, and because of the need for effective integration across Commonwealth and State funded health care services;
 - b. the Commonwealth will prepare a state-wide GP and primary health care plan to be agreed bilaterally; and
 - c. in relation to the services where funding and policy responsibility is transferred to the Commonwealth:
 - i. where coordination is required for reasons of service planning or service integration, the Commonwealth and the relevant State will work together to develop an agreed implementation plan; and
 - ii. the Commonwealth will develop a policy framework for these services in consultation with the States.
- B7. States will continue to ensure the operation of transferred GP and primary health care services as outlined in provision B10, and the Commonwealth will not substantially alter delivery mechanisms for these services, without agreement by the relevant state or territory, for 5 years from 1 July 2011.

Responsibilities of the States

- B8. The States will be responsible for:
- a. the ongoing operation of services funded by the Commonwealth, unless the relevant State agrees with the Commonwealth to divest this responsibility;
 - b. negotiating and agreeing with the Commonwealth for the delivery of relevant GP and primary health care services, where the Commonwealth agrees to provide those services through LHNs; and
 - c. contributing to the development of a system-wide plan for the provision of transferred GP and primary health care services, in collaboration with the Commonwealth, for the delivery of GP and primary health care services within their jurisdictions, as outlined in provision B6.
- B9. States will have continuing policy and funding responsibility for the following services which have been agreed as excluded from transfer to the Commonwealth:
- a. ambulance services;
 - b. existing public dental services;
 - c. health care for prisoners;
 - d. school and workplace primary care programs;
 - e. hospital avoidance programs that relate more specifically to patients who are predominantly being treated in acute care; and

- f. specialist sexually transmitted infection services and general sexual health services.

Responsibilities of the Commonwealth

B10. Subject to the other provisions of this Schedule, the Commonwealth will take full funding responsibility, and policy responsibility, for the following categories of GP and primary health care services currently funded by State governments, from 1 July 2011:

- a. community health centre (CHC) primary health care services, such as generalist counselling, integrated care, GP and primary care coordination programs, including Indigenous and rural and remote primary health care services;
- b. primary mental health care services which target the more common mild to moderate mental illnesses;
- c. hospital avoidance programs that do not relate specifically to patients who are predominantly being treated in acute care;
- d. primary and secondary prevention programs for early intervention and care coordination that focus on the management of patients with chronic disease in the community;
- e. screening programs for cancer delivered in a primary health care setting;
- f. immunisation; and
- g. any further services to be agreed between the Commonwealth and one or more of the States.

B11. The Commonwealth will be responsible for:

- a. undertaking planning for the provision of transferred GP and primary health care services. This will involve working with States to develop a system-wide plan as outlined in provision B6(b);
- b. maintaining funding levels and indexation for transferred GP and primary health care services, as agreed with the States, unless they choose to divest responsibility as outlined in provision B8(a);
- c. coordinating service provision to ensure service integration and improve the continuity of patient care, as outlined in provision B6(c)(i). This will usually involve consulting with States, PHCOs and other key stakeholders including clinicians.

Primary Health Care Organisations

B12. The Commonwealth Government will work with States and primary care stakeholders to establish PHCOs across Australia, with the first to be operational by mid 2011.

B13. PHCOs will be the GP and primary health care partners of LHNs, and are integral to delivering the National Health and Hospitals Network.

B14. PHCOs will deliver better integrated and responsive local GP and primary health care services to meet the needs and priorities of patients and communities.

Primary Health Care Organisation structure and governance

- B15. PHCOs 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.
- B16. The Commonwealth and PHCOs will agree a service contract, in consultation with the relevant state or territory, as well as other relevant stakeholders, including health professionals.
- B17. PHCOs will operate with strong local governance, including broad community and health professional representation, as well as business and management expertise. Strong clinical leadership will also be a key feature.
- B18. PHCOs and LHNs will be expected to have some common membership of governance structures where possible. PHCOs' service contracts will require PHCOs and LHNs to work closely together.
- B19. PHCOs will establish a formal engagement protocol with local LHNs.
- B20. PHCOs will be subject to the performance monitoring and reporting requirements of the Performance and Accountability Framework outlined in Schedule D, and the governance arrangements for that framework outlined in Schedule E.
- B21. The Commonwealth will establish performance management arrangements for PHCOs. The Commonwealth will ensure States have opportunities to contribute and access information on the outcomes of these arrangements.
- B22. The Commonwealth and State governments will work together to create linkages and coordination mechanisms between PHCOs and other State services that interact with the health system, e.g. children at risk, people with serious mental illness and homeless Australians.
- B23. State governments will not establish duplicate GP and primary health care organisations, and to the extent that they already exist they will become part of arrangements for PHCOs as coordinating entities for GP and primary health care services, once an implementation plan has been agreed between the Commonwealth and the relevant state or territory, as part of the transfer of responsibility for funding of primary care outlined in provision B4.
- B24. In establishing PHCOs, the Commonwealth will work cooperatively with States to ensure, wherever possible, common geographic boundaries with LHNs as outlined in provision A7.
- B25. The final number and boundaries of PHCOs will be primarily a matter for the Commonwealth to resolve. However:
 - a. as a transitional matter to establish the new system, the boundaries will be initially resolved bilaterally between First Ministers by 31 December 2010; and
 - b. beyond this date, the Commonwealth will continue to consult with the States on PHCO structures and boundaries as changes are made.

Responsibilities of Primary Health Care Organisations

- B26. PHCOs will be responsible for a range of functions aimed at making it easier for patients to navigate the local health care system and to provide more integrated care. They will:
- a. work with local health care professionals to ensure services cooperate and collaborate with each other so that patients can easily and conveniently access the full range of services they need;
 - b. facilitate allied health care and other support for people with chronic conditions, as identified in personalised care plans prepared by GPs;
 - c. identify groups of people missing out on GP and primary health care, or services that a local area needs, and better target services to respond to these gaps, for example, targeting gaps in GP services for aged care recipients;
 - d. work with LHNs to identify the best pathways between services, and to assist with patients' transitions out of hospital, and where relevant into aged care;
 - e. deliver health promotion and preventive health programs targeted to risk factors in communities, in cooperation with the National Preventive Health Agency, once it is established; and
 - f. as needed in the execution of other functions, undertake population level planning and potential fund-holding roles in areas of market failure and where patient needs are not being met.

Home and Community Care and related programs

- B27. As part of building a unified health system, all governments agree to improve outcomes in aged care services.
- B28. The Commonwealth will take full funding and program responsibility for a consistent and unified aged care system covering basic home care through to residential care, on a budget-neutral basis for both Commonwealth and State governments.
- B29. The SPP for the jointly funded Home and Community Care (HACC) program will cease from 30 June 2011. Beyond this date, the transfer in funds associated with the transfer of responsibilities between governments outlined at B32-B33 will be included in the calculation of the GST to be dedicated in each State from 2011-12.
- B30. Until otherwise agreed, the changes to roles and responsibilities in relation to HACC and related programs do not apply for Victoria. Existing arrangements for the relevant programs will remain in place until otherwise decided.
- B31. Further detail about these reforms is outlined at Appendix 3.

Responsibilities of the States

- B32. The States will assume responsibility for:
- a. funding and regulating basic community care services currently delivered under HACC for people under the age of 65 (under 50 for Indigenous Australians); and

- b. funding packaged community and residential aged care services delivered on behalf of the Commonwealth for people under the age of 65 (under 50 for Indigenous Australians).

Responsibilities of the Commonwealth

B33. The Commonwealth will assume:

- a. funding and program responsibility for basic community care services currently provided under HACC for people 65 years or over (50 years and over for Indigenous Australians); and
- b. funding responsibility for specialist disability services provided under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians).

Future work and transition

B34. The Commonwealth and States commit to undertaking further work to consider the following services, either for transfer to the Commonwealth or for strong national reform efforts with current roles and responsibilities:

- a. with a recommendation to be put to COAG in December 2010:
 - i. community health promotion and population health programs including preventive health, in order to determine how to maximise the value of the new National Health and Hospitals Network and National Preventive Health Agency;
 - ii. drug and alcohol treatment services;
 - iii. child and maternal health services; and
 - iv. community palliative care; and
- b. for inclusion as part of the overall mental health report back to COAG in 2011:
 - i. specialist community mental health services, for people with severe mental illness.

B35. The Commonwealth and States commit to undertaking further work in regards to Patient Assistance Transport Schemes, with a view to higher and more consistent national standards.

B36. In considering transfer of the services in provision B34, appropriate linkages to other State services outside the health system will be taken into account.

B37. As part of the transition to these new arrangements:

- a. it is recognised that local governments have a substantial role in the delivery of certain GP and primary health care services in some States, and should be consulted in developing transition processes;

- b. the Commonwealth will continue to fund immunisation programs through a range of settings, including child and maternal health services and schools, on an ongoing basis. Victoria is not transferring immunisation programs at this stage; this issue may be reconsidered as part of the further work on primary care described at provision B34;
- c. notwithstanding the broad disposition to transfer funding and policy responsibility for primary mental health services to the Commonwealth, further work will be undertaken by Tasmania to determine the definition and timeframe for transfer of these services;
- d. the Commonwealth and States agree that during the period between signature of this Agreement and 1 July 2012, States will continue to maintain their current level of effort in the delivery of GP and primary health care services; and
- e. the Commonwealth and States commit to working collaboratively, in accordance with a work plan, to finalise the transition to the new arrangements.

SCHEDULE C – FINANCING

Objectives

- C1. The Commonwealth will take clear financial leadership in the health system, to provide:
- a. leverage for system reform;
 - b. a secure funding base for public hospitals; and
 - c. a better integrated, more unified national health system that will ultimately improve performance and health outcomes.
- C2. The financial arrangements associated with the National Health and Hospitals Network will create a strong incentive for States to be as efficient as possible in their role in the health and hospital system.

Key elements

- C3. The reforms will be financed through:
- a. a new Healthcare SPP with continuation of funding equal to the current Healthcare SPP, which will be indexed from 1 July 2010 and each year thereafter by the growth factor set out in Schedule D of the IGA FFR;
 - b. dedicating a proportion of the Goods and Services Tax (GST) such that in the period 2011-12 to 2013-14, the new Healthcare SPP and the dedicated GST will fund the 60 per cent Commonwealth hospital funding contribution outlined in provision 4, 100 per cent of GP and primary health care services undertaken by States, and the budget neutral funding transfer for changes in roles and responsibility in HACC and related programs. The amount of GST dedicated to health care will be fixed from 2014-15, based on 2013-14 costs, and indexed at the rate of overall GST growth; and
 - c. from 2014-15, Commonwealth top up funding, determined as follows:
 - i. the additional top-up payment will reflect the additional expenditure, over and above the growth of the new Healthcare SPP and the fixed dedicated share of the GST, required to fund the 60 per cent Commonwealth hospital funding contribution outlined in provision 4 and 100 per cent of GP and primary health care services;
 - ii. the Commonwealth commits that the payment will be no less than \$15.6 billion between 2014-15 and 2019-20;
 - iii. if the amount determined under provision C3(c)(i) is less than \$15.6 billion, the residual funds under the guarantee will be paid into the National Health and Hospitals Network Fund for distribution to States;

iv. these residual funds will be spent by the States as funding for any health service that will assist in ameliorating the growth in demand for hospital services, including

1. chronic disease management programs;
2. preventive health programs;
3. mental health programs;
4. hospital admission avoidance programs; and
5. hospital early discharge programs

as jointly agreed by the Commonwealth and States. Funding will be additional to and not to replace existing spending on these programs; and

v. the detail of the mechanism and timing to give effect to this commitment will be developed by Treasurers for COAG agreement in 2010-11.

C4. The Commonwealth will establish a National Funding Authority to oversee a National Health and Hospitals Network Fund and the distribution of the Commonwealth funding contribution through this fund, in line with provision C3 and the funding mechanisms set out in Schedules A and B. This National Funding Authority will be established from 1 July 2011 as an independent Commonwealth statutory authority under the Financial Management 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.

C5. In relation to the dedicated GST:

- a. the proportion of the GST dedicated to health care will be allocated only to fund health care services provided by States;
- b. from 2014-15 when the proportion of dedicated GST is fixed, each state or territory's share will be determined by the actual amounts in each state or territory required to bring the combined contributions from the new Healthcare SPP arrangement and dedicated GST to 60 per cent of hospital funding as outlined in provision 4 (including the amount required to pay for capital) and 100 per cent of GP and primary health care in 2013-14;
- c. for 2014-15 and subsequent years, dedicated GST amounts in dollar terms will increase (or decrease) for each State in line with growth in the overall GST pool;
- d. dedicated GST will be treated as part of the GST pool by the Commonwealth Grants Commission (CGC) using the 'absorption method' for the purpose of horizontal fiscal equalisation;
- e. Heads of Treasuries will be tasked to advise Treasurers on further implementation issues including:

- i. the method for allocating state expenditures to COAG-agreed definitions for hospital and primary health care services for the purposes of developing consistent jurisdictional costings;
 - ii. reflecting the transition of the Healthcare SPP to an equal per capita payment in 2014-15;
 - iii. determining whether indexation of dedicated GST should apply to actual amounts per capita; and
 - iv. the treatment of capital in determining dedicated GST; and
 - f. there will be a review and adjustment as appropriate of the level of the dedicated GST for each State once the system has transitioned to an efficient price. A periodic review and recommendation to COAG on adjustment as appropriate of the level of dedicated GST will also occur every 3 years during the transition period.
- C6. Funding under the new Healthcare SPP arrangements will have the same treatment as the current Healthcare SPP for the purposes of horizontal fiscal equalisation, that is, treatment by inclusion.
- C7. Facilitation and reward payments to States under this Agreement will be treated by exclusion.
- C8. Any reward payments under this Agreement will be provided for health care purposes, to support ongoing innovation and service delivery reform.
- C9. Heads of Treasuries will consider and advise Treasurers on the CGC treatment of the Commonwealth top up payment, including Commonwealth payments (and associated expenditure) on GP and primary health care, in consultation with Senior Officials, with a view to ensuring that the policy objectives of horizontal fiscal equalisation and the National Health and Hospitals Network are achieved.
- C10. Heads of Treasuries will consider and advise Treasurers on the CGC treatment of Commonwealth payments (and associated expenditure) on GP and primary health care services, in consultation with Senior Officials, in the event that all or part of the payments cease to be paid as an SPP in the future and the CGC treatment of the budget neutral funding transfer for changes in roles and responsibility in HACC and related programs.
- C11. Mechanisms will be developed to ensure that all States are better off overall under the reforms, as follows:
- a. between 2010-11 and 2013-14, the transfer of roles and responsibilities will be budget neutral to both the Commonwealth and the States;
 - b. from 2014-15, States will receive no less than what they would have received through GST and current Healthcare SPP indexation arrangements, apart from funding required to give effect to changes in roles and responsibility in HACC, related programs and for any GP and primary health care services that a state or territory chooses to divest; and
 - c. further details of the mechanisms will be developed by Treasurers.

C12. Treasurers will further develop mechanisms to ensure that appropriate levels of health expenditure (including hospital capital investment and funding from both levels of government) are maintained until the end of 2013-14.

C13. The following approach will be adopted for the Commonwealth funding for capital:

- a. Heads of Treasuries will be tasked to advise COAG on the mechanism for meeting the Commonwealth's commitments on capital spending on the basis of a 'user cost of capital' approach incorporating both depreciation and cost of capital components;
- b. the main features of the mechanism will be as follows:
 - i. there will be a stream of funding for capital, to operate from 1 July 2011, with technical details on a user cost of capital model to be developed;
 - ii. States will continue to manage capital, except minor capital managed directly by LHNs, with the capital funding stream directly paid to each State varying over time to reflect:
 1. nature and location of hospital services;
 2. service activity; and
 3. size of the state or territory's capital program;
 - iii. LHNs will directly receive and manage payments for minor capital from the Funding Authority in the relevant State, including for maintenance and small scale operational needs;
 - iv. an appropriate arrangement will be developed to deliver the Commonwealth's 60 per cent capital funding for those functions and services and small regional and remote public hospitals which are funded on a block grant basis, rather than on an ABF basis;
 - v. the intention will be to provide a neutral treatment over time for States at different stages in their capital cycles and their service strategies; and
 - vi. standardised and transparent accounting across jurisdictions will be developed;
- c. all governments agree that the capital stream provided for through this mechanism will be used in regional and remote areas to the extent that it arises (whether through a user cost of capital approach or through capital support associated with block grants) from hospital services in regional and remote areas, averaged over 5 years; and
- d. over and above the capital mechanism provided for in this Agreement, the Commonwealth may choose to invest in national priority areas, or in geographic or functional areas of identified capital under-investment, following consultation with relevant states or territories.

C14. Funding for the governance arrangements outlined in Schedule E will be as follows:

- a. the Commonwealth will fund the establishment and recurrent costs of the IHPA and the NPA;

- b. the CRC funding arrangements will remain as currently agreed by COAG; and
- c. the Commonwealth and States will continue to fund the ACSQHC in accordance with current arrangements and will each meet their share of any additional funding agreed by Health Ministers for an expanded ACSQHC role, in accordance with provision E29.

Future work

- C15. Treasurers, through Heads of Treasuries (and supported by an expert reference group), will undertake work to develop in more detail advice to COAG on the framework and practical mechanisms for incorporating the user cost of capital into ABF, the transitional arrangements to this payment mechanism, and the detailed responsibilities of the IHPA with respect to capital.
- C16. More broadly, further detailed work by all parties will be required to align jurisdictional budget data and program specification with the agreed proposal, with a view to achieving consistency of approach across the jurisdictions. This will need to be done, in tandem with systems specification and development, in the period through to 1 July 2011 when the new arrangements will commence, as follows:
- a. these issues will be pursued through Heads of Treasuries in the first instance with advice to feed into Senior Officials implementation arrangements. Heads of Treasuries will establish a working group to draw on appropriate areas of expertise across the Commonwealth, States and bodies external to government as appropriate and maintain links, where appropriate, with other work being undertaken on ABF and primary care issues; and
 - b. Treasurers will report back to COAG, out of session, by 1 July 2010 outlining a detailed work program and making further recommendations to ensure that the necessary data work is completed for further consideration by COAG at its December 2010 meeting. Heads of Treasuries will report back to COAG ahead of time should there be a risk that the necessary work will not be completed in time.
- C17. The IGA FFR will be amended by COAG as soon as possible, out of session, to reflect the arrangements outlined above and in particular to provide for the dedication of a proportion of GST to health care. In addition, it will be necessary to amend the Federal Financial Relations Act 2009 to reflect changes to the IGA FFR.
- C18. There may be a range of transitional and consequential matters that flow from this Agreement, which will require further work between the Commonwealth and States on a collaborative basis during the transition period.
- C19. It is not intended that, as a result of this Agreement, there will be any change to the financial arrangements in respect of private patients in public hospitals. Further work is required to clarify and resolve the funding implications for treatment of private patients in public hospitals, and to resolve any necessary consequences. This work will occur during 2010-11, with any necessary changes to be brought back to COAG for agreement prior to being implemented with the related reforms on 1 July 2011.

- C20. Further work is required to clarify and resolve the funding implications arising from cross-border service delivery under these reforms, including the relationship with GST dedication arrangements. This work will occur during 2010-11, for any necessary changes to be implemented with the related reforms on 1 July 2011.
- C21. A review of funding arrangements will be commissioned by COAG, to be undertaken by a panel of reviewers agreed by COAG, 5 years from the commencement of the new public hospital funding arrangements or earlier if agreed by COAG. The review will be set against the principles and objectives of the National Health and Hospitals Network, including consideration of the following matters:
- a. whether the Commonwealth has maintained its intention to fund a 60 per cent share of total government expenditure on public hospitals, including capital and recurrent hospital funding;
 - b. whether the mechanics of hospital payment as implemented are giving effect to the policy intent of this agreement; and
 - c. other matters as agreed by COAG.

SCHEDULE D – PERFORMANCE AND ACCOUNTABILITY FRAMEWORK

Objectives

- D1. The reforms will introduce clear and transparent performance reporting against a new Performance and Accountability Framework to provide Australians with information about the performance of their health and hospital services in a way that is both nationally consistent and locally relevant.
- D2. New National Standards will be used over time to drive improved performance across hospital and GP and primary health care services.

Key elements

- D3. The reforms will include a new Performance and Accountability Framework which will be agreed and adopted by the Commonwealth and the States, and which will include:
 - a. national performance indicators already agreed by COAG through the NHA to report on national trends and the performance of all jurisdictions through the CRC;
 - b. national clinical quality and safety standards developed by the ACSQHC; and
 - c. new Hospital Performance Reports and Healthy Communities Reports providing clear and transparent reporting on the performance of every LHN, the hospitals within it, every private hospital and every PHCO. These reports will be developed and agreed by COAG in the first instance, and thereafter reviewed by Health Ministers. Reports will reflect:
 - i. new service and financial performance standards (drawing on NHA performance indicators where possible);
 - 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. These will be monitored at the LHN, PHCO and hospital levels by the NPA, and at the national and State level by the CRC; and
 - iii. selected clinical quality and safety measures drawn from the quality and safety standards developed by the ACSQHC.
- D4. New National Standards will be initially developed by COAG in the following areas:
 - a. emergency departments; and
 - b. elective surgery.
- D5. In regards to the development of performance measures:
 - a. the following principles will be taken into consideration for the development of new National Standards, the Hospital Performance Reports and Healthy Communities Reports and the new national clinical and quality standards:

- i. where appropriate, performance measures should address access to services, quality of service delivery, financial responsibility, patient outcomes and/or patient experience; and
 - ii. performance measures should be few in number and supported by data which is timely, comparable, administratively simple, cost effective, and accurate; and
 - b. the CRC will continue its role of reviewing the national performance indicators, as already agreed in the NHA.
- D6. To support monitoring and reporting on PHCO and LHN activity against the Performance and Accountability Framework, the Commonwealth (in regard to PHCOs) and the States (in regard to LHNs), will:
- a. provide the NPA with patient-level and hospital-level service data, financial payment and other financial information relating to the provision of public hospital and primary health care services, according to a timetable determined by the NPA and agreed by Health Ministers;
 - b. agree that the NPA can provide any of the information outlined in provision D6(a) necessary for the performance of the CRC's functions to the CRC; and
 - c. provide such de-identified clinical data to the ACSQHC and/or the NPA as is required for, respectively, development of agreed quality and safety standards, and reporting against these standards, according to a timetable determined by the ACSQHC and the NPA and agreed by Health Ministers.
- D7. States agree to the publication of data provided to the NPA, the CRC and the ACSQHC under provision D6, for the purpose of performance of the functions outlined in Schedule E.
- D8. The legislation creating the IHPA and the NPA, as outlined in provisions E7 and E23(b), will determine appropriate information and performance reporting data that private hospitals will provide to the IHPA and the NPA, taking into account commercial confidentiality.
- D9. In the interim period – from 1 July 2010 – States agree that hospital-level data on performance can be made publicly available through a website to be developed by the AIHW, with Health Ministers to agree on the timeline and data to be published.
- D10. 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.
- D11. The IHPA, the NPA and the Commonwealth Department of Health and Ageing will share data, to perform functions to give effect to this Agreement.
- D12. Further work to develop and agree the Performance and Accountability Framework will be undertaken by Senior Officials for agreement at COAG.

SCHEDULE E – NATIONAL GOVERNANCE

The Independent Hospital Pricing Authority

Objectives

- E1. The introduction of nationally consistent funding by the Commonwealth, based on the national efficient price of each public hospital service, will:
- a. use a system of ABF to ensure each LHN is funded for the services it provides; and
 - b. enable the provision of more information to communities on how public hospitals are performing and funded, and what services are provided.
- E2. Creating equitable access to public hospitals for Australians is a core design intention of the National Health and Hospitals Network funding approach, particularly in regional and remote areas and particularly for disadvantaged groups such as Indigenous Australians. In order to deliver on this intention, the new funding model will include state-specific prices (during transition) and a national efficient price based on ABF, cost weights and loadings, and block funding, as outlined in provisions E8 and E12.
- E3. The establishment of the IHPA will provide confidence that health dollars are being used efficiently and effectively. The state-specific prices and national efficient price to be used for Commonwealth funding will be calculated in a manner which ensures:
- a. reasonable access to public hospital services;
 - b. clinical safety and quality;
 - c. efficiency and effectiveness; and
 - d. financial sustainability of the public hospital system.

Key elements and functions

- E4. The IHPA will be established from 1 July 2011 as an independent Commonwealth statutory authority under the Financial Management 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.
- E5. The costs associated with the establishment and ongoing functioning of the IHPA will be borne by the Commonwealth.
- E6. The final terms of reference of the IHPA will developed by Senior Officials for COAG agreement, subject to consultation with Health Ministers and Heads of Treasuries, and will be set by the Commonwealth in accordance with COAG's agreement. These will build on the interim terms of reference outlined in provision E21.

- E7. The functions and responsibilities of the IHPA outlined in this Schedule will be set out in the legislation which establishes the IHPA, as well as arrangements for ensuring the IHPA's continued independence.
- E8. In order to deliver on the objectives in provisions E1-E3, the IHPA will:
- a. calculate and determine the national efficient price, state-specific prices, and the relevant cost weights to be applied to Commonwealth payments for admitted patient, emergency department, subacute and outpatient services in line with the provisions contained in Appendix 2; and
 - b. maintain, update and determine the national ABF classification and costing models.
- E9. States that are operating above the national efficient price will have overall funding levels protected during the transition period because of the commitment by the Commonwealth that no state or territory will be worse off in any year in respect of Commonwealth transfers.
- E10. Commonwealth payments on the basis of state-specific prices will transition over a period of time to a national efficient price basis as outlined in provision E8 and Appendix 2. The IHPA will provide advice to COAG on:
- a. the process of transition from state-specific prices to a national efficient price for admitted patient, emergency department, sub acute and outpatient services; and
 - b. the length of time for this transition, for agreement at COAG, with the aim of ensuring that any structural changes for states and LHNs are gradual and achievable.
- E11. The IHPA will calculate and determine the Commonwealth Government funding contribution for public hospitals, for:
- a. training and research undertaken in public hospitals;
 - b. block funding paid against a COAG-agreed funding model, including for agreed functions and services and community service obligations required to support small regional and rural public hospitals; and
 - c. capital, on the basis of the agreed arrangements for a user cost of capital approach, where possible.
- E12. In respect of Commonwealth Government block funding for public hospitals, as outlined in provision E11(b), the process will be as follows:
- a. the IHPA will provide advice to COAG on the definition and typology of public hospitals eligible for:
 - i. block funding only;
 - ii. mixed ABF and block funding; and
 - iii. ABF only;
 - b. COAG will make a decision on the definition and typology of public hospitals; and
 - c. the IHPA will calculate and determine the quantum of Commonwealth payment of block funding to States in accordance with COAG's decision. This calculation will be

based on historical State expenditure levels until the IHPA develops a COAG-agreed model for block funding allocation.

- E13. In respect of the Commonwealth Government funding contribution for outpatient services, as outlined in provision E8(a):
- a. the IHPA will provide advice to COAG to distinguish between those outpatient services that are acute care related and those that are better characterised as primary health care; and
 - b. once an agreement has been reached by COAG on 'primary health care equivalent' outpatient services to be funded at 100 per cent of the national efficient price, IHPA will calculate the national efficient price for these primary health care services.
- E14. The IHPA will play no role in determining State funding to LHNs, which will continue to be the responsibility of the States.
- E15. Forward estimates of Commonwealth funding for the States, including to LHNs, will be provided in the Commonwealth Budget papers. In addition, the IHPA will provide to State governments confidential projections of the national efficient price for a 4 year period, updated on an annual basis.
- E16. As outlined in provision A28, States will provide the IHPA with data for the purpose of calculating the national efficient price and state-specific prices, or executing other functions of the IHPA.
- E17. Where jurisdictions are unable to reach bilateral agreement on a dispute, either party may request the IHPA to make a binding determination on cost-shifting issues between jurisdictions, and on cross-border issues, with a view to resolving issues in a definitive, lasting and nationally consistent manner. In addition:
- a. further details on this process, including mechanisms to enforce the binding nature of the determinations, will be agreed by COAG in 2010-11; and
 - b. this capacity will be excluded from the Commonwealth's reserve powers in relation to the IHPA as outlined in provisions E18-E20.
- E18. The Commonwealth Health Minister and the Commonwealth Treasurer will retain reserve powers to provide direction to the IHPA, or to substitute alternative determinations in place of those made by the IHPA. These reserve powers will be used only in exceptional circumstances, including where jurisdictions have formed the opinion that the IHPA is significantly mistaken in its determination. The reserve powers do not apply where the matter concerned is a binding determination on cost-shifting issues between jurisdictions, or a cross-border issue, as outlined in provision E17.
- E19. The Commonwealth Health Minister and Treasurer, in using the reserve power, would be required to table in the Commonwealth Parliament within 28 days of an IHPA decision (or the first available day of Parliament if Parliament is not sitting for that period):
- a. the basis for the decision to override the IHPA; and
 - b. direction to the IHPA on how to reconsider their determination; or
 - c. the overriding decision.

E20. The Commonwealth Health Minister and Treasurer would only exercise the reserve power when the Prime Minister and the First Ministers of 4 States and Territories, including at least 3 States, have agreed, prior to exercise of their reserve power and tabling any direction or decision in the Commonwealth Parliament.

Interim terms of reference

E21. The terms of reference for the IHPA will be as follows:

- a. the IHPA will calculate the Commonwealth's funding contribution for:
 - i. public hospital services to public patients;
 - ii. 'primary health care equivalent' outpatient services;
 - iii. research;
 - iv. training;
 - v. block funding paid against a COAG-agreed funding model, including for agreed functions and services and community service obligations required to support small regional and rural public hospitals; and
 - vi. capital, on the basis of the agreed arrangements for a user cost of capital approach where possible;
- b. the IHPA will provide advice to COAG for decision on the definition and typology of public hospitals eligible for:
 - i. block funding only;
 - ii. mixed ABF and block funding; and
 - iii. ABF only;
- c. the IHPA will calculate and determine the quantum of Commonwealth payment of block funding to States in accordance with COAG's decision. This calculation will be based on historical State expenditure levels until the IHPA develops a COAG-agreed model for block funding;
- d. the IHPA will provide advice to COAG on outpatient services, to distinguish between those services which are acute care related and those that are better characterised as primary health care;
- e. once an agreement has been reached by COAG on 'primary health care equivalent' outpatient services to be funded at 100 per cent of the national efficient price, the IHPA will calculate the national efficient price for these primary health care services;
- f. the IHPA will base the calculation of the Commonwealth's funding contribution to public hospitals for training and research on an assessment of the level of expenditure proposed by State governments;
- g. the IHPA will base the calculation of the Commonwealth funding contribution for capital on agreed arrangements for a user cost of capital approach, allowing for transitional arrangements and block funding as required;

- h. in calculating and determining the national efficient price, the IHPA must:
 - i. base the calculation of the national efficient price on the cost of the efficient delivery of public hospital services;
 - ii. take into account:
 - 1. actual prices paid in each jurisdiction;
 - 2. the need for continuity and predictability in these arrangements; and
 - 3. the need for robust analysis of the underlying cost drivers;
 - iii. calculate and determine the extent to which the national efficient price and state-specific price is adjusted for a small number of loadings, to reflect variations in wage costs and other legitimate and unavoidable inputs which affect the costs of service delivery, including:
 - 1. hospital type and size;
 - 2. hospital location, including regional and remote status; and
 - 3. patient complexity, including Indigenous status;
 - iv. design this small number of loadings such that the Commonwealth's funding contribution provides a strong and relevant price signal for both States and LHNs, but not undertake an exhaustive assessment which would duplicate the work of the CGC in determining relativities;
 - v. establish 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; and
 - vi. determine a model for annual adjustment/indexations of the payments to be made by the Commonwealth under this provision;
- i. the IHPA will provide advice to COAG on:
 - i. the process of transition from state-specific prices to a national efficient price for admitted patient, emergency department, sub acute and outpatient services; and
 - ii. the length of time for this transition, for agreement at COAG, with the aim of ensuring that any structural changes for states and LHNs are gradual and achievable;
- j. the IHPA will make binding determinations on bilateral cost-shifting and cross-border issues between jurisdictions, at the request of either party;
- k. the IHPA will provide to State governments confidential projections of the national efficient price for a 4 year period, updated on an annual basis; and
- l. the IHPA will seek private submissions from the Commonwealth and State governments to inform its deliberations on a national efficient price and appropriate weighting on payments. All governments will be able to make a submission at any time.

Performance monitoring

Objectives

E22. Nationally consistent and independent performance monitoring at the local level will:

- a. identify high-performing public hospitals and GP and primary health care services, facilitating sharing of effective and innovative practices; and
- b. incorporate strong national service standards and financial performance standards, to increase accountability and drive improved patient outcomes.

The National Performance Authority

E23. The NPA will be established from 1 July 2011 as an independent Commonwealth statutory authority (under the Financial Management Act), with:

- a. the following governance structure:
 - i. a Chairperson appointed by the Commonwealth;
 - ii. a Deputy Chairperson appointed by the states; and
 - iii. five members to be agreed by COAG, with at least one member having regional and rural expertise; and
- b. the following functions outlined in provision E24-E25 set out in a legislative charter for the NPA, as well as arrangements to ensure the continued independence of the NPA.

E24. The functions of the NPA are to:

- a. provide clear and transparent quarterly public reporting of the performance of every LHN, the hospitals within it, every private hospital and every PHCO, through the new Hospital Performance Reports and Healthy Communities Reports, as outlined in provision D3(c);
- b. monitor the performance of LHNs, PHCOs and hospitals against these performance measures and standards in order to identify:
 - i. high-performing LHNs, PHCOs and hospitals, to facilitate sharing of innovative and effective practices; and
 - ii. poorly performing LHNs and PHCOs to the Commonwealth and States, to assist with performance management activities as outlined in provisions A14(c) and B21; and
- c. develop additional performance indicators as appropriate, when asked by the Commonwealth Health Minister at the request of COAG.

E25. In undertaking its work, the NPA will provide comparative analysis across jurisdictions, identify best practice and focus on the achievement of results.

The COAG Reform Council

E26. The role of the CRC will be continued, with the following functions:

- a. providing clear and transparent regular public reporting on all jurisdictions' performance against:
 - i. the existing performance indicators set out in the NHA;
 - ii. the new National Standards; and
 - iii. the new national clinical quality and safety standards, as developed by the ACSQHC;
- b. providing an independent assessment of whether predetermined performance benchmarks have been achieved prior to reward payments being made; and
- c. advising COAG on changes that might be made to improve performance reporting against the NHA performance indicators.

The Australian Commission on Safety and Quality in Health Care

Objectives

E27. New national clinical standards and strengthened clinical governance will support clinicians to lead the drive towards continuous improvement in quality and safeguarding high standards of care.

Key elements and functions

E28. The existing role, governance and funding arrangements of the ACSQHC will continue.

E29. It is intended that the ACSQHC role will expand, subject to detailed agreement on the scope and financial implications by Health Ministers, in order to develop national clinical safety and quality standards as outlined in Schedule D.

APPENDIX 1 – RE-ENDORSEMENT OF NATIONAL HEALTHCARE AGREEMENT PRINCIPLES

1. This Agreement re-endorses:
 - a. the Medicare principles provided for in the NHA:
 - i. *“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 hospitals¹;*
 - ii. *“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*
 - iii. *“arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location”;*
 - b. the following health system principles agreed by COAG in November 2008, that Australia’s health system should:
 - i. *“be shaped around the health needs of individual patients, their families and communities;*
 - ii. *“focus on the prevention of disease and injury and the maintenance of health, not simply the treatment of illness;*
 - iii. *“support an integrated approach to the promotion of healthy lifestyles, prevention of illness and injury, and diagnosis and treatment of illness across the continuum of care; and*
 - iv. *“provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country”;* and
 - c. the following long-term objectives agreed by COAG:
 - i. *“Prevention: Australians are born and remain healthy;*
 - ii. *“Primary and Community Health: Australians receive appropriate high quality and affordable primary and community health services;*
 - iii. *“Hospital and Related Care: Australians receive appropriate high quality and affordable hospital and hospital related care;*
 - iv. *“Aged Care: Older Australians receive appropriate high quality and affordable health and aged care services;*
 - v. *“Patient Experience: Australians have positive health and aged care experiences which take account of individual circumstances and care needs;*

¹ This Agreement recognises that clinical practice and technology changes over time and that this will impact on modes of service and methods of delivery.

- vi. *“Social Inclusion and Indigenous Health: Australia’s health system promotes social inclusion and reduces disadvantage, especially for Indigenous Australians; and*
- vii. *“Sustainability: Australians have a sustainable health system.”*

APPENDIX 2 – ACTIVITY BASED FUNDING TRANSITION

1. In December 2008 all governments committed to move to a more nationally consistent approach to ABF for public hospital services.
2. Under this Agreement, that work program will be accelerated and an implementation plan developed for nationally consistent ABF classification and costing models to achieve the following milestones:
 - a. for admitted acute patient services, work is completed for payments to begin to be paid on an ABF basis against state-specific prices from 1 July 2012; and
 - b. for emergency department, subacute and outpatient services, development work is completed by the end of 2012-13 so that, for services to be funded on an ABF basis (that is, excluding services eligible for block funding):
 - i. each service is funded using nationally consistent activity ‘proxies’ and state-specific prices from 1 July 2012; and
 - ii. moving over time to payment on an ABF basis against state-specific prices and transitioning to payment against a national efficient price.
3. Key timeframes in the transition to nationally consistent ABF will be as follows:
 - a. over 2010–11:
 - i. the Commonwealth will work with State governments to determine the current and projected future costs of delivering public hospital services, to calibrate the financial transfers required to meet 60 per cent of recurrent expenditure as outlined in provision 4;
 - ii. the IHPA will commence assessment and classification of outpatient services, as outlined in provision E13;
 - iii. costing methodologies for block funding will be finalised and agreed, as outlined in provisions E11-E12; and
 - iv. funding methodologies for training and research activities will be finalised by the IHPA;
 - b. from 1 July 2011, the Commonwealth will increase its funding contribution to 60 per cent of actual recurrent expenditure on public hospital services, research and training, and capital under agreed arrangements in the transition to the user cost of capital approach;
 - c. over 2011-12:
 - i. the Commonwealth’s payments will be made to State governments to provide to public hospitals and LHNs where they have been established;
 - ii. the IHPA will commence development of the national efficient price and relevant cost weights for admitted acute patient services, as outlined in provision E8;

- iii. the IHPA will commence calculation of block funding levels according to the agreed costing methodology, as outlined in provision E11-E12; and
 - iv. the IHPA will commence calculation of funding for training and research activities;
 - d. from 1 July 2012, for admitted acute patient services the Commonwealth will shift its funding to payment on an ABF basis against state-specific prices to be paid to LHNs through the Funding Authority in each State;
 - e. over 2012-13:
 - i. the IHPA will develop advice on the process of transition to the national efficient price, as outlined in provision E10; and
 - ii. the IHPA's assessment and classification of outpatient services will be finalised as outlined in provision E13, and ABF for those relevant services will begin; and
 - f. from 1 July 2012, for emergency department, outpatient, sub-acute and non-acute services, the Commonwealth will shift its funding to payment on an ABF basis using proxy-based state-specific prices and moving, as this becomes feasible, to payment on an ABF basis against state-specific prices to be paid to LHNs through the Funding Authority in each State.

APPENDIX 3 – HOME AND COMMUNITY CARE (HACC) AND RELATED PROGRAMS

Parties

1. These reforms apply for the Commonwealth, the state of New South Wales, the state of Queensland, the state of South Australia, the state of Western Australia, the state of Tasmania, the Australian Capital Territory, and the Northern Territory.
2. The state of Victoria is not a party to these reforms. Within Victoria the existing arrangements will remain in place until otherwise determined for funding and delivering HACC, packaged community and residential aged care, and specialist disability services under the National Disability Agreement.
3. References to 'the States' in this appendix do not include the state of Victoria.
4. A new National Partnership agreement consistent with the framework for federal financial relations will be agreed between the Commonwealth and Victoria to govern arrangements for the HACC program within Victoria from 1 July 2011.

Objectives

5. To improve client services in community aged care and disability services by enabling the creation of integrated and coordinated care systems that are easier for clients to access and navigate, and respond more flexibly to clients' changing care needs.

Scope

6. These changes clarify the responsibilities of governments in relation to the jointly-funded Home and Community Care (HACC) program, which provides basic community care services, Commonwealth funded and managed community and residential aged care, and certain specialist disability services funded through the National Disability Agreement and managed by States.
7. A clean split of responsibilities for these national aged care and disability services programs at age 65 (age 50 years or over for Indigenous people) is intended to avoid the complications that arise in situations where responsibility for funding services to address a particular care need rely on an assessment of the causes and age of onset of that care need. It is not intended that this split of responsibilities by age be carried through into programs outside those mentioned at provisions 9 and 10 of this Appendix.

Simplified government responsibilities

8. The SPP for the jointly-funded HACC program will cease on 30 June 2011. Governments will take on the following funding and program responsibilities to enable the creation of a national aged care system and national disability services system, subject to specific implementation arrangements.
9. The Commonwealth will assume:
 - a. funding and program responsibility from 1 July 2011 for basic community care services for people 65 years and over (50 years and over for Indigenous Australians), in line with its responsibility for the rest of the national aged care system (packaged community care, respite care, and residential care); and
 - b. funding responsibility from 1 July 2011 for specialist disability services delivered under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians).
10. 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), in line with their principal responsibility for delivery of other disability services under the National Disability Agreement. The roles and responsibilities, performance indicators and annual reporting provisions of the National Disability Agreement will be amended to include coverage of these former HACC services for people under the age of 65 years. The Commonwealth will continue to contribute funding to the States for specialist disability services through the Disability Services Specific Purpose Payment. Current arrangements for access to disability services under the National Disability Agreement for people 65 years and over (50 and over for Indigenous Australians) will remain unchanged; 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 for Indigenous Australians). Current arrangements for access to Commonwealth aged care services for people under 65 will remain unchanged.
11. The Commonwealth and States will share program responsibility for community care and residential care services for Indigenous Australian clients aged 50 to 64 years. Indigenous Australians in this age group will be able 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 with a functional limitation aged 50 years to 64 seeking community or residential care services. Where care services are provided under a state or territory funded program to an Indigenous person 50 years or older, the Commonwealth will meet the cost of the service.
12. Each level of government will continue to deliver basic community care services for the client groups under its responsibility. There is no requirement for services to be delivered under competitive tender processes.

Roles and responsibilities of each party

13. The clarifications to roles and responsibilities set out below should be read together with the broader roles and responsibilities of governments detailed in the National Healthcare Agreement and National Disability Agreement.
14. The Commonwealth is responsible for:
 - a. regulating packaged community and residential aged care delivered under Commonwealth aged care programs, as currently;
 - b. funding packaged community and residential aged care delivered under Commonwealth aged care programs for people aged 65 years and over, as currently;
 - c. funding and regulating basic community care services for people aged 65 years and over;
 - d. funding basic community care services for Indigenous Australians aged 50 years and over; and
 - e. funding specialist disability services delivered under the National Disability Agreement for people aged 65 years and over and for Indigenous Australians aged 50 years and over.
15. States are responsible for:
 - a. regulating specialist disability services delivered under the National Disability Agreement, as currently;
 - 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 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.
16. The Commonwealth and States share responsibility for providing continuity of care across health services, aged care and disability services to ensure smooth client transitions.

Implementation arrangements

17. 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. The first phase of the implementation will include commitments from all governments to continue to deliver the current HACC Triennial Plans for each jurisdiction (end 30 June 2011). The Commonwealth will work with States to develop new funding arrangements to come into effect from 1 July 2011, 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.

18. 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 both during the implementation period and beyond, as many do now.
19. The process for reconciliation of State government funding of packaged community and residential aged care services to people under the age of 65 years, and Commonwealth funding of specialist disability services for people 65 years and over, would involve the exchange of invoices and payments between levels of government under bilateral funding agreements. These arrangements would therefore have little or no direct impact on service providers and clients.

APPENDIX 4 – FUTURE WORK PLAN

Provisional workplan

The provisional workplan set out below reflects the tasks, processes, timing and role allocation outlined in the provisions of this Agreement. The workplan will be developed by Senior Officials.

Task	Process for resolution	Timing	By whom (indicative)
Public hospitals and LHNs			
Establish LHNs	Establish LHNs as separate legal entities under state or territory legislation. A4	Commence 2010-11	State governments
Determine the size and location of LHNs	The final number and boundaries of LHNs will be resolved, consistent with PHCO boundaries where appropriate. A6-A7	By 31 December 2010	Bilaterally between State Health Ministers and the Commonwealth Health Minister
Establish Funding Authority in each State	Agree detailed implementation arrangements regarding the establishment of joint intergovernmental authorities in each State. A8		COAG
Governing Council composition review	Review of the alignment between the actual composition of Governing Councils and the appointment criteria set out in provision A10(b). A12		COAG, based on advice commissioned by NPA
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. A14		Health Ministers
ACT/NT arrangements	Territories to enter parallel LHN arrangements with the Commonwealth. A16		ACT/NT bilateral negotiations with the Commonwealth
Determine payment process to LHNs	Determine detail of payment process, including payment frequency, reconciliation process and data provision process. A21		COAG

Task	Process for resolution	Timing	By whom (indicative)
Primary health care and PHCOs			
Determine scope of additional GP and primary health care services to be transferred to the Commonwealth. Determine arrangements for the transfer of agreed GP and primary health care services to the Commonwealth.	Undertake further work to determine whether the service types outlined in provisions B34 should be included for transfer to the Commonwealth.	Report to COAG in December 2010	Senior Officials Consultation with local government on transition arrangements
Determine arrangements for the transfer of agreed GP and primary health care services to the Commonwealth.	States to provide data on the current level of funding and service delivery arrangements for each of the services identified for transfer to the Commonwealth. B37(e) The Commonwealth and the States to agree on a transition plan for the transfer of services. B37	Report to COAG in December 2010	Senior Officials Consultation with local government on transition arrangements
Transfer of funding and policy responsibility for primary mental health care services	Undertake further work to determine the definition and timeframe for transfer of primary mental health care services. B37(c)		Tasmania
Patient Assistance Transport Schemes	Further work, with a view to higher and more consistent national standards. B35		The Commonwealth and the States
Arrangements for the HACC program within Victoria	Agree National Partnership consistent with the IGA FFR, as outlined in Appendix 2.	To govern arrangements from 1 July 2011.	The Commonwealth and Victoria
Establishment of PHCO boundaries	The final number and boundaries of PHCOs will be resolved, consistent with LHN boundaries where appropriate. B24	31 December 2010	Bilaterally between State Health Ministers and the Commonwealth Health Minister
PHCO governance and performance management approach	Develop appropriate governance arrangements and a performance management framework for PHCOs, consistent where appropriate with the performance framework for LHNs. B20-B21		The Commonwealth, in consultation with States

Task	Process for resolution	Timing	By whom (indicative)
Financing			
\$15.6 billion top-up payment commitment	Develop mechanism and timing. C3	In 2010-11	Treasurers for COAG agreement
Establish National Funding Authority	Establish as an independent statutory authority. C4	1 July 2011	The Commonwealth
Resolve implementation issues for GST dedication	Determine: <ul style="list-style-type: none"> • the method for allocating state expenditures to agreed definitions for hospital and GP and primary health care services; • reflecting the transition of the Healthcare SPP to an equal per capita payment in 2014-15; • whether indexation of dedicated GST should apply to actual amounts per capita; and • the treatment of capital in determining dedicated GST. C5 		HoTs to advise Treasurers
Determine CGC treatment of Commonwealth top-up and GP and primary health care payments	Determine CGC treatment of relevant payments. C9-C10		HoTs to advise Treasurers
Mechanism to ensure expenditure level during transition	Further develop mechanisms to ensure that appropriate levels of health expenditure are maintained until the end of 2013-14. C12		Treasurers
User cost of capital approach to capital funding	Undertake work to develop in more detail: <ul style="list-style-type: none"> • the framework and practical mechanisms for incorporating the user cost of capital into ABF; • the transitional arrangements to this payment mechanism; and • the detailed responsibilities of the IHPA with respect to capital. C15 		Treasurers work through Heads of Treasury (supported by an expert reference group), to provide advice to COAG
Detailed costings and GST dedication	Report back to COAG on: <ul style="list-style-type: none"> • alignment of jurisdictional budget data and program specification; and • systems specification and development. 	Treasurers report back to COAG out of session by 1 July 2010, for	COAG to agree Treasurers' report, with issues pursued through Heads of Treasuries in the first instance, with advice to feed into

Task	Process for resolution	Timing	By whom (indicative)
	Outline a detailed work program and making further recommendations to ensure that the necessary data work is completed for further consideration by COAG. C16	consideration at December 2010 COAG meeting	Senior Officials implementation arrangements
Amendment of IGA FFR	Amend to reflect the arrangements outlined in this Agreement, and in particular to provide for the dedication of a proportion of GST to health care. Amend the Federal Financial Relations Act 2009 to reflect changes to the IGA FFR. C17	ASAP (out of session)	COAG and the Commonwealth
Treatment of transitional and consequential matters	The Commonwealth and States will agree on approach to the treatment of these matters. C18		The Commonwealth and the States
Treatment of private patients in public hospitals	Clarify and resolve the funding implications, and resolve any necessary consequences. C19	During 2010-11, for any changes to be implemented with the relevant reforms on 1 July 2011.	The Commonwealth and the States
Cross-border service delivery	Clarify and resolve the funding implications, and resolve any necessary consequences. C20	During 2010-11, for any changes to be implemented with the relevant reforms on 1 July 2011.	The Commonwealth and the States

Task	Process for resolution	Timing	By whom (indicative)
National governance (IHPA)			
IHPA final terms of reference	Develop final terms of reference. E6		COAG through Senior Officials, subject to consultation with Health Ministers and Heads of Treasuries
Establish IHPA	Pass legislation establishing the IHPA, in line with the functions and responsibilities outlined in Schedule E, and the final terms of reference agreed by COAG. E4	To be established from 1 July 2011	Commonwealth Government
ABF transition	Develop transition process from state specific to national efficient price, as outlined in Appendix 2. E10		The IHPA to provide advice to COAG
Block funding calculation methodology	Advice on definition and typology of public hospitals eligible for: <ul style="list-style-type: none"> • block funding only; • mixed ABF and block funding; and • ABF only. Develop a block-funding calculation model. E12		The IHPA to provide advice to COAG for decision. The IHPA to develop a block funding calculation model for agreement by COAG.
ABF for outpatient services	Assess and classify outpatient services, to distinguish between those services that are acute care related and those that are better characterised as primary health care. E13		The IHPA to provide advice to COAG for decision
Binding IHPA determinations on cost-shifting	Develop and agree further details, including mechanisms to enforce the binding nature of the determinations. E17	2010-11	COAG
Performance and accountability framework and national governance (performance monitoring)			
Establish NPA	Establish as an independent Commonwealth statutory authority. E23	1 July 2011	The Commonwealth
Expanded ACSQHC role to develop national clinical safety and quality standards	Reach detailed agreement on scope and financial implications. E29		Health Ministers
Develop structure and approach to Performance Reports	Hospital Performance Reports and Healthy Communities Reports on the performance of every LHN, the hospitals within it, every private hospital and every PHCO. D3		COAG

Task	Process for resolution	Timing	By whom (indicative)
Develop service and financial performance standards	Drawing on NHA performance indicators where possible. D3		COAG
Develop clinical standards	ACSQHC to develop clinical standards. D3		ACHQSC
Set new National Standards	Selected national standards will be set in areas such emergency departments and elective surgery. D4		COAG
AIHW website	Make publicly available hospital-level data on performance. D9		AIHW. Health Ministers to agree data to be published.

APPENDIX 5: LIST OF ACRONYMS

ABF – Activity Based Funding

ACSQHC – Australian Commission on Safety and Quality in Health Care

AIHW – Australian Institute of Health and Welfare

CEO – Chief Executive Officer

CGC – Commonwealth Grants Commission

COAG – Council of Australian Governments

CRC – COAG Reform Council

GP – General Practitioner or General Practice

GST – Goods and Services Tax

HACC - Home and Community Care

Health SPP – Healthcare Specific Purpose Payment

IGA FFR – Intergovernmental Agreement on Federal Financial Relations

IHPA – Independent Hospital Pricing Authority

LHN – Local Hospital Network

NPA – National Performance Authority

NHA – National Health Agreement