NATIONAL PARTNERSHIP ON COVID-19 RESPONSE

An agreement between

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

This Agreement will contribute to supporting the Australian health system to respond effectively to the outbreak of Novel Coronavirus (COVID-19).

National Partnership on COVID-19 Response

OVERVIEW

1. This National Partnership (the Agreement) is created subject to the provisions of the Intergovernmental Agreement on Federal Financial Relations (IGA FFR) and should be read in conjunction with that Agreement and its Schedules, which provide information in relation to performance reporting and payment arrangements under the IGA FFR.

Purpose

2. In entering this Agreement, the Commonwealth and the States and Territories (the States) recognise that they have a joint responsibility to act to protect the Australian community by ensuring that the health system can respond effectively to the outbreak of Novel Coronavirus (COVID-19).

3. The Commonwealth and States commit to working together to respond to the outbreak of COVID-19 and minimise the risk to the people of Australia and keep the community safe, in line with existing government responsibilities for the health system.

4. The Commonwealth and States will respond to the outbreak through the Australian Health Sector Emergency Response Plan for Novel Coronavirus (AHSERP), the broader healthcare sector and existing mechanisms including the National Health Reform Agreement, as amended by the 2017 Addendum of the NHRA and the 2020-21 to 2024-25 Addendum to the NHRA once in operation (the NHRA).

5. This Agreement is separate from, but will complement, the NHRA and will provide states funding to respond to the COVID-19 outbreak. This is in recognition of the costs and burden incurred by state health services (including but not limited to public hospitals, contracting of existing private hospitals, primary care, aged care and any other community expenditure).

Reporting Arrangements

6. The States will report as set out in Part 5 – Financial Arrangements.

Financial Arrangements

7. The Commonwealth will provide a financial contribution to the States as set out in Part 5 – Financial Arrangements, in relation to COVID-19 expenditure incurred by any state from 21 January 2020, when Human Coronavirus with pandemic potential was made a Listed Human Disease under the *Biosecurity Act 2015*.

PART 1 – FORMALITIES

Parties to this Agreement

8. This Agreement is between the Commonwealth of Australia (the Commonwealth) and the States and Territories (the States).

Term of the Agreement

9. This Agreement commenced on 13 March 2020, when the Commonwealth and all States signed it.

    a. The amendments relating to the financial viability payment for private hospitals will commence when the Commonwealth and a State agree.

10. The Agreement will operate for the period of the activation of the Australian Health Sector Emergency Response Plan for Novel Coronavirus 2019 (COVID-19 plan) as declared by the Australian Health Protection Principal Committee (AHPPC), and then for sufficient additional time to allow for the final reconciliation of any payments made under this Agreement.

11. The Agreement may be terminated earlier or extended as agreed in writing by the Parties.

PART 2 – OBJECTIVES, OUTCOMES AND OUTPUTS

Objective

12. The objective of this Agreement is to provide financial assistance for the additional costs incurred by state health services in responding to the COVID-19 outbreak, including as a result of the diagnosis and treatment of patients with COVID-19 or suspected of having COVID-19, and efforts to minimise the spread of COVID-19 in the Australian community.

Outcomes

13. This Agreement will facilitate achievement of the following outcomes:

    a. The capacity of our health system is lifted to effectively assess, diagnose and treat people with COVID-19 while minimising the spread of the disease in the community;

    b. People at risk from COVID-19 can access essential health care in a way that reduces their potential exposure to infection; and

    c. Guarantee the viability of private hospitals, to retain capacity for responding to COVID-19 and enable them to resume operations at the end of the pandemic.

Outputs

14. The objectives and outcomes of this Agreement will be achieved by:

    a. the provision of health services by the Parties to effectively manage the COVID-19 outbreak; and

    b. the transfer of payments by the Commonwealth to States to facilitate that provision.

PART 3 – ROLES AND RESPONSIBILITIES OF EACH PARTY

15. In managing the outbreak the Commonwealth and States will refer to roles and responsibilities as outlined in the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)*, and to the division of responsibilities as set out in Schedule A and Schedule B to this Agreement.

16. This Agreement reaffirms that responsibility for health is shared between the Commonwealth and the States.

    a. The States will remain system managers for public hospitals and will remain responsible for their infrastructure, operation, delivery of services and performance;

    b. The Commonwealth will continue to have lead responsibility for general practice (GP) and primary health care, including the Primary Health Networks, aged care and continue to support private health services through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS), the Private Health Insurance Rebate; and

    c. All governments have a shared responsibility to integrate systems and services to improve health outcomes for Australians, acknowledging the interoperability of the health system, as well as areas such as aged care and disability services.

17. The Commonwealth and States recognise that during this emergency response to COVID-19 there is the need for governments to flexibly respond to the outbreak as it unfolds. The parties to this Agreement will continue to work together in preparing, planning and reviewing resourcing requirements and funding arrangements for all health services.

18. The Commonwealth and the States recognise there is the need for an integrated health system to effectively and flexibly respond to COVID-19. Public and private hospitals need to work through an integrated system to increase capacity to respond to the demand from COVID-19 and to ensure the sustainability and viability of the private hospital sector.

19. As system managers of public hospitals, each State will enter into agreements with existing private hospitals (including day hospitals) within their jurisdiction, through a consistent agreement, to ensure there is:

    a. increased capacity for the Commonwealth and States to rapidly respond to COVID-19; and

    b. the viability of private hospitals is maintained during the COVID-19 pandemic and they are able to resume operations once the pandemic response ends.

20. The Commonwealth and States agree to use existing governance and consultation arrangements of the National Health Reform Agreement, as amended by the 2017 Addendum of the NHRA and the 2020-21 to 2024-25 Addendum to the NHRA once in operation (the NHRA), to manage implementation and to identify and resolve issues associated with this Agreement.

PART 4 – PERFORMANCE MONITORING AND REPORTING

21. Performance monitoring and reporting will be in accordance with Part 5 of this Agreement.

PART 5 – FINANCIAL ARRANGEMENTS

Overarching Arrangements

22. There will be three sets of payments provided by the Commonwealth to the States under this Agreement, and financial contribution rates for COVID-19 related activities and services are outlined at Schedule A:

    a. The Upfront Advance Payment – the Commonwealth will provide an upfront advanced payment of $100 million to the States to be paid on a population share basis. This is payable to the individual State when they sign and commit to the Agreement. This is an advance payment to ensure the timely availability of funds under this Agreement and other payments will be adjusted to reflect the prospective nature of the payment.

    b. Hospital Services Payments – the Commonwealth will provide a 50 per cent contribution for costs incurred by States, through monthly payments, for the diagnosis and treatment of COVID-19 including suspected cases. This payment will be provided monthly based on estimates provided by States and reconciled three monthly against actual expenditure.

        i. This payment will also include a 50 per cent contribution from the Commonwealth to the States for costs related to hospital services delivered to public patients in private hospitals.

    c. The State Public Health Payments – the Commonwealth will provide a 50 per cent contribution for costs incurred by States, through monthly payments, for other COVID-19 activity undertaken by State public health systems for the management of the outbreak. This is in addition to public health funding provided through the NHRA once in operation. This payment will be provided monthly based on estimates provided by States and reconciled three monthly against actual expenditure.

        i. Under the State Public Health Payment a 100 per cent contribution will be paid to the States for costs incurred from 31 March 2020, to ensure the minimum viability of private hospitals, in accordance with Schedule B.

        ii. Under the State Public Health Payment, an Upfront Payment, which is a minimum funding amount, will be paid to the States per vaccination dose delivered at the agreed price, in accordance with Schedule C.

        iii. Under the State Public Health Payment, a contribution will be paid to the States per vaccination dose delivered at the agreed price, in accordance with Schedule C.

23. The Parties agree that the payments set out in this Agreement will flow through the National Health Funding Pool, as per Clause B22 of the NHRA.

24. The Parties agree that the NHRA is amended to :

    a. specify payments under this Agreement will be paid into the National Health Funding Pool; and

    b. provide for the functions of the Administrator of the National Health Funding Pool (the Administrator) to extend to the administration and reconciliations of the payments set out in this Agreement.

25. The Parties agree that the Independent Hospital Pricing Authority (IHPA) must have regard to the operation of this Agreement.

26. The Administrator shall determine what constitutes activity that is attributable to the response to COVID-19 and what constitutes in-scope and out-of-scope public hospital activity on the basis of advice from IHPA and, where necessary, in consultation with the Parties.

27. The Parties agree that any public hospital or other health service that attracts Commonwealth funding through this Agreement will not be eligible for funding through the NHRA.

28. Parties agree that payments under this Agreement are to be considered payments under the NHRA. For this Agreement, the following arrangements supersede the relevant clauses in the NHRA:

    a. any payment made under this Agreement will not be included for the purpose of calculating the National Funding Cap and the Soft Caps under the NHRA;

    b. while the operation of Clause I24 (which limits the amount that can be paid to a state in a year to its soft cap) will continue for other payments under the NHRA, it will not operate with respect to any payments under this Agreement.

    c. any payment made under this Agreement will not be included for the purpose of calculating the Commonwealth's Funding Entitlement under the NHRA for a financial year; and

    d. any payment made under this Agreement in a financial year will not be included as part of a State's base funding entitlement for the next financial year.

The Upfront Advance Payment to assist with COVID-19

29. The Commonwealth agrees to pay into the National Health Funding Pool for each State an Upfront Advance Payment for an amount as set out in the table below.

New South Wales	$ 31,899,187
Victoria	$ 26,005,094
Queensland	$ 20,091,356
Western Australia	$ 10,337,993
South Australia	$ 6,907,399
Tasmania	$ 2,106,814
Australian Capital Territory	$ 1,682,629
Northern Territory	$ 969,528

30. Payment from the Commonwealth will occur to each state as soon as is practicable following the signature between that State and the Commonwealth.

31. Once the Upfront Advance Payment is paid into the National Health Funding Pool by the Commonwealth, the Administrator will provide to each State their payment from the Pool.

32. As this payment is an advance payment, future hospital services or state public health payments will be adjusted to reflect the prospective nature of the payment.

The Hospital Services Payment

33. For the duration of this Agreement, each State agrees to provide the Administrator a forecast of their state public hospital systems' activity for each month prior to the beginning of that month.

    a. This forecast will be for activity that is estimated to be attributable to the diagnosis and treatment of Medicare-eligible patients with COVID-19 or suspected of having COVID-19.

    b. This forecast can also include elective surgeries that have been rescheduled to free up public hospital capacity to respond to the COVID-19 outbreak, but the volume of elective surgeries included in this forecast shall only be for that number of elective surgeries above the amount performed in the State's public hospital system in 2018-19.

    c. This forecast shall only be for state public hospital system activity that would otherwise be considered in-scope public hospital activity under the operation the NHRA.

    d. This forecast will be expressed in that financial year's Nationally Weighted Activity Units (NWAU), as per the relevant financial year's National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations by IHPA.

    e. This forecast may include activities related to the care of public patients being treated in private hospitals, at the direction of the Commonwealth and States as part of the

response to COVID-19. This includes patients who have been diagnosed with COVID-19 or have had their care provided in a private hospital for other reasons (such as to free up capacity for public hospitals to treat patients diagnosed with COVID-19).

34. As an exception to Clause 33 above, the first monthly payment will instead cover expenditure for the period from 21 January 2020 to 30 March 2020. States will work with the Administrator as quickly as is practicable to establish arrangements for estimating eligible activity for that period.

35. The Administrator will advise the Commonwealth Treasurer in writing of the Hospital Services Payment Estimate amount for each State for a month, by multiplying the State-provided estimated NWAU by the relevant financial year's NEP and then further multiplying the product by 50 per cent.

36. The Commonwealth agrees that it will pay the Hospital Services Payment Estimate amount for each State for a month into the National Health Funding Pool in the next available payment round in accordance with Schedule D of the Intergovernmental Agreement on Federal Financial Relations after receiving advice from the Administrator.

    a. Once paid into the National Health Funding Pool by the Commonwealth, the Administrator will provide to each State that quarter's Hospital Services Payment Estimate amount from the Pool.

37. Each State agrees to provide the Administrator (through the IHPA portal) with relevant cost and activity sets that support the Administrator's advice to the Commonwealth Treasurer as detailed in Clause 38.

    a. Activity data will be reported no later than 90 days following the completion of a financial quarter and shall only include activity that is attributed to the diagnosis and treatment of Medicare-eligible patients with COVID-19 or suspected of having COVID-19.

    b. Estimated actual cost data will be provided on a best endeavours basis, no later than 90 days following the completion of a financial quarter, with actual cost data provided to the Administrator as part of usual NHRA reconciliation timeframes.

    c. This data shall also include elective surgeries that have been rescheduled to free up public hospital capacity to respond to the COVID-19 outbreak, but the volume of elective surgeries included in this forecast shall only be for that number of elective surgeries above the amount performed in the State's public hospital system in 2018-19. This data set shall be of a format that allows the Administrator to derive the NWAU of individual episodes of care in accordance with the relevant financial year's NEP and NEC.

    d. If the Administrator and IHPA consider that the NEP as determined for the relevant financial year by IHPA does not adequately price episodes of care for COVID 19, the IHPA will develop a more accurate pricing before deriving the NWAU at this step. This may include consideration of the pricing of services contracted to private hospitals in relation to this Agreement.

    e. This data set shall only include state public hospital system activity that would be considered in-scope public hospital activity under the operation of the NHRA.

f. Each State will provide the Administrator with a statement of data quality for estimated actual cost data submissions and a statement of assurance on final data submissions as part of the usual NHRA reconciliation process and timeframes.

38. The Administrator will advise the Commonwealth Treasurer in writing of the Hospital Services Payment Actual amount for each State for a financial quarter, by multiplying the Administrator-derived NWAU by the relevant financial year's NEP and then further multiplying the product by 50 per cent.

    a. The Commonwealth will not fund patient services through this Agreement if the same service, or any part of the same service, is funded through MBS, the PBS and Private Health Insurance Rebate or any other Commonwealth program. The Administrator is to ensure that there are appropriate processes in place to ensure that the same service is not paid for twice for the duration of this Agreement.

       In developing this advice, the Administrator will apply the same rules as required by clauses A6 and A7 of the NHRA.

    b. As part of this advice, the Administrator will also advise of the difference between the quarterly Hospital Services Payment Actual and quarterly Hospital Services Payment Estimate amount (which is the sum of the estimates for the relevant months) for each State, this being the quarterly Hospital Services Payment Reconciliation amount for each State.

    c. The Hospital Services Payment Reconciliation amount for the first quarter will be adjusted to take into account the amount of the Upfront Advance Payment.

39. If the quarterly Hospital Services Payment Reconciliation amount for a State is positive (that is, the Hospital Services Payment Actual is greater than the quarterly Hospital Services Payment Estimate), the Parties agrees that the Commonwealth will pay the quarterly Hospital Services Payment Reconciliation amount into the National Health Funding Pool no later than the next regular payment to states in accordance with schedule D of the Intergovernmental Agreement on Federal Financial Relations after receiving the advice from the Administrator.

40. If the quarterly Hospital Services Payment Reconciliation amount for a State is negative (that is, the Hospital Services Payment Actual is less than the quarterly Hospital Services Payment Estimate), the Parties agrees that the Commonwealth will deduct the quarterly Hospital Services Payment Reconciliation amount from the next quarter Hospital Services Payment Estimate.

    a. Should this not be possible (for instance there are no further quarterly Hospital Services Payment Estimates to be made) the Parties agree that the Commonwealth will deduct the amount owing from its next NHRA payment.

The State Public Health Payment

41. For the duration of this Agreement, each State agrees to provide the Administrator an estimate of the funding required for their state public health systems' activity for that month attributable to the treatment of patients with diagnosed or suspected COVID-19 or for activities directed at preventing the spread of COVID 19.

    a. This estimate shall only be for be for activity that would not receive a Commonwealth contribution through the Hospital Services Payment or the NHRA.

b. This funding estimate can include public health activities detailed at Schedule A and Schedule B.

c. Where the Commonwealth and a State agree that an aged care facility has needed or will need a temporary staffing surge due to COVID-19, the State may include these costs in the monthly State Public Health Payment Estimate.

    i. For the first three days of an aged facility being under such an arrangement, the Commonwealth agrees to provide the State with 50 per cent of the estimated monthly funding required for that facility.

    ii. If an aged care facility is under such an arrangement, the Commonwealth agrees to provide the State with 100 per cent of the estimated monthly funding required for that facility.

    iii. The Commonwealth can decide that an aged care facility is no longer in need of a temporary staffing surge due to COVID-19 at any time, but will generally do so on advice from the relevant State.

d. From 3 April 2020, the State Public Health Payment Estimate may include the estimated Financial Viability Payments for all private hospitals in that State, for which the Commonwealth agrees to provide the State 100 per cent of the estimated monthly funding. The first payment in relation to these costs will be provided as soon as possible after 3 April 2020.

e. From 3 April 2020, the State Public Health Payment Estimate may include the estimated costs of a private hospital delivering any services, workforce, equipment or other assistance with the COVID-19 response.

    i. Where the Commonwealth has requested a State to facilitate this to meet a Commonwealth responsibility. In these cases, the Commonwealth will provide, the State 100 per cent of the estimated monthly funding.

    ii. These estimates should not include costs of any services covered under the Hospital Services Payment, and must not duplicate any other payments made to a Private Hospital by the Commonwealth (including the JobKeeper payment), the States, any other government, revenue or insurance received.

    iii. This arrangement is intended to contribute only to ongoing viability and not profits or loan or debt repayments.

    iv. The first payment in relation to these costs will be provided as soon as possible after 3 April 2020.

f. From 15 February 2021, the State Public Health Payment Estimate may include estimated or actual vaccination doses delivered in the month prior under the Vaccination Dose Delivery Payment as outlines in Schedule C.

42. The Administrator will advise the Commonwealth Treasurer in writing of the State Public Health Payment Estimate amount for each State for a month, on the basis of the forecast of funding requirements provided by each the State.

43. The Commonwealth agrees that it will pay the State Public Health Payment Estimate amount for each State monthly into the National Health Funding Pool no later than the next regular

payment to states in accordance with Schedule D of the Intergovernmental Agreement on Federal Financial Relations after receiving the advice from the Administrator.

a. Once paid into the National Health Funding Pool by the Commonwealth, the Administrator will provide to each State that month's State Public Health Payment Estimate amount from the Pool.

44. States agree to provide the Administrator with an actual funding requirement data set, on a best endeavours basis, no later than 90 days following the completion of a financial quarter, that sets out the actual state public health systems' activity for that quarter that is estimated to be attributable to the treatment of patients with diagnosed or suspected COVID-19 or for activities directed at preventing the spread of COVID 19, and that supports the Administrator's advice to the Commonwealth Treasurer as detailed in Clause 46.

a. This data set will not include any activity that is in receipt of a Commonwealth contribution through the Hospital Services Payment, the NHRA, the MBS, the PBS and Private Health Insurance Rebate or any other Commonwealth program.

b. Each State will provide the Administrator with a statement of assurance for this data set.

45. In relation to private hospitals, the State agrees to provide to the Administrator, no later than 90 days following the completion of a financial quarter:

a. a report demonstrating how the state has ensured that as much as possible of the available private hospital workforce has been deployed to assist with the COVID-19 response; and

b. a report prepared by an independent auditor, including:

i. The total amount of revenue received by each private hospital, including any revenue from activities under the Hospital Services Payment, Private Health Insurance, Medicare and other activities, which is to be deducted from the estimated Financial Viability Payment.

ii. Confirmation that the Financial Viability Payment for each private hospital has been the minimum to ensure viability and retention of staff, and does not include any provision for profit, loan repayments, or any other expenses not consistent with this principle or with Schedule B.

iii. Confirmation that each private hospital has met all conditions required by the Commonwealth under this Agreement, as detailed in Schedule B.

46. In relation to the Vaccination Dose Delivery Payment, the State agrees to provide the Administrator, no later than 90 days following the completion of a financial quarter:

a. Activity data that is attributable to vaccination dose deliver and reported in line with requirements set out in Schedule C.

b. A Statement of Assurance outlining how the State has met its responsibilities outlines in the Australian COVID-19 Vaccination Policy, agreed jurisdictional implementation plans, and the Australian Government's COVID-19 Vaccine National Roll-out Strategy.

47. The Administrator will advise the Commonwealth Treasurer in writing of the State Public Health Payment Actual amount for each State for a month.

    a. The Commonwealth will not fund patient services through this Agreement if the same service, or any part of the same service, is funded through the MBS, the PBS and Private Health Insurance Rebate or any other Commonwealth program. The Administrator is to ensure that there are appropriate processes in place to ensure that the same service is not paid for twice for the duration of this Agreement.

       In developing this advice, the Administrator will apply the same rules as required by clauses A6 and A7 of the NHRA.

    b. As part of this advice, the Administrator will also advise of the difference between the quarterly State Public Payment Health Actual and quarterly State Public Health Payment Estimate amount for each State (which is the sum of the estimates for the relevant months), this being the quarterly State Public Health Payment Reconciliation amount for each State.

48. If the quarterly State Public Health Payment Reconciliation amount for a State is positive (that is, the State Public Health Payment Actual is greater than the quarterly State Public Health Payment Estimate), the Parties agrees that the Commonwealth will make pay the quarterly State Public Health Payment Reconciliation amount in to the National Health Funding Pool no later than the next regular payment to states in accordance with Schedule D of the Intergovernmental Agreement on Federal Financial Relations after receiving the advice from the Administrator.

49. If the quarterly State Public Health Payment Reconciliation amount for a State is negative (that is, the State Public Health Payment Actual is less than the quarterly State Public Health Payment Estimate), the Parties agrees that the Commonwealth will deduct the quarterly State Public Health Payment Reconciliation amount from the next quarter State Public Health Payment Estimate.

    a. Should this not be possible (for instance there are no further quarterly State Public Health Payment Estimates to be made) the Parties agree that the Commonwealth will deduct the amount owing from its next NHRA payment.

PART 6 – GOVERNANCE ARRANGEMENTS

Enforceability of the Agreement

50. The Parties do not intend any of the provisions of this Agreement to be legally enforceable. However, this does not lessen the Parties' commitment to this Agreement.

Variation of the Agreement

51. The Agreement may be amended at any time by agreement in writing by all the Parties.

52. In relation to the States contracting of private hospitals, this aspect of the Agreement will be reviewed by 30 September 2020, to ensure it is meeting the objectives of all Parties.

53. A Party to the Agreement may terminate their participation in the Agreement at any time by notifying all the other Parties in writing.

Dispute resolution

54. Any Party may give notice to other Parties of a dispute under this Agreement.

55. Officials of relevant Parties will attempt to resolve any dispute in the first instance.

56. The States and Commonwealth agree to resolve any financial disputes to ensure each party is not unduly left with carrying significant financial risk, particularly in relation to private hospital arrangements.

57. If a dispute cannot be resolved by officials, it may be escalated to the relevant Ministers.

AMENDMENTS TO THE BODY OF THE NATIONAL PARTNERSHIP ON COVID-19 RESPONSE

Current	Amendments
22c. The State Public Health Payments – the Commonwealth will provide a 50 per cent contribution for costs incurred by States, through monthly payments, for other COVID-19 activity undertaken by State public health systems for the management of the outbreak. This is in addition to public health funding provided through the NHRA once in operation. This payment will be provided monthly based on estimates provided by States and reconciled three monthly against actual expenditure. i Under the State Public Health Payment a 100 per cent contribution will be paid to the States for costs incurred from 31 March 2020, to ensure the minimum viability of private hospitals, in accordance with Schedule B.	**Addition** ii. Under the State Public Health Payment a 100 per cent contribution will be paid to the States for costs incurred from 1 July 2020 for support for Aged Care Prevention, Preparedness and Response activities and additional targeted Infection Prevention and Control Training in accordance with Schedule D.
41. For the duration of this Agreement, each State agrees to provide the Administrator an estimate of the funding required for their state public health systems' activity for that month attributable to the treatment of patients with diagnosed or suspected COVID-19 or for activities directed at preventing the spread of COVID 19. a. This estimate shall only be for be for activity that would not receive a Commonwealth contribution through the Hospital Services Payment or the NHRA. b. This funding estimate can include public health activities detailed at Schedule A and Schedule B. c. Where the Commonwealth and a State agree that an aged care facility has needed or will need a temporary staffing surge due to COVID-19, the State may include these costs in the monthly State Public Health Payment Estimate. i For the first three days of an aged facility being under such an arrangement, the Commonwealth agrees to provide the State with 50 per cent of the estimated monthly funding required for that facility.	**Addition** f. From 1 February 2021, the State Public Health Payment Estimate may include the estimated Support for Aged Care Preparedness and Response activities, and additional targeted Infection Prevention and Control Training outlined in Schedule D, for which the Commonwealth agrees to provide the State 100 per cent of the estimated monthly funding. This may include back-dated amounts for activities that incurred on or after 1 July 2020.

Current	Amendments
ii If an aged care facility is under such an arrangement, the Commonwealth agrees to provide the State with 100 per cent of the estimated monthly funding required for that facility. iii The Commonwealth can decide that an aged care facility is no longer in need of a temporary staffing surge due to COVID-19 at any time, but will generally do so on advice from the relevant State. d. From 3 April 2020, the State Public Health Payment Estimate may include the estimated Financial Viability Payments for all private hospitals in that State, for which the Commonwealth agrees to provide the State 100 per cent of the estimated monthly funding. The first payment in relation to these costs will be provided as soon as possible after 3 April 2020. e. From 3 April 2020, the State Public Health Payment Estimate may include the estimated costs of a private hospital delivering any services, workforce, equipment or other assistance with the COVID-19 response. i Where the Commonwealth has requested a State to facilitate this to meet a Commonwealth responsibility. In these cases, the Commonwealth will provide, the State 100 per cent of the estimated monthly funding. ii These estimates should not include costs of any services iii covered under the Hospital Services Payment, and must not duplicate any other payments made to a Private Hospital by the Commonwealth (including the JobKeeper payment), the States, any other government, revenue or insurance received.	

Current	Amendments
iv This arrangement is intended to contribute only to ongoing viability and not profits or loan or debt repayments. v The first payment in relation to these costs will be provided as soon as possible after 3 April 2020.	
	New clause 46. In relation to the Aged Care Support Payment, the State agrees to provide to the Administrator, no later than 90 days following the completion of a financial quarter: a. Evidence of actual costs incurred by the State in delivering the activities set out in Schedule D. b. A Statement of Assurance by the relevant Senior Official demonstrating how the state has met the Commonwealth requirements for funding as outlined in Schedule D.

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

Signed *for and on behalf of the Commonwealth of Australia by*

The Honourable Josh Frydenberg MP
Treasurer of the Commonwealth of Australia

14 / 12 / 2021

Signed *for and on behalf of the State of New South Wales by*

The Honourable Matt Kean MP
Treasurer of the state of New South Wales

/ /

Signed *for and on behalf of the State of Victoria by*

The Honourable Tim Pallas MP
Treasurer of the state of Victoria

/ /

Signed *for and on behalf of the State of Queensland by*

The Honourable Cameron Dick MP
Treasurer of the state of Queensland

/ /

Signed *for and on behalf of the State of Western Australia by*

The Honourable Mark McGowan MLA
Premier and Treasurer of the state of Western Australia

/ /

Signed *for and on behalf of the State of South Australia by*

The Honourable Rob Lucas MLC
Treasurer of the state of South Australia

/ /

Signed *for and on behalf of the State of Tasmania by*

The Honourable Peter Gutwein MP
Premier and Treasurer of the state of Tasmania

/ /

Signed *for and on behalf of the Australian Capital Territory by*

Andrew Barr MLA
Chief Minister and Treasurer of the Australian Capital Territory

/ /

Signed *for and on behalf of the Northern Territory by*

The Honourable Michael Gunner MLA
Chief Minister and Treasurer of the Northern Territory of Australia

/ / 10 JAN 2022

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

Signed *for and on behalf of the Commonwealth of Australia by*

The Honourable Josh Frydenberg MP
Treasurer of the Commonwealth of Australia

14 / 12 / 2021

Signed *for and on behalf of the State of New South Wales by*

The Honourable Matt Kean MP
Treasurer of the state of New South Wales

/ /

Signed *for and on behalf of the State of Victoria by*

The Honourable Tim Pallas MP
Treasurer of the state of Victoria

/ /

Signed *for and on behalf of the State of Queensland by*

The Honourable Cameron Dick MP
Treasurer of the state of Queensland

10 / 02 / 2022

Signed *for and on behalf of the State of Western Australia by*

The Honourable Mark McGowan MLA
Premier and Treasurer of the state of Western Australia

/ /

Signed *for and on behalf of the State of South Australia by*

The Honourable Rob Lucas MLC
Treasurer of the state of South Australia

/ /

Signed *for and on behalf of the State of Tasmania by*

The Honourable Peter Gutwein MP
Premier and Treasurer of the state of Tasmania

/ /

Signed *for and on behalf of the Australian Capital Territory by*

Andrew Barr MLA
Chief Minister and Treasurer of the Australian Capital Territory

/ /

Signed *for and on behalf of the Northern Territory by*

The Honourable Michael Gunner MLA
Chief Minister and Treasurer of the Northern Territory of Australia

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SCHEDULE A

Roles and Responsibilities

All jurisdictions have public health responsibilities under the Constitution and the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19).*

All jurisdictions are committed to fulfilling their expectations under the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19).*

The Commonwealth will through programs separate from this Agreement provide 100 per cent of the funding for the following COVID-19 related activities:

- Respiratory clinics in the primary care setting;
- National central patient triage line;
- MBS items for telehealth and private pathology testing;
- Community pharmacy dispensing costs; and
- Aged care accommodation and additional temporary workforce requirements.

Financial arrangements for this Agreement

Hospital Payments

The Commonwealth will share the funding equally with state and territory governments for the following COVID-19 related hospital activities (in-scope hospital activities as defined by the NHRA):

- Respiratory clinics;
- Hospital services regardless of the setting – hospital, home or residential facility;
- Bringing forward elective surgery, including the purchase of public surgery in private hospitals, in excess of the elective surgery performed by a state or territory public hospital system in 2018-19; and
- Testing and diagnostics.

State Public health payments

The Commonwealth will share the funding equally with state and territory governments for the following COVID-19 related public health activities:

- Additional health services expenditure, including COVID 19-related costs of care outside hospitals, when providing health services to rural, remote and/or Indigenous patients;
- Additional expenditure for paramedic and ambulance service when compared to the same period in the year before;
- Personal protective equipment for staff and those in need, where consumption is greater than the same period in the 2018-19 year;
- Services provided in a primary care and/or community health setting, to manage the outbreak of COVID-19;
- Emergency public health response staffing support for any aged care facility, with the Commonwealth share to increase to 100 per cent of the cost should the support be required for longer than three days;

- Transport costs, including medical related transport in rural and remote areas, where they are higher compared to the same period in the 2018-19 year; and
- Minor capital expenditure for the purchase of respiratory equipment and establishment of respiratory clinics.

The Commonwealth and states will agree further activities on an as needs basis, as the COVID-19 outbreak evolves.

SCHEDULE B

Private hospital capacity and viability during CoVID-19

All jurisdictions acknowledge the critical role of private hospitals (both overnight and day hospitals) during the CoVID-19 national health emergency in contributing to an integrated hospital system response.

Under this Agreement, the Commonwealth will provide financial assistance to enable:

- States to purchase private hospital services as needed; and
- private hospitals to retain capacity for responding to State or Commonwealth public health requirements related to both CoVID-19 and non-CoVID-19 activities, and support viability to resume normal operations at the end of the CoVID-19 pandemic.

Private hospitals are expected to retain their full workforce as at 31 March 2020, including medical, nursing, other clinical and ancillary staff, for service delivery or redeployment as needed.

All States will enter into agreements with all private hospitals in their respective jurisdictions, with the following minimum requirements that private hospitals must:

- accept CoVID-19 and non-CoVID-19 patients, as directed by the State, as public patients;
- provide ventilators, intensive care type equipment, and personal protective equipment (PPE) and distribute such equipment as directed by the State;
- provide the States with rapid access to data in relation to facilities, occupied and unused beds (particularly ICU), employees, PPE and current activity;
- provide each State with rapid access to their employees (including, without limitation, use of its clinical workforce and other capacity where needed);
- provide efficient, cost effective and flexible access to private hospital facilities, equipment and workforce, as required;
- ensure the private hospitals continue, to the extent possible, business as usual activities and collect revenue where possible;
- provide 'open book' access to their accounts, to undertake any auditing and verify claims against service activity, costs, revenue and other viability measures; and
- timely data is collected and available to support decision making and the coordinated response of all governments on issues outlined under this Agreement including issues of capacity, workforce, funding, equipment, and provide to the Commonwealth 'open book' information provided by private hospitals.

Under this Agreement, States must also work with private hospitals to:

- ensure professional indemnity and medical malpractice insurance for any clinical workforce redeployed to public hospitals is covered;
- ensure professional indemnity and medical malpractice insurance for any employees of a private hospital is covered when a public patient has been admitted to a private hospital under this Agreement; and
- work with the Administrator and the Independent Hospitals Pricing Authority to rapidly provide relevant data requested by the Commonwealth for the purposes of verifying any claims against activity or viability payments to private hospitals.

Financial arrangements for this Schedule

Hospital services payments

The Commonwealth will share costs equally with state and territory governments for any activity purchased from a private hospital under this Agreement.

Any patient treated in a private hospital under this Agreement will be treated as a public patient. Private hospital operators can continue to admit people as private patients for any business as usual activity (not covered by this service payment).

State public health payments

Private hospital financial viability payments

The Commonwealth will contribute 100 per cent of the financial viability payments, which are intended to cover only the gap between each private hospital's minimum viability costs and any revenue received by that private hospital, including from private patient activity and activity funded by a State (whether under this Agreement or a separate arrangement).

These payments are only to guarantee ongoing minimum viability and are not to contribute to any profit or loan or debt repayments. The payments will be calculated and paid monthly in advance based on cost recovery estimates provided by private hospitals to States, who will then provide these estimates to the Administrator of the National Health Funding Pool.

To be eligible for financial viability payments, private hospitals must:

- ensure their facilities and workforce are available to the State public hospital systems as needed;
- identify all payments or benefits received from all sources, including Commonwealth, State, and local government bodies and under any insurance policy; and
- commit to full transparency of their accounts and provide the States with the right to audit and inspect private hospitals' records, accounts and data on an open book basis to assess compliance with the funding arrangement and to confirm the costs incurred by private hospitals, as required.

The Commonwealth considers fixed operational costs to include (except for the provision of services for these categories):

- labour costs (or similar) of employees and other essential workforce;
- costs of consumables and supplies; and
- insurance costs (including business interruption, workers compensation, professional indemnity/medical malpractice).

The Parties will agree guidelines in relation to reasonable costs to be included in the private hospital Financial Viability payment.

The Commonwealth funding contribution is expressly not to be used to compensate private hospitals for loss of profit, or to gain a return on investment, or to repay debt, finance leases, or interest.

States must provide information to the Administrator on all costs sought by private hospitals in order to assess appropriateness and all payments will be adjusted for additional revenue received by private hospitals.

Private hospital equipment or workforce redeployment

Where a State requires that any equipment or workforce from a private hospital be redeployed to a public hospital or other health service, the Commonwealth will pay 50 per cent of the cost where this is not already covered by hospital services payments above.

Commonwealth-directed private hospital activity

In some cases, the Commonwealth will need to direct a State to undertake a particular activity with a private hospital.

Where this function is a Commonwealth responsibility, the Commonwealth will pay 100 per cent of the cost incurred where this occurs, with payments to be made through this Agreement and administered by the relevant State.

Examples of purposes for which the Commonwealth may seek access to private hospitals include, but are not limited to:

- Accommodation for quarantine and isolation cases.
    - cruise and flight COVID-19 passengers;
    - quarantine of vulnerable members of the community (for example aged care residents that do not have COVID-19 despite other residents becoming infected); and
    - isolation of infected vulnerable COVID-19 patients (for example if an outbreak in an aged care facility is caught early then infected patients could be isolated in private hospitals to avoid the spread throughout the aged care facility).
- Utilisation by ADF medical workforce (avoids requirement for ADF field hospitals to be established).
- Establishment of temporary influenza clinics.
- Establishment of temporary COVID-19 respiratory clinics.
- Supply of facilities, PPE and equipment, including ventilators.

The Commonwealth recognises each State as the system administrator and if the Commonwealth needs access to private hospitals for Commonwealth directed activities, the State will act as the agent to ensure these occur.

The State will treat any such request from the Commonwealth as a high priority. Should there be any disagreement about the most appropriate use of particular private hospital resources, these will be resolved by the respective Health Department Secretaries, and if unable to be resolved this will be escalated to Ministers for resolution.

Payments and reconciliation

The reconciliation for the financial viability payments must account for any additional revenue private hospitals receive such as:

- car parking, cafes and retail rents;
- any other CoVID-19 related economic packages (for example, business grants, rent relief and employee wage subsidies); and
- business interruption or business continuity insurance claims.

Private hospitals in receiving support through their agreement with the State, will not apply for the JobKeeper payment. If a private hospital receives revenue from the JobKeeper payment, the State must not pay a financial viability payment. The State will also ensure private hospitals, where using workforce from labour hire companies, will take into account any assistance the labour hire firm is getting from the JobKeeper payment.

SCHEDULE C

Coordination and delivery of a safe and effective COVID-19 vaccine

Making safe and effective COVID-19 vaccines available free-of-charge to all Australians is a key priority of all jurisdictions. The roll-out of the Australian COVID-19 Vaccination Program is critical to Australia's efforts to minimise the risk of spread of COVID-19 and keep the community safe.

Schedule C complements *Australia's COVID-19 Vaccine National Roll-out Strategy* (published by the Commonwealth on 7 January 2021). The Schedule recognises the National Cabinet's ongoing commitment to the *Australian COVID-19 Vaccination Policy* (endorsed 13 November 2020) and recalibrated delivery model (agreed 22 April 2021).

The Schedule outlines clear lines of responsibility across governments and delivers funding to the States to support successful vaccination of all eligible people living in Australia with a COVID-19 vaccine. Under this Schedule, all jurisdictions affirm their commitment to key principles under the COVID-19 Vaccination Program. These include:

- Free-of-charge vaccination for all people living in Australia.
- Roll-out on the basis of Commonwealth specified priority populations, linked to delivery schedules, with scope to flexibly respond to outbreaks.
- Centralised Commonwealth oversight, with defined responsibilities for the Commonwealth and State governments.

Schedule C will cover costs of vaccination dose delivery on an activity basis from 15 February 2021 and will continue for the duration of the Agreement. Funding under the Schedule will be conditional on the States meeting responsibilities outlined in the *Australian COVID-19 Vaccination Policy*, *Australia's COVID-19 Vaccine National Roll-out Strategy* and agreed jurisdictional implementation plans.

At the National Cabinet meeting of 22 April 2021, all Parties agreed to recognise the recalibrated vaccine delivery model through addendums to the COVID-19 Vaccination Program Implementation Plans. In line with this decision, all Parties are committed to agreeing jurisdictional implementation plans under this Schedule. This includes any amendments or additions required under the recalibrated delivery approach and the details of State-run vaccination sites that are stood up to deliver the target number of vaccinations at each site.

Funding Arrangements for this Schedule

The Commonwealth will provide an Upfront Payment of $100 million, with each State to be provided a share based on their population. The Upfront Payment will ensure funds are available for set up costs and offer a guarantee that each State will receive as a minimum the amount of their Upfront Payment, regardless of the amount of vaccination activity delivered under the Vaccination Dose Delivery Payment.

Under the existing State Public Health Payment mechanism contained within this Agreement, the Commonwealth will provide a 50 per cent contribution to the Vaccination Dose Delivery Payment and Vaccination Roll-out Support Payment.

- The Vaccination Dose Delivery Payment will provide activity based funding for each vaccination dose delivered by the States from 15 February 2021.
- The Vaccination Roll-out Support Payment will provide block funding in recognition of genuine net additional costs incurred by States to set up additional sites to deliver COVID-19 vaccinations in line with the recalibration approach from 21 April 2021.

In line with existing arrangements for the State Public Health Payment under this Agreement, the Administrator is responsible for reconciling the Vaccination Dose Delivery Payment, Upfront Payment and the Vaccination Roll-out Support Payment.

The Administrator is responsible for determining what constitutes in-scope activity under the Vaccination Roll-out Support Payment in accordance with this Schedule and consistent with the scope agreed at National Cabinet's meeting of 22 April 2021.

Upfront Payment

The Commonwealth agrees to pay into the National Health Funding Pool for each State an Upfront Payment for an amount as set out in the table below.

Upfront Floor Payment	**$ millions**
NSW	32.0
VIC	26.0
QLD	20.0
WA	10.5
SA	7.0
TAS	2.0
ACT	1.5
NT	1.0

Payment from the Commonwealth will be paid to each State once the Commonwealth has agreed respective jurisdictional implementation plans or other written agreement with that State. Jurisdictional implementation plans may include details of State-run vaccination sites that are to be stood up to deliver the target number of vaccinations at each site. Once the Upfront Payment is paid into the National Health Funding Pool by the Commonwealth, the Administrator will provide each State their payment from the Pool.

The Commonwealth guarantees that each State will receive as a minimum the amount of their Upfront Payment, regardless of the amount of vaccination activity delivered under the Vaccination Dose Delivery Payment.

The Upfront Payment will be reconciled against the Vaccination Dose Delivery Payment. Once a State has delivered more vaccination activity under the Vaccination Dose Delivery Payment than the amount of Upfront Payment for that State, the State will receive monthly payments and be funded through the Vaccination Dose Delivery Payment.

Part A: Vaccination Dose Delivery Payment

Through the Vaccination Dose Delivery Payment, the Commonwealth will provide a 50 per cent contribution to the agreed price per vaccination dose delivered by the States, through monthly payments.

The Commonwealth will contribute to the agreed price per vaccination dose delivered for all persons living in Australia. This includes all Australian citizens, permanent residents and all visa holders including those who are not eligible for Medicare.

The agreed price per vaccination dose delivered is $27.50. Where a person receives the vaccine in a State vaccination facility that is in an area classified as Modified Monash 2-7, the agreed price per vaccination is $32.45.

The agreed price covers the costs directly related to the delivery of vaccinations. Additional costs incurred by States other than those eligible under the Vaccination Roll-out Support Payment are not included in recognition of the Commonwealth's significant upfront investment in the acquisition and delivery of vaccines, as well as costs for consumables.

In line with this Agreement, the Commonwealth will pay the Vaccination Dose Delivery Payment amount for each state for the month in the next available payment round after receiving advice from the Administrator.

Initial Payment Arrangements

At the beginning of each month, States agree to provide the Administrator actual vaccination doses delivered in the month prior. The Administrator will calculate the Vaccination Dose Delivery Payment Amount for each State for the month prior using the following calculation:

$$Vaccination\ Dose\ Delivery\ Payment\ Amount = State\ Dose\ Actual\ \times\ Agreed\ Price\ \times\ 50\ Per\ Cent$$

The Administrator will then reconcile the total Vaccination Dose Delivery Payment Amount against each State's Upfront Payment, using the following calculation:

$$Upfront\ Payment\ -\ Total\ Vaccination\ Dose\ Delivery\ Payment\ Amount = Remaining\ Upfront\ Payment$$

Once the Administrator has determined that the Remaining Upfront Payment for a State has reached zero that State will receive the Vaccination Dose Delivery Payment according to the payment arrangements set out below.

Once the Remaining Upfront Payment Reaches Zero

Prior to the beginning of a month, States agree to provide the Administrator with an estimate of vaccinations doses to be delivered in the month. The Administrator will advise the Commonwealth Treasurer in writing of the Vaccination Dose Delivery Estimate amount for each State for a month using the following calculation:

$$Vaccination\ Dose\ Delivery\ Estimate\ Amount = State\ Dose\ Estimate \times Agreed\ Price \times 50\ Per\ Cent$$

States will provide the Administrator actual activity data no later than 90 days following the completion of a financial quarter. The Administrator will advise the Commonwealth Treasurer in writing of the Vaccination Dose Delivery Final Amount for each State for the financial quarter using the following calculation:

$$Vaccination\ Dose\ Delivery\ Actual\ Amount = (State\ Dose\ Actual \times Agreed\ Price \times 50\ Per\ Cent) - Vaccination\ Dose\ Delivery\ Estimate\ Amount$$

Part B: Vaccination Roll-out Support Payment

Through the Vaccination Roll-out Support Payment, the Commonwealth will provide a 50 per cent contribution through monthly payments for genuine net additional costs incurred by the States to set up additional sites to deliver COVID-19 vaccinations in line with the recalibration delivery approach agreed at National Cabinet on 22 April 2021.

The Vaccination Roll-out Support Payment will cover genuine net additional costs incurred for sites established on or after 21 April 2021. This includes mass vaccination sites, mobile vaccination sites, temporary vaccination sites, repurposing of existing vaccination sites where appropriate and other sites agreed in advance of establishment. The Vaccination Roll-out Support Payment will be in addition to the Upfront Payment and Vaccination Dose Delivery Payment, and limited to establishment costs.

Funding will be provided on a block funded basis. Prior to the beginning of a month, States agree to provide the Administrator an estimate of funding attributable to the Vaccination Roll-out Support Payment. To facilitate reconciliation, States will provide the Administrator actual cost data and supporting evidence in line with any guidance issued by the Administrator no later than 90 days following the completion of a financial quarter.

In-scope activity under the Vaccination Roll-out Support Payment

As agreed at National Cabinet's meeting of 22 April 2021:

- In-scope activity will include leasing and fit-out of facilities, equipment such as freezers, and the costs of transporting necessary equipment.
- In-scope activity will not include costs related to workforce, workforce and patient transport, IT, consumables and goods that the Commonwealth is responsible for the purchase and supply of under the *Australian COVID-19 Vaccination Policy,* jurisdictional

implementation plans, and/ or the *Australian Government's COVID-19 Vaccine National Roll-out Strategy*.

The Commonwealth and the States at Senior Officials level may agree guidelines in relation to activity agreed to be in-scope by National Cabinet, or between the Prime Minister and the relevant First Minister. The guidelines will clarify what constitutes genuine net additional costs to support reconciliation. The guidelines will not vary the scope of the Vaccination Roll-out Support Payment agreed by National Cabinet on 22 April 2021.

Any other additional costs essential under the Vaccination Roll-out Support Payment must be agreed at National Cabinet or between the Prime Minister and the relevant First Minister in writing prior to the cost being incurred, or no later than 90 days from the commencement of the Vaccination Roll-Out Support Payment amendment.

Interaction with the NHRA and other Agreement Components

For the avoidance of doubt, any payments made under this Schedule will be considered part of the State Public Health component of the Agreement. Activities related to COVID-19 vaccination delivery are not eligible for any funding additional to the Vaccination Dose Delivery Payment and Vaccination Roll-out Support Payment under the State Public Health Payment.

The Administrator is to ensure the same service is not paid for twice under this Agreement. The Commonwealth will not fund any services under this Schedule if the same service, or any part of the same service is funded through the NHRA, the Medicare Benefits Schedule, any other Commonwealth program, or any other Commonwealth contract, as per the relevant clauses of the NHRA and legislation underpinning the Medicare Benefits Schedule and other Commonwealth programs.

The Vaccination Dose Delivery Payment and Vaccination Roll-out Support Payment amounts will not count towards the calculation of the soft caps or the national cap of the NHRA, nor will they be included in a State's base funding for future years.

Vaccination Roll-out Responsibilities

In delivering COVID-19 vaccines, States will follow the processes and requirements as agreed by the National Cabinet and those set out in the *Australian COVID-19 Vaccination Policy* and jurisdictional implementation plans*,* and the *Australia's COVID-19 Vaccine National Roll-out Strategy*.

The States are each responsible for:

- developing jurisdictional implementation plans that give effect to agreed national policy and legislative requirements;
- ensuring appropriately qualified and trained workforce to support delivery of its jurisdictional implementation plan, in collaboration with relevant peak bodies and training providers;
- authorising, under State legislation, the selected workforce identified in the jurisdictional implementation plans to possess and administer COVID-19 vaccines;

- identifying specific vaccination sites (including in external territories) in accordance with the *Australian COVID-19 Vaccination Policy* and in line with the *Commonwealth COVID-19 Vaccination Program Implementation Plan* that meet or exceed the minimum requirements;
- ensuring that immunisation providers remain compliant at all times with their safety, ethical, and reporting obligations; and
- any other activity agreed between the Commonwealth and a State, agreed by the National Cabinet, or recommended by the Australian Health Protection Principal Committee (AHPPC).

The Commonwealth and State governments are jointly responsible for:

- ensuring that the needs of the following groups are met in consultation with relevant stakeholders including the Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHS):
    - residential aged care and residential disability settings;
    - Aboriginal and Torres Strait Islander peoples;
    - culturally and linguistically diverse communities; and
    - other hard to reach or at-risk groups.
- working together to ensure doses of vaccine are distributed to where they are most needed, based on live information on need and uptake at vaccination locations; and
- any other activity agreed between the Commonwealth and a State, agreed by the National Cabinet, or recommended by the AHPPC.

On 5 November 2021, National Cabinet noted the booster roll-out will continue to utilise the existing vaccination infrastructure and delivery arrangements, with sufficient capacity across primary care channels to deliver a large share of primary course and booster doses for the remainder of 2021 and 2022. Where a jurisdiction delivers vaccination dose under the booster roll-out, the Commonwealth will contribute funding under the Vaccine Dose Delivery Payment.

Reporting Arrangements for this Schedule

Each jurisdiction will ensure that vaccination activity under this Schedule is reported as a non-admitted service through appropriate coding and submission of data using processes specified under the NHRA, and following any relevant guidance provided by the Administrator and the IHPA.

The Administrator will determine, on the basis of data submitted, the number of vaccination doses delivered by each jurisdiction. The Administrator will also determine, on the basis of the location of relevant facilities, the number of vaccination doses for which each agreed price applies.

In addition, each jurisdiction will ensure that each vaccination is recorded in the Australian Immunisation Register (AIR), adhering to any processes or guidelines specified by the Commonwealth.

The Commonwealth and the States will work to streamline reporting requirements and reduce the need for duplicate reporting. The Administrator may take into account data from AIR in providing advice in relation to this Agreement.

Each jurisdiction will also ensure that any adverse events that are or may be related to administration of a COVID-19 vaccine are advised to the Therapeutic Goods Administration and to the relevant jurisdictional officials, adhering to any processes or guidelines specified by the Commonwealth and the relevant jurisdiction.

Referenced Documents

- *Australian COVID-19 Vaccination Policy*
- *Australia's COVID-19 Vaccine National Roll-out Strategy*
- Jurisdictional Implementation Plans include:
    - *Commonwealth COVID-19 Vaccination Program Implementation Plan*
    - *New South Wales COVID-19 Vaccination Program Implementation Plan*
    - *Victoria COVID-19 Vaccination Program Implementation Plan*
    - *Queensland COVID-19 Vaccination Program Implementation Plan*
    - *Western Australia COVID-19 Vaccination Program Implementation Plan*
    - *South Australia COVID-19 Vaccination Program Implementation Plan*
    - *Tasmania COVID-19 Vaccination Program Implementation Plan*
    - *Australian Capital Territory COVID-19 Vaccination Program Implementation Plan*
    - *Northern Territory COVID-19 Vaccination Program Implementation Plan*
- *COVID-19 Vaccination Program Aged Care Implementation Plan*
- *COVID-19 Vaccination Program Disability Sector Implementation Plan*
- *COVID-19 Vaccination Program Aboriginal and Torres Strait Islander Peoples Implementation Plan*
- *COVID-19 Vaccination Program Culturally and Linguistically Diverse Communities Implementation Plan*

SCHEDULE D

Support for aged care preparedness and response during COVID-19

All jurisdictions recognise the critical importance of minimising the risk of the COVID-19 pandemic to people receiving aged care services and the need for a rapid, coordinated response to future outbreaks in residential aged care facilities (RACFs).

Schedule D is in response to the Royal Commission into Aged Care Quality and Safety's special report on *Aged Care and COVID-19,* and recognises National Cabinet's 21 August decision to endorse the *Commonwealth, State and Territory Plan to Boost Aged Care Preparedness for a Rapid Emergency Response to COVID-19*. The Schedule will allow States to assist aged care providers prevent, prepare for and respond to outbreaks of COVID-19.

In recognition of the responsibility of the Commonwealth for aged care, under this Schedule the Commonwealth will provide financial assistance to enable the States to:

- deliver additional targeted Infection prevention and control (IPC) training to enhance RACF staff IPC skills; and
- undertake prevention, preparedness and response activities to address a COVID-19 outbreak in RACFs, including establishing a dedicated aged care emergency response capability to respond to COVID-19 outbreaks and supporting RACFs to uplift IPC capacity by providing IPC training.

This Schedule will cover eligible costs incurred from 1 July 2020 and will continue for the duration of the Agreement.

Funding under the Aged Care Response Payment will be conditional on the below national guidelines or other state guidelines that were in place before the national guidelines were endorsed where there is written agreement between the Commonwealth and a state or territory:

- delivering additional targeted IPC training in line with the requirements outlined in the *Australian Health Protection Principal Committee (AHPPC) approved Guide for Jurisdictions' Deployment of Infection Prevention and Control Training for staff working in Residential Aged Care Facilities* (the IPC Training Guide); and
- undertaking COVID-19 prevention, preparedness and response activities to address a COVID-19 outbreak in RACFs, outlined in the *National COVID-19 Aged Care Plan*.

<u>Additional Infection prevention and control, including targeted training</u>

In recognition of Recommendation 6 of the Special Report of the Royal Commission into Aged Care Quality and Safety *'Aged Care and COVID – a Special Report'* released on 1 October 2020, under this Schedule States will be funded to deploy additional targeted IPC training to enhance IPC skills and capacity in RACFs.

States will deploy additional targeted IPC training into RACFs, based on the needs of each RACF, informed by the observations and assessment of IPC capabilities, undertaken by the IPC lead in each RACF. IPC training will provide:

- assistance with the preparation and implementation of outbreak management plans;
- IPC skills and capacity enhancement in RACFs;
- training to RACF staff (including ongoing and contract staff) with an identified training needs; and

- a proportion of face-to-face training to RACF staff on IPC.

Funding for additional targeted IPC training will be conditional on being compliant and delivered in line with the IPC Training Guide, or compliance with state training guidelines, following written agreement between the Commonwealth and a state or territory.

COVID-19 prevention, preparedness and response activities to address a COVID-19 outbreak in RACFs

To address the commitment made by National Cabinet on 21 August 2020, under this Schedule, the Commonwealth will provide funding to States to undertake COVID-19 prevention, preparedness and response activities as outlined in pages 15 to 17 of the *National COVID-19 Aged Care Plan*

In-scope prevention, preparedness and response activities include:

- establishing a dedicated aged care emergency response capability to respond to COVID-19 outbreaks;
- establishing pre-agreed arrangements by developing and maintaining plans to respond to COVID-19 outbreaks in RACFs;
- supporting delivery of IPC Training to RACFs;
- ensuring resources are available and ready for rapid response; and
- scenario testing of plans and aged care emergency response capability to ensure ongoing readiness.

Under this Schedule, the Commonwealth will provide funding to States to establish an Aged Care Emergency Response Operations Centre[1] to enable a prompt response to any future outbreaks in aged care. These centres will supplement and boost state and territory capacity to respond to outbreaks of COVID-19 in RACFs by:

- Providing a coordinated response mechanism to mobilise resources;
- Providing capability to rapidly respond to COVID-19 outbreaks in RACFs (where available);
- Providing additional surge capacity as a last resort, if the surge capacity of the RACF provider and Commonwealth has been exhausted;
- Draw on health system clinical governance expertise, when and if required; and
- Provide a point of coordination for the use of emergency resources.

Aged Care Emergency Response Operations Centres are to work within existing State public health coordination and Emergency Response Centres. Centres will have clear lines of responsibility to support coordination, surge capacity and capability, and resource allocation, including between State governments and the Commonwealth.

[1] All States have established an aged care emergency response capability, integrated with state health emergency response arrangements, scalable and flexible in response to the COVID-91 outbreak and which can be activated within 48 hours. This capability, if activated would include the functions of an Aged Care Emergency Response Operations Centre and will work within existing State public health and emergency response frameworks.

Financial arrangements for this Schedule

Under the existing State Public Health Payment mechanism contained within this Agreement, the Commonwealth will contribute 100 per cent of costs incurred by the States in delivering the activities described above. The Australian Government has separately provided more than $1.7 billion in additional support to aged care.

Funding is provided monthly based on estimates provided by States and reconciled against actual costs incurred in delivering the activity during the quarterly reconciliation process. In line with existing arrangements for State Public Health Payments under this Agreement, the Administrator of the National Health Funding Pool (Administrator) is responsible for receiving estimates from the States and reconciling these.

The Administrator will remain responsible for determining what constitutes in-scope activity under the Aged Care Response Payment, having particular regard to the Commonwealth requirements for funding, given the Commonwealth is the sole funder of these activities.

States will co-operate in the provision of any information reasonably requested by the Commonwealth, and will rectify any issues as reasonably requested by the Commonwealth. Any information provided to the Commonwealth may be shared with the Administrator.

States may include in their monthly estimates (per clause 41) costs for delivering activities under this Schedule for the period commencing from 1 July 2020. States must provide information to the Administrator on all costs incurred to assess eligibility.

Consistent with clause 41(a), no State will seek funding under this Schedule for costs that have been claimed under the Hospital Services Payment, other elements of the State Public Health Payment, or any other Commonwealth funded program. No other supports provided by a State to RACFs will be funded through the Aged Care Response Payment.

Commonwealth guidelines for funding

<u>Additional IPC, including targeted training</u>

Under this Schedule, the Commonwealth will contribute 100 per cent of costs incurred by the States to provide additional targeted IPC training where it can be demonstrated the training complies with the IPC Training Guide, approved by AHPPC. States must provide assurance to demonstrate that targeted IPC training has been provided to staff (ongoing and contract staff) in RACFs.

RACF compliance with the Aged Care Quality Standards, including appropriate IPC and engagement of an IPC lead, will continue to be monitored by the Aged Care Quality and Safety Commission.

In addition to this IPC training, residential aged care facilities are required to have a dedicated clinical IPC Lead. This requirement is designed to increase infection prevention and control expertise across the aged care sector. It will ensure that each service has a dedicated expert responsible to support the design, implementation and continuous improvement of infection prevention and control policies, procedures and practices within a service. The IPC Lead will support staff within each service, and be a source of advice for both staff and management to ensure IPC responsibilities are upheld.

Where there is a written agreement between the Commonwealth and a state, a state may implement an alternative approach to IPC training.

COVID-19 prevention, preparedness and response activities to address a COVID-19 outbreak in RACFs

Under this Schedule, the Commonwealth will contribute 100 per cent of costs incurred by the States for COVID-19 prevention, preparedness and response activities to address a COVID-19 outbreak in RACFs, including if required the establishment of an Aged Care Emergency Response Operation Centres, where it can be demonstrated these activities comply with the *National COVID-19 Aged Care Plan* or comply with state training guidelines, following written agreement between the Commonwealth and a state or territory.

Where established, the Commonwealth will only fund 100 per cent of activities related to Aged Care Emergency Response Operation Centres. All other activities undertaken in State Emergency Response Centres do not qualify for funding under the Aged Care Response Payment. The Administrator will ensure there is no double funding for Aged Care Emergency Response Operation Centres.

Activities related to Aged Care Emergency Response Operation Centres and other prevention, preparedness and response activities will include staffing where additional costs are incurred. States should provide evidence to demonstrate that the activity or work performed is a genuine additional cost and is solely related to Aged Care Emergency Response Operation and other prevention, preparedness and response activities to address a COVID-19 outbreak in RACFs, including supporting RACFs to uplift IPC capacity by providing IPC training. An employee or contractor will be considered new if they are recruited on or after 1 July 2020 and were not an existing employee or contractor to the State's Public Health Service prior to their employment.