

ADDENDUM TO NATIONAL HEALTH REFORM AGREEMENT

2020-2025

This document is a compilation and is provided for ease of reference.

The Addendum as signed by First Ministers is available at:

www.federalfinancialrelations.gov.au/content/national_health_reform.aspx

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PRELIMINARIES, SYSTEM WIDE OBJECTIVES AND ROLES AND RESPONSIBILITIES

Preliminaries

1. This Addendum:
 - a. sets out the shared intention of the Commonwealth, State and Territory governments (the States) to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system;
 - b. re-affirms that all governments:
 - i. agree that the healthcare system will strive to eliminate differences in health status of those groups currently experiencing poor health outcomes relative to the wider community; and
 - ii. acknowledge that private providers and community organisations play a significant role in delivering health services to the community and will continue to be partners with government in meeting the objectives of this Addendum.
 - c. recognises that responsibility for health is shared between the Commonwealth and the States, and that all governments have a responsibility to ensure that systems work together effectively and efficiently to produce the best outcomes for people, including interfaces between health, aged care and disability services, regardless of their geographic location;
 - d. amends the National Health Reform Agreement (NHRA) for the period 1 July 2020 to 30 June 2025;
 - e. implements and supersedes the Heads of Agreement on public hospital funding and health reform as agreed by the Council of Australian Governments (COAG) in 2018;
 - f. re-affirms the Medicare Principles, as set out in clause 8;
 - g. builds on and re-affirms the high-level service delivery principles and objectives for the health system in the National Healthcare Agreement (agreed by COAG in 2008 and amended in July 2011) for the period of this Addendum;
 - h. continues the financial arrangements for Australian public hospital services, including Activity Based Funding (ABF) and block funding, as set out in in Schedule A of this Addendum;
 - i. acknowledges the shared commitment of the Commonwealth and States to work in partnership with Aboriginal and Torres Strait Islander communities in closing the gap through the COAG-agreed agenda;
 - j. recognises the responsibility for improving the mental health outcomes of Australians and preventing suicides is shared and that all governments are committed to reforming the provision of mental health care across the key areas of prevention, diagnosis, treatment and recovery, with the aim of:
 - i. promoting the mental health and wellbeing of the Australian community and,

where possible, prevent the development of mental health problems and mental illness;

- ii. reducing the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community;
- iii. promoting recovery from mental health problems and mental illness; and
- iv. assuring the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society; and

k. is subject to the Intergovernmental Agreement on Federal Financial Relations (IGA FFR) and should be read in conjunction with that Agreement and subsidiary schedules.

2. The Commonwealth and the States agree the following four strategic priorities will guide further reform of our health system between 2020 and 2025:

- a. Improving efficiency and ensuring financial sustainability (Schedule A);
- b. Delivering safe, high-quality care in the right place at the right time, including long-term reforms in:
 - i. Nationally cohesive health technology assessment;
 - ii. Paying for value and outcomes; and
 - iii. Joint planning and funding at a local level.
- c. Prioritising prevention and helping people manage their health across their lifetime, including long-term reforms in:
 - i. Empowering people through health literacy; and
 - ii. Prevention and wellbeing; and
- d. Driving best practice and performance using data and research, including long-term reforms in:
 - i. Enhanced health data.

3. High level principles outlining the focus of reforms in clause 2 (b)-(d) are included in Schedule C, and implementation plans will be attached to this Addendum when agreed.

4. Included at Appendix A is a list of definitions for words and phrases used in this Addendum.

Objectives

5. The Commonwealth and the States recognise that this Addendum provides an opportunity to work together to ensure the best possible outcomes for the Australian people through the collective investments governments make in health. The Parties recognise that improving value in our health system means developing and implementing

reforms that:

- a. deliver improvements in outcomes that matter most to people and communities;
 - b. improve outcomes, experiences, quality, safety and efficiency of care through public reporting, such as promoting the uptake of Patient Reported Measures;
 - c. create stronger incentives for providers and funders to work together to better integrate care and drive efficiency across the system; and
 - d. ensure equitable access to care regardless of geographic location.
6. As part of the shared commitment to improving mental health outcomes, the Parties agree to work together informed by the Productivity Commission’s final report into mental health, the National Suicide Prevention Adviser’s final report and other inquiries, including the Victorian Royal Commission into Mental Health Services.
7. The Commonwealth and the States will work in partnership to implement arrangements for a nationally unified and locally controlled health system which will:
- a. improve patient outcomes, patient experience and access to services, including by focussing on what matters most to patients, supporting innovative models of care and trialling new funding arrangements (Schedule C);
 - b. improve the provision of GP and primary health care services, including Aboriginal and Torres Strait Islander community controlled health organisations, and the effective integration of health services at a local and national level (Schedule C);
 - c. improve care coordination for people with chronic and complex needs, building on the activities set out in the 2017 Bilateral Agreements on Coordinated Care and incorporating them into relevant long-term health reforms (Schedule C);
 - d. improve the safety and quality of health services through continuation of hospital pricing reforms agreed by COAG in 2017 (Schedule A);
 - e. improve standards of clinical care, including through guidance from the Australian Commission on Safety and Quality in Health Care (ACSQHC) (Schedule B);
 - f. improve accountability and performance reporting on the health system through the Australian Health Performance Framework and supporting national performance indicators (Schedule D);
 - g. improve local accountability and responsiveness to the needs of communities through continued operation and collaboration between Local Hospital Networks (LHNs) and Primary Health Networks (PHNs) (Schedule E);
 - h. work effectively with the aged care and disability support systems to deliver better outcomes (Schedule F);
 - i. improve access to and use of data to support service delivery and improved patient outcomes (Schedule C);
 - j. improve public hospital efficiency through the use of ABF based on a national efficient price (Schedule A);

- k. ensure the sustainability of funding for public hospitals by increasing the Commonwealth's share of public hospital funding through a 45 per cent contribution to the costs of growth, subject to the operation of the National Funding Cap (Schedule A); and
- l. maintain transparency of public hospital funding through the National Health Funding Pool (Schedule A).

Roles and responsibilities

- 8. Under this Addendum, States will provide health and emergency services through the public hospital system, based on the following Medicare Principles:
 - a. eligible persons must be given the choice to receive public hospital services free of charge as public patients;¹
 - b. access to public hospital services is to be on the basis of clinical need and within a clinically appropriate period; and
 - c. arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.
- 9. Under this Addendum, the Commonwealth and the States will be jointly responsible for:
 - a. funding public hospital services, using ABF where appropriate and block funding in other cases;
 - b. funding growth in public hospital services and the increasing cost of public hospital services;
 - c. determining funding policy and exploring innovative models of care in the national funding model;
 - d. establishing and maintaining nationally consistent standards for healthcare and reporting to the community on the performance of health services;
 - e. collecting and providing patient-level data to support the objectives of this Addendum;
 - f. working together on policy decisions or areas of the system that impact on each other's responsibilities;
 - g. ensuring that the commitments outlined in this Addendum contribute to closing the gap in Aboriginal and Torres Strait Islander disadvantage and life expectancy. This will be given effect by:
 - i. working with Aboriginal and Torres Strait Islander communities to design approaches tailored to their needs, recognising and enabling Aboriginal and Torres Strait Islander leadership and local decision making processes;
 - ii. working to achieve cultural safety in the health system with Aboriginal and

¹ This Addendum recognises that clinical practice and technology changes over time and that this will impact on modes of service and methods of delivery. These principles should be considered in conjunction with the definition of public hospital services set out in Schedule A.

Torres Strait Islander people by co-developing and co-delivering culturally safe and secure health services;

- iii. developing a National Aboriginal and Torres Strait Islander Health Workforce Strategy; and
- iv. monitoring the impact of reforms through Aboriginal and Torres Strait Islander-led evaluation, including assessing the differential impact prior to implementation and during implementation, and making appropriate changes in partnership with Aboriginal and Torres Strait Islander organisations and communities;

- h. identifying rural and remote areas where there is limited access to health and related services with a view to developing new models of care to address equity of access and improve outcomes; and
- i. maintaining and improving population health.

10. Under this Addendum, the States will be responsible for:

- a. system management of public hospitals, including:
 - i. ensuring the legislative basis and governance arrangements for Local Hospital Networks are consistent with the objectives of this Addendum;
 - ii. system-wide public hospital service planning and performance;
 - iii. purchasing of public hospital services and monitoring delivery of services purchased;
 - iv. planning, funding and delivering capital;
 - v. planning, funding (with the Commonwealth) and delivering teaching, training and research;
 - vi. managing Local Hospital Network performance; and
 - vii. State-wide public hospital industrial relations functions, including negotiation of enterprise bargaining agreements and establishment of remuneration and employment terms and conditions to be adopted by Local Hospital Networks;
- b. taking a lead role in managing public health activities; and
- c. sole management of the relationship with Local Hospital Networks to ensure a single point of accountability in each State for public hospital performance, performance management and planning.

11. States affirm their commitment to the following:

- a. providing public patients with access to all services provided to private patients in public hospitals;
- b. ensuring that eligible persons who have elected to be treated as private patients have done so on the basis of informed financial consent;
- c. providing and funding pharmaceuticals for public and private admitted patients, and for public non-admitted patients in public hospitals (except where Pharmaceutical Reform Arrangements are in place); and

- d. maintaining a Public Patients Hospital Charter and an independent complaints body and ensuring that people are aware of how to access these provisions.
12. In providing these services States will adhere to the Business Rules and other requirements set out in Schedule G.
13. Under this Addendum the Commonwealth will be responsible for:
 - a. maintaining the legislative basis and governance arrangements for the key independent national bodies (“national bodies”), comprising the Australian Commission on Safety and Quality in Health Care, Australian Institute of Health and Welfare, Independent Hospital Pricing Authority and Administrator of the National Health Funding Pool;
 - b. system management and support, policy and funding for GP and primary health care services including lead responsibility for Aboriginal and Torres Strait Islander Community Controlled Health Services (noting contributions of the States);
 - c. maintaining Primary Health Networks to promote coordinated GP and primary health care service delivery, and service integration over time;
 - d. working with each State and with PHNs on system-wide policy and State-wide planning for GP and primary health care;
 - e. supporting and regulating private health insurance to enable an effective private health sector and patient choice;
 - f. planning, funding, policy, management and delivery of the national aged care system;
 - g. continuing to focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions; and
 - h. functions transferred from Health Workforce Australia and the National Health Performance Authority when these organisations ceased operations on 6 August 2014 and 30 June 2016 respectively.
14. The Commonwealth affirms its commitment to the following:
 - a. funding the Medicare Benefits Schedule to ensure equitable and timely access to affordable primary health care and specialist medical services;
 - b. funding the Pharmaceutical Benefits Scheme to ensure timely and affordable access to safe, cost-effective and high quality medicines; and
 - c. affordable aged care services so that people needing this care can access it when required, regardless of geographic location.
15. The roles and responsibilities of the following national bodies and organisations under this Addendum are outlined in Schedule B:
 - a. Australian Commission on Safety and Quality in Health Care (ACSQHC);
 - b. Australian Institute for Health and Welfare (AIHW);
 - c. Independent Hospital Pricing Authority (IHPA); and

d. Administrator of the National Health Funding Pool.

16. The Commonwealth, States and relevant national bodies will comply with applicable privacy legislation and principles during the implementation of this Addendum.

Implementation

17. This Addendum will be implemented through the following mechanisms:

- a. COAG will provide overall leadership, supported by COAG Councils (Health and Federal Financial Relations);
- b. the COAG Health Council (CHC) will take responsibility for implementing this Addendum and further developing the six long-term reforms outlined in Schedule C, which will guide further reform of our national health system between 2020 and 2025;
- c. the long-term reforms will need to take into account each State's particular circumstances. Implementation will allow individual States the flexibility to identify priority reforms and determine the scope and timing of activities that best suit local needs and support local health system diversity, readiness, and funder and provider capabilities;
- d. CHC will be responsible for jointly developing multilateral implementation plans that will provide a broad framework and allow individual States the flexibility to identify priority reforms and determine the scope and timing of activities. Multilateral implementation plans will be considered by CHC as per clause 25 and, once approved, appended to this Addendum;
 - i. where appropriate, CHC will monitor multilateral implementation against the commitments in this Addendum and will escalate implementation issues to COAG when required; and
- e. bilateral implementation plans for the long-term reforms will be developed where required by the relevant Commonwealth and State Ministers for Health and will take into account each States' particular circumstances:
 - i. relevant Ministers will monitor implementation against the commitments in the implementation plans.

18. In addition to the Medicare Principles outlined at clause 8, this Addendum affirms that the following implementation principles will underpin reform:

- a. all Australians should have equitable access to high quality health care, including those living in regional and remote areas;
- b. all Australians should be able to access transparent, timely, meaningful and nationally comparable performance data and information on the hospital, GP and primary health care, aged care, disability and other health services systems; and
- c. better coordination between the hospital, GP and primary health care, disability services and aged care systems is needed to ensure the health system meets the needs of communities.

19. Reforms will also:
 - a. support and encourage integrated person-centred care;
 - b. incentivise local diversity and innovation in the health system as a crucial mechanism to achieve better outcomes;
 - c. promote positive health and wellbeing outcomes, social equity and the reduction of disadvantage, especially for Aboriginal and Torres Strait Islander people;
 - d. be evidence-based;
 - e. be evaluated to assess their impact on sustainability and patient outcomes;
 - f. consider the impacts of health workforce matters; and
 - g. engage providers, clinicians and patients when new approaches to care are developed.
20. To support implementation of the reforms, the Commonwealth provided \$100 million for a Health Innovation Fund for trials that support health prevention and the better use of health data. This funding is managed separately through a Project Agreement under the *Intergovernmental Agreement on Federal Financial Relations*.

Review

21. An external review of the Addendum commissioned by CHC will be undertaken at the midpoint of this Addendum, completed by December 2023. The review will assess if the Addendum is meeting its stated objectives and will consider the following matters:
 - a. implementation of the long-term reforms and other governance and funding arrangements, and whether practice and policy in place delivers on the objectives of the Addendum;
 - b. the impact of external factors on the demand for hospital services and the flow-on effects on Addendum parameters;
 - c. for small rural and small regional hospitals, whether they continue to meet the block funding criteria determined by the IHPA;
 - d. whether any unintended consequences such as cost-shifting, perverse incentives or other inefficiencies that impact on patient outcomes have arisen, and the capacity of Parties to adopt and deliver innovative models, as a result of financial and other arrangements in this Addendum;
 - e. the performance of the national bodies against their functions, roles and responsibilities;
 - f. arrangements for approval and funding of high cost therapies offered in public hospitals, as outlined in Schedule C (clauses C11 and C12) and Appendix B; and
 - g. other matters as agreed by CHC or COAG.
22. Outcomes and learnings from the long-term health system reforms will be provided to CHC to inform future reforms and agreements.

23. The reviewer(s) and the terms of reference for the reviews are to be agreed by CHC. The review will be completed by December 2023, or at another time as agreed by CHC.

Process for amending the Agreement

24. Subject to clause 25, the NHRA may be amended at any time in writing with the agreement of all parties and with terms and conditions as agreed by all the parties.
25. The schedules to the NHRA may be amended or revoked, and new schedules added at any time, with the written agreement of the relevant portfolio Commonwealth Minister and all State and Territory Ministers for Health. Where an amendment has material funding implications for more than one State or Territory, agreement will be sought from First Ministers.

Dispute resolution

26. Any party may give notice to other parties of a dispute under the NHRA.
27. The Officials of relevant parties will attempt to resolve any dispute in the first instance. If a dispute cannot be resolved by Officials it may be escalated to the relevant Ministers, and if necessary, the relevant COAG Council.
28. If a dispute cannot be resolved by the relevant Ministers, it may be referred to COAG for consideration.

SCHEDULE A – SUSTAINABILITY OF FUNDING FOR PUBLIC HOSPITAL SERVICES

Preliminaries

- A1. This Schedule details public hospital funding arrangements between the Parties from 1 July 2020 to 30 June 2025. Arrangements for 1 July 2025 and beyond will be subject to negotiations between the Commonwealth and all jurisdictions.
- A2. The Parties agree the Commonwealth's contribution to health services in respect of this agreement will comprise funding relating to:
 - a. hospital services provided to public patients in a range of settings and funded on an activity basis;
 - b. hospital services provided to eligible private patients in public hospitals;
 - c. hospital services provided to patients in public hospitals better funded through block grants, including relevant services in rural and regional communities;
 - d. teaching and training functions funded by States undertaken in public hospitals or other organisations (such as universities and training providers);
 - e. research funded by States undertaken in public hospitals; and
 - f. public health activities as determined by clause A15.
- A3. Commonwealth funding will be provided on the basis of activity through Activity Based Funding (ABF) except where it is neither practicable nor appropriate.
- A4. To provide financial predictability and sustainability as the national funding model evolves over time, funding arrangements will be implemented in accordance with the following principles:
 - a. Information will be shared between jurisdictions and the national bodies on a timely and transparent basis to support development of the national funding model each year, implementation of services under the model, and final reconciliation of payments.
 - b. Data reporting and calculations of activity and funding should be accurate, transparent, accountable, and in accordance with the national funding model;
 - c. Activity and cost data will progressively be incorporated into the development of the national funding model;
 - d. Data reporting from jurisdictions and advice from national bodies should be provided as early as feasible to facilitate timely payments to local hospital networks and the determination of funding entitlements;
 - e. Where an error or unexpected outcome in activity or cost data has been identified, national bodies must consult with jurisdictions before taking any further action;
 - f. funding entitlements should be determined in a timely manner; and

- g. Parties, the Administrator and the IHPA will seek to resolve any disputes in a timely and transparent manner.
- A5. Growth in the Commonwealth's total annual funding contribution to health services nationally under this Addendum as outlined at clauses A6 and A7 will not exceed 6.5 per cent a year (the national funding cap). Details on the operation of the national funding cap are outlined in clauses A56 to A58.
- A6. The Commonwealth will fund 45 per cent of efficient growth of ABF service delivery, subject to the operation of the national funding cap. Efficient growth consists of:
 - a. the national efficient price for any changes in the volume of services provided; and
 - b. the growth in the national efficient price of providing the existing volume of services.
- A7. Where services or functions are more appropriately funded through block grants, the Commonwealth will fund 45 per cent of growth in the efficient cost of providing the services or performing the functions. The efficient cost will be determined annually by the IHPA, taking account of changes in utilisation, the scope of services provided and the cost of those services, to ensure the Local Hospital Network has the appropriate capacity to deliver the relevant block funded services and functions.
- A8. Commonwealth funding for public hospital services and functions under this Addendum is dependent on the provision of data requested by the national bodies outlined in this Addendum, including in relation to services to patients, information identifying the patient to whom the services were provided, the public or private status of the patient, the nature of the service and the facility providing the service.
- A9. The Commonwealth will also continue to support private health services through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and Private Health Insurance Rebate. Subject to any exceptions specifically made in this Addendum or through variation to the Addendum, the Commonwealth will not fund patient services through this Addendum if the same service, or any part of the same service, is funded through any of these benefit programs or any other Commonwealth program.
- A10. The Parties agree that the following Commonwealth benefits constitute exceptions to the principle outlined at clause A9:
 - a. MBS payments covered by a determination made by the Commonwealth Health Minister, or a delegate of the Minister, under s19(2) of the *Health Insurance Act 1973*;
 - b. MBS payments relating to services provided to eligible admitted private patients in public hospitals;
 - c. PBS benefits dispensed under Pharmaceutical Reform Arrangements agreed between the Commonwealth and the relevant State; and
 - d. the default bed day rate (or equivalent payment) supported through the private health insurance rebate.
- A11. Parties agree that from 1 July 2020, the Administrator should identify instances not covered by the exceptions outlined at clause A10 where services appear to have been paid under this Addendum and other Commonwealth programs, such as through the MBS

and PBS, and should refer these matters to the relevant Commonwealth officer in the first instance to support Commonwealth compliance activities through mechanisms outside this Addendum.

- a. The Administrator will determine the data matching business rules, with consultation of the Parties, to identify services funded by the Commonwealth through both this Addendum and other Commonwealth programs. Rationale for new business rules will be provided to Parties in the financial year preceding the introduction of the business rules.
- b. Data matching business rules will be reviewed as required by the Administrator. Upon the request of a party, the Administrator is to initiate a review of data matching business rules where material false positives or false negatives in matched data are demonstrated through Commonwealth compliance activities.
- c. Any data provided by the Administrator to the Commonwealth or a State or Territory for compliance activities will be de-identified matched data only and will include the relevant Medicare PIN. The relevant State or Territory will receive a copy of any matched data provided by the Administrator for verification purposes. Data provision will comply with applicable Commonwealth and State legislation including privacy legislation and principles.
- d. The relevant Commonwealth officer responsible for compliance will notify, consult and validate with the States and Territories and have regard to timely advice provided by affected States or Territories prior to undertaking any compliance activity relating to duplicate payments. State health departments will raise any validation or verification issues with the relevant Commonwealth officer responsible for compliance. This consultation will include providing relevant data back to the State or Territory.
- e. The Commonwealth will provide an annual report to the Administrator on the outcomes of compliance activities taken in relation to instances of duplicate payments.
- f. Commonwealth compliance activities, where possible, will be undertaken in a timely manner.

A12. Where instances of matched payments are identified and referred by the Commonwealth through compliance activities as outlined in clause A11, this will not impact Commonwealth national health reform funding, except when:

- a. amounts are identified where the services or any part of the service is funding through any Commonwealth program, that is not excepted through clause A10, and evidence is provided that reasonably demonstrates the amount is unable to be recovered through the process outlines in clause A11; and
- b. The relevant jurisdiction has been offered the opportunity outside of this agreement to address over-payments unable to be recovered through Commonwealth compliance activities. In this case, the Administrator will:
 - i. work with the relevant jurisdictions to identify additional mechanisms to prevent payment for patient services through this Addendum; and
 - ii. adjust Commonwealth NHR funding by the amount of the over-payment.

- c. the Administrator identifies that a matched payment is a false positive – for instance, a privately-funded hospital service has incorrectly been coded as a publicly-funded hospital service – the Administrator will not be required to directly adjust national health reform funding, but instead work with the relevant jurisdiction to correct the source data coding and reprocess the necessary calculations.

A13. The Parties agree to the principle that both the Commonwealth and States' funding models will be financially neutral with respect to all patients, regardless of whether patients elect to be private or public under the Addendum.

Public health activity funding

A14. The Commonwealth's commitment to public health will continue to grow by the former National Healthcare Specific Purpose Payment (SPP) growth factor.

- a. Payments for public health activities will be equal to the previous year's payment indexed by the former National Healthcare SPP growth factor.

A15. States will have full discretion over the application of public health funding to the outcomes set out in the National Healthcare Agreement 2012.

Public hospital funding arrangements

Scope of 'public hospital services'

A16. States will provide health and emergency services through the public hospital system, based on the Medicare principles set out at clause 8 and interpreted consistently with this section (clauses A17 to A32).

A17. Unless a State chooses to reach bilateral agreement with the Commonwealth under clauses A25 to A28 on this matter, the scope of public hospital services funded on an activity or block grant basis that are eligible for a Commonwealth funding contribution will include:

- a. all admitted services, including hospital in the home programs;
- b. all emergency department services provided by a recognised emergency department service; and
- c. other outpatient, mental health, subacute services and other services that could reasonably be considered a public hospital service in accordance with clauses A18 to A24.

A18. States will provide the IHPA with recommendations for other services that could reasonably be considered to be a public hospital service and which are not captured by clauses A17(a) and A17(b) that they consider should be eligible for a Commonwealth funding contribution.

A19. The IHPA will maintain and publish criteria for assessing services for inclusion on a general list of hospital services eligible for Commonwealth growth funding. The IHPA will consider each State's recommendations against the published criteria. If the IHPA considers the service should continue to be included or excluded, it will publicly release its determination and its rationale. In doing so, the IHPA will establish a general list of other services eligible for a Commonwealth funding contribution.

- A20. The COAG Health Council (CHC) may then request the IHPA to revise its determination of services included on or excluded from the general list. If the IHPA considers the service should continue to be included or excluded from the general list, the IHPA will publicly release its determination and the basis of that determination.
- A21. The IHPA may update the criteria and will update the general list based on any updated criteria, or as required to reflect innovations in clinical pathways. States may request the IHPA to update the list or to assess specific services against the criteria for inclusion on the general list.
- A22. In publishing criteria a primary consideration will be whether the service could reasonably be considered to be a public hospital service during 2010.
- A23. Services named on the general list will attract a Commonwealth funding contribution if provided by any Local Hospital Network as agreed between the State and that Local Hospital Network.
- A24. In addition to services on the general list (clause A17 of this Addendum) and services covered under a bilateral agreement (clause A25), grandfathered services in specific hospitals will also be eligible for Commonwealth funding. Grandfathered services in specific hospitals were made eligible under clause A17 of the 2011 National Health Reform Agreement (NHRA). In 2011, these services were agreed as eligible for Commonwealth funding for specific hospitals as they were purchased or provided by that hospital during 2010 (i.e. prior to the 2011 NHRA being agreed).
- A25. A State Health Minister and State Treasurer and the Commonwealth Health Minister and Commonwealth Treasurer may enter into a bilateral agreement to determine the scope of public hospital services funded on an activity or block grant basis that are eligible for a Commonwealth funding contribution.
- A26. The scope of public hospital services under a bilateral agreement will include:
- a. all admitted services, including hospital in the home programs;
 - b. all emergency department services provided by a recognised emergency department service;
 - c. all other services agreed between Ministers as being provided or purchased by a public hospital within the State during 2010; and
 - d. any other services, agreed between Ministers, provided or purchased by public hospitals in Australia.
- A27. Unless otherwise agreed by Ministers, the bilateral agreement will include lists of services which will be funded by the Commonwealth if provided by individual hospitals, and lists of services which will be funded by the Commonwealth if provided at any hospital in the State, or by types of hospital in the State.
- A28. A bilateral agreement will be reviewed every two years to reflect changing patterns of service delivery, and may be varied at any other time by mutual consent.
- A29. Public hospital services which attract a Commonwealth funding contribution will continue to be eligible for Commonwealth funding, even if they are subsequently provided outside a hospital in response to changes in clinical pathways.

- A30. States agree they will not change the management, delivery and funding of health and related services for the dominant purpose of making that service eligible for Commonwealth funding.
- A31. Should the IHPA identify anomalies in service volumes or other data which suggest that services have been transferred from the community to public hospitals, the IHPA will analyse those services and provide a report to the CHC. In performing the analysis the IHPA will consult with the relevant State, LHNs, PHN, and other stakeholders. Following an appropriate consultation period, the IHPA may determine that those particular services provided by that hospital have been transferred for the dominant purpose of making that service eligible for Commonwealth funding and those particular services provided by that hospital will not be eligible for Commonwealth funding.
- A32. The Commonwealth agrees that it will not change the management, delivery and funding of health and related services for the dominant purpose of directing services from the community into the hospital setting.

Activity based funding calculation

- A33. The Commonwealth will fund 45 per cent of the efficient growth of ABF Service delivery, subject to the operation of the national funding cap.
- A34. The Commonwealth's funding for all ABF Service Categories will be calculated individually for each State by summing:
- previous year amount*— the Commonwealth's contribution rate for the relevant State in the previous year, multiplied by the volume of weighted ABF Services provided in the previous year, multiplied by the national efficient price in the previous year;
 - price adjustment*—the volume of weighted services provided in the previous year, multiplied by the change in the national efficient price relative to the previous year, multiplied by 45 per cent; and
 - volume adjustment*—the net change in volume of weighted services provided in the relevant State (relative to the volume of weighted ABF Services provided in the previous year), multiplied by the national efficient price, multiplied by 45 per cent.
- A35. Commonwealth funding will be distributed across all ABF Service Categories in each State at a single Commonwealth contribution rate:
- The single Commonwealth contribution rate in each State for all ABF service categories will be calculated by dividing the sum of clause A34 by the relevant year's total volume of weighted services multiplied by the national efficient price.
 - On implementation of the single Commonwealth contribution rate there will be an initial re-distribution of Commonwealth funding at the LHN level within each State but no aggregate change in the amount of Commonwealth funding that a State receives as a result of the introduction of the single Commonwealth contribution rate.
 - States will manage their funding levels such that there will be no impact on service level delivered at individual LHNs as a result of the introduction of a single Commonwealth contribution rate. Adjustments in service levels at individual LHNs and hospitals may still be made by the system managers for reasons other than the

introduction of the single Commonwealth contribution rate.

- A36. The Commonwealth's contribution to funding public hospital services on an ABF basis (including efficient growth) will be calculated at the start of each financial year, and may be updated or revised during a year based on updated activity estimates, finalised reconciliation processes for prior years, and final activity data from jurisdictions and advice from the Administrator, including a final reconciliation of public hospital services.
- A37. All parties will participate in the development of parameters of the national funding model each year, through the IHPA process outlined in clauses B21 to B40, including efficient price, classifications and cost weights. This process will rely on transparent sharing of analysis, commissioned costing data, and shadow pricing and reporting (where appropriate) to support robust decision making.
- A38. The Administrator will provide the Commonwealth and States with a formal forecast of the Commonwealth's funding contribution for each ABF service category before the start of each financial year. The formal forecast will be provided within 14 calendar days of receipt of both:
 - a. service volume information for all Local Hospital Networks within a State, as provided in Service Agreements; and
 - b. the published national efficient price from the IHPA.
- A39. The Administrator will also provide informal estimates of the Commonwealth's funding contribution to jurisdictions where requested.
- A40. The methodologies set out in clauses A34 to A35 relate to the calculation of preliminary payment entitlements. Final payment entitlements will be made after the reconciliation adjustments, as specified in clauses A63 to A76 have been completed.
- A41. The national activity based funding model will improve every year, informed by previous years' cost and activity data. If the IHPA makes significant changes to the ABF classification systems or costing methodologies, the effect of such changes must be back-cast to the year prior to their implementation for the purpose of the calculations set out in clauses A34 and A35.
- A42. The IHPA will use transitional arrangements when developing new ABF classification systems or costing methodologies, including shadow pricing classification system changes and pricing based on a costing study, for two years or a period agreed with the Commonwealth and a majority of States to ensure robust data collection and reporting to accurately model the financial and counting impact of changes on the National Funding Model.
 - a. Where a jurisdiction participates fully in the shadow pricing, including the provision of the best available data over the shadow period to support the implementation of the new ABF classification systems or costing methodologies, the Parties agree there will be no retrospective adjustments to the National Funding Model, excluding adjustments to Commonwealth contributions as a result of service volume reconciliations as set out in clauses A63, A65 and A73.
 - b. Business rules will be developed by the national bodies in consultation with Parties, addressing significance of changes, process and consultation around retrospective adjustments where appropriate.

- i. If the national bodies consider there is a potential need for a retrospective adjustment to the national funding model, national bodies will communicate, consult and collaborate with Parties. The national bodies will hold a consultation period of 45 days to allow Parties an opportunity to provide submissions on the matter.
- ii. Within 45 days following the jurisdiction 45-day consultation period, national bodies will prepare a report to the CHC, advising them of the national bodies' decision and the nature and circumstances of the recommended adjustment to the national funding model.
- iii. Once the report is provided to the CHC, the national bodies will incorporate the decision regarding the retrospective adjustment into the national funding model and provide parties with an updated report on funding entitlements from the national model.
- iv. When providing payment advice to the Commonwealth Treasurer following the six-month or annual reconciliation, the Administrator will include a section that notes any matters or concerns raised by State Ministers in the 45-day consultation period in the formation of that advice.

A43. ABF payments for eligible private patients must utilise the same ABF classification system as for public patients with the cost weights for private patients being calculated by excluding or reducing, as appropriate, the components of the service for that patient which are covered by:

- a. Commonwealth funding sources other than ABF;
- b. patient charges including:
 - v. prostheses; and
 - vi. accommodation and nursing related components/charge equivalent to the private health insurance default bed day rate (or other equivalent payment).

A44. To give effect to the principle agreed at clause A13, the IHPA will, in determining cost-weight price for private patients in any year, further adjust the price to the extent required to achieve overall payment parity between public and private patients in the relevant jurisdiction. These adjustments will take into account all hospital revenues, be subject to back-casting, and will apply from 1 July 2021, to ensure there are no funding incentives for hospitals to treat public or private patients differently.

Principles for determining the national efficient price

A45. The role of the national efficient price is to:

- a. form the basis for the calculation of the Commonwealth funding contribution; and
- b. provide a relevant price signal to States and Local Hospital Networks that will improve patient access to services, public hospital efficiency and funding effectiveness.

- A46. In determining the national efficient price, the IHPA must:
- a. have regard to ensuring reasonable access to public hospital services, clinical safety and quality, efficiency and effectiveness and financial sustainability of the public hospital system;
 - b. consider the actual cost of delivery of public hospital services in as wide a range of hospitals as practicable;
 - c. consider the expected changes in costs from year to year when making projections;
 - d. have regard to the need for continuity and predictability in prices;
 - e. have regard to any input costs funded through other Commonwealth programs, such as pharmaceuticals supplied under arrangements pursuant to section 100 of the *National Health Act 1953* and magnetic resonance imaging services funded through MBS bulk-billing arrangements; and
 - f. develop methods which allow consideration of reasonable and likely growth in cost inputs, so that the national efficient price can be projected into the future in a predictable and transparent manner.
- A47. In determining adjustments to the national efficient price, the IHPA must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including:
- a. hospital type and size;
 - b. hospital location, including regional and remote status; and
 - c. patient complexity, including Indigenous status.
- A48. While these adjustments to the national efficient price should provide a relevant price signal to States and Local Hospital Networks, the IHPA should not seek to duplicate the work of the Commonwealth Grants Commission in determining relativities.

Block funded services funding

- A49. The Commonwealth will continue to provide funding to States for public hospital services or functions that are more appropriately funded through block funding, and will fund 45 per cent of the growth in the efficient cost of providing these services or performing these functions.
- A50. Payments will consist of the previous year's payment plus 45 per cent of the growth in the efficient cost of providing the services, adjusted for the addition or removal of block services as provided in clauses A52 to A55 (calculated in accordance with clause A7).
- A51. The IHPA, in consultation with jurisdictions, maintains block funding criteria and identifies whether hospital services and functions are eligible for block funding only or mixed ABF and block funding.
- A52. From 2013-14, the process for determining the discrete amounts for block funding is set out below:
- a. the IHPA, in consultation with jurisdictions, develops Block Funding Criteria and

identifies whether hospital services and functions are eligible for block funding only or mixed ABF and block funding

- b. States, during the consultation period, assess their hospital functions and services against the block funding criteria and, if necessary, provide advice to the IHPA on the potential impact of the criteria;
- c. the IHPA provides the block funding criteria to CHC for endorsement; and
- d. CHC considers the block funding criteria proposed by the IHPA and either:
 - vii. endorse the recommendation; or
 - viii. request the IHPA to refine the block funding criteria and bring it back to CHC.

A53. States provide advice to the IHPA on how their hospital services and functions meet the block funding criteria on an annual basis.

A54. On the basis of this advice, the IHPA will determine which hospital services and functions are eligible for Commonwealth funding on a block grant basis.

A55. Using the IHPA's determination the Administrator will then calculate the Commonwealth's funding contribution for block funded services and functions.

Funding cap

A56. Overall growth in Commonwealth funding will be capped at 6.5 per cent a year (the national funding cap). In doing so:

- a. A soft cap will be applied to the Commonwealth funding entitlement of each State throughout the relevant financial year;
- b. Any funding remaining under the national funding cap will be subject to proportionate redistribution as part of the annual reconciliation under clause A77;
- c. while the national funding cap applies to Commonwealth contributions to public hospital services in aggregate, any adjustments to funding as a result of the national funding cap will be applied to the Commonwealth funding contribution for ABF Services only;
- d. should the growth in Commonwealth funding under this Addendum not exceed 6.5 per cent at a national level, each State will receive its uncapped Commonwealth funding entitlement for that State; and
- e. no State will receive more than its uncapped Commonwealth funding entitlement for public hospital services delivered in a relevant financial year.

Interaction of pricing and funding for safety and quality reforms with the funding cap

A57. Adjustments to Commonwealth funding for an individual State resulting from sentinel events, hospital acquired complications (HACs) and avoidable hospital readmissions will be incorporated in the calculation and determination of the State's Commonwealth funding entitlement. The Commonwealth funding entitlement for a given year,

incorporating these adjustments, will form the base for the calculation of the State's soft cap in the following year.

- A58. Any downward adjustment to an individual State for sentinel events, HACs and avoidable hospital readmissions will not be deducted from the total available pool of Commonwealth funding under the national funding cap and will be available for redistribution under clause A56(b).

Calculating Commonwealth funding

Determining preliminary Commonwealth funding

- A59. Prior to the commencement of a relevant financial year covered by this Addendum, the Administrator will calculate a State's estimated Commonwealth funding entitlement as the lower of:
- a. 106.5 per cent of the State's most recent estimated Commonwealth funding entitlement for the State for the previous financial year, excluding any adjustments relating to prior year activities; or
 - b. That State's estimated uncapped Commonwealth funding entitlement for the relevant financial year.
- A60. Estimated Commonwealth funding entitlements can be updated during the course of the year as outlined in clause A143. Adjustments to payments remain subject to the soft cap.
- A61. The Administrator will provide information to jurisdictions about progress against the caps when the estimated Commonwealth funding is calculated or when the Commonwealth's funding contribution is adjusted.
- A62. For the avoidance of doubt, a State will not receive any Commonwealth funding in excess of the soft cap until the annual adjustment, at which time it may be entitled to payment of a redistribution amount.

Adjustments to the Commonwealth's contribution

- A63. There will be two levels of adjustments to the Commonwealth's funding contribution to Local Hospital Networks:
- a. a six-monthly adjustment, and
 - b. an annual adjustment.
- A64. Having regard to technological and operational improvements, States will consider moving to more frequent reconciliation and adjustment arrangements. Jurisdictions may agree to increase the frequency of reconciliation and adjustments through correspondence between health ministers.

Six-monthly adjustment

- A65. The six-monthly adjustment will be conducted in arrears and will arise from the reconciliation conducted to determine the actual volume for services provided by the Local Hospital Networks for Commonwealth payment purposes. Any State may request that the reconciliation be conducted more frequently.

- A66. States will provide to the Administrator, within three months (with a preference to reducing the period over time) of the end of December, gross volume and patient identified data regarding actual services delivered for those public hospital functions funded by the Commonwealth on an activity basis to enable the six monthly adjustment to be undertaken in accordance with clause A65.
- A67. Any variation to Commonwealth payments arising from the six-monthly adjustments will be spread equally across payments for a subsequent quarter, or an appropriate period as determined by the Administrator.
- A68. Variation to the Commonwealth payments arising from the six-monthly adjustments may be deferred until the annual adjustment if the relevant State/Territory health minister and the Commonwealth Minister for Health agree.
- A69. The Administrator will provide timely advice to the Commonwealth Treasurer, contingent on the data, preliminary and revised calculations, reports and advice being provided in a timely manner and on jurisdictions being able to resolve issues in trilateral discussions.
- A70. At the point of six-month reconciliation, and based on the data submitted by States, national bodies will inform Parties if there is any indication of an unexpected outcome from a change to the national funding model where transitional arrangements were not used.

Annual Adjustment

- A71. The Parties agree to seek to finalise the annual adjustment activities ahead of the Commonwealth Budget. To support this commitment, all parties agree to the principles outlined in clause A4.
- A72. The Administrator will undertake annual reconciliation for each State following the receipt of required data from all States. The Administrator will not finalise an annual reconciliation for individual States that have provided the required data until all other States have provided required data.
- A73. The annual adjustment will be conducted in arrears once actual volumes have been validated by the service volume reconciliations to ensure the Commonwealth meets its agreed contribution to the funding of efficient growth.
- A74. In order to attract a Commonwealth funding contribution for each public hospital service provided on an activity basis, States must ensure that all data relevant to the funding of that service has been provided.
- A75. In undertaking the annual reconciliation the Administrator will calculate any sentinel event or safety and quality adjustment that applies to a State in a relevant financial year.
- A76. The issues the Administrator should have regard to as part of the annual reconciliation process will include, but not be limited to, the reconciliation of general transcription errors, including the incorrect coding of services provided and duplicate entries, and the exclusion of services paid for by the Commonwealth via other funding streams, the exclusion of services for which data has not been provided (in either the year being reconciled or the prior year), and the exclusion of services with incomplete data (in either the year being reconciled or the prior year).

Annual Adjustment – Application of the Caps

A77. Following the completion of the annual reconciliation, the Administrator will calculate the final Commonwealth funding entitlements for a State for that year as follows:

- a. Where a State has an uncapped Commonwealth funding entitlement less than or equal to the soft cap, then the State's Commonwealth funding entitlement will equal its uncapped Commonwealth funding entitlement.
- b. Where a State has an uncapped Commonwealth funding entitlement that is more than its soft cap and the sum of all of the States uncapped Commonwealth funding entitlements is less than or equal to the national funding cap, then the State's Commonwealth funding entitlement will equal its uncapped Commonwealth funding entitlement.
- c. Where a State has an uncapped Commonwealth funding entitlement that is more than its soft cap, and the sum of all of the States' uncapped Commonwealth funding entitlements is more than the national funding cap, then the State's Commonwealth funding entitlement is its soft cap, plus a redistribution amount, calculated by the following formula:

National funding available for redistribution	X	$\frac{\text{Individual State's funding shortfall}}{\text{National funding shortfall}}$
Where: i. The 'national funding available for redistribution' is the sum of the difference of each State's uncapped Commonwealth funding entitlement and the soft cap where the State's uncapped Commonwealth funding entitlement is less than the soft cap. ii. The 'individual State's funding shortfall' is the amount by which its uncapped Commonwealth funding entitlement exceeds the soft cap. iii. The 'national funding shortfall' is the sum of all the 'individual State's funding shortfall'.		

Annual Adjustment – Certainty of reconciliation

A78. The Parties agree that the final Commonwealth funding entitlement of a State for a year, once decided by the Commonwealth Treasurer's determination, will not be adjusted under the national funding model.

- a. This does not restrict the Administrator's ability to make adjustments at any time if Auditors General or other relevant bodies find fraud or other illegal or dishonest activity.
- b. Notification of fraud or other illegal or dishonest activity for the purpose of clause A78(a) must be issued in writing by a senior officer of the relevant health department and provide full particulars of the nature and extent of the issue and the likely impact on the Commonwealth funding. A Statement of Assurance must accompany any further submission of data by a State to remedy an identified issue.

- c. If an issue is identified or raised with the Administrator through clause A78(a), the Administrator will notify the Commonwealth and States of the issue and how the Administrator plans to resolve the issue.
- d. The Administrator will calculate the impact on the Commonwealth funding entitlement of each State, including any applicable redistribution amounts, following the assessment of an A78(a) issue by the Administrator.
- e. The Administrator will assess and advise whether adjustments to the Commonwealth funding entitlement of the States should be made. Following resolution of an A78(a) issue, the Administrator will notify the Commonwealth and States of the outcome.

Annual Adjustment – process and timeframes for advice

- A79. States will provide to the Administrator, within at least three months (with a preference to reducing the period over time) of the end of each reconciliation period, gross volume and patient identified data regarding annual actual services delivered for those public hospital functions funded by the Commonwealth on an activity basis to enable reconciliations to be undertaken in accordance with clause A73.
- A80. The Administrator will provide all Parties with a preliminary report on funding entitlements and reconciliation adjustments no later than 30 November following the end of the reconciliation period financial year.
- A81. The Administrator will facilitate a discussion between each of the States and the Commonwealth to resolve any issues or disputes with the application of the national funding model to the calculation of funding entitlements and reconciliation adjustments up to 28 February following the end of the reconciliation period financial year. The Administrator may release revised reconciliation advice following this consultation.
- A82. If the Administrator is not able to resolve the issue within the remit of the Administrator's functions, the issue may be dealt with under the resolution clauses B16 to B20.
- A83. The Administrator will provide advice on the annual entitlements and adjustments to the Commonwealth Treasurer by the end of March, contingent on the data, reports and advice being provided in a timely manner. Jurisdictions will be provided a copy of that advice contemporaneously.

Annual Adjustment – determination and payment

- A84. The Commonwealth Treasurer will aim to finalise the determination on funding within one month, or as soon as practicable after receiving the Administrator's final advice.
- A85. Where the Commonwealth Treasurer's Determination of funding differs from the Administrator's final advice on funding entitlements for a reconciliation period the Commonwealth will publish a Statement of Difference at the time of the Determination outlining the new final entitlement amounts and the reason for the dissimilarity between the Determination and the Administrator's final advice.
- A86. In addition to the Commonwealth's statement above, the Administrator will provide parties with detail on the funding and National Weighted Activity Units related to the Commonwealth Treasurer's Determination, by detailed classification at the local hospital network. The Administrator will also publish this information on its website.

- A87. The determination by the Commonwealth Treasurer will be reflected in Commonwealth payments into the National Health Funding Pool in the next practicable monthly payment run.
- A88. Any variation to Commonwealth payments arising from the adjustment will be spread equally across payments for a subsequent quarter, or appropriate period where the Administrator deems necessary.

State and Territory funding arrangements

Determining the State Funding Contribution

- A89. The State contribution to the funding of public hospital services and functions will be calculated on an activity basis or provided as block funding in accordance with the process outlined above in the eligibility clauses A17 to A24.
- A90. States will determine the amount they pay for public hospital services and functions and the mix of those services and functions, and will meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution.
- A91. Variations in the State funding contribution in respect of individual Local Hospital Networks for services and functions funded under this Addendum may be required to enable States to play their role of system managers of the public hospital system. States may use their own proportion of public hospital funding, or Commonwealth block funding paid to the States (other than funding for teaching, training or research), to retain some funding from Local Hospital Networks and use it to adjust service levels across the State, and to respond to unforeseen events and other contingencies as set out at clause A141.
- A92. State funding paid on an activity basis to Local Hospital Networks will be based for each service category on:
- a. the price set by that State (which will be reported in Service Agreements); and
 - b. the volume of weighted services as set out in Service Agreements.
- A93. It is expected that these arrangements will create incentives for Local Hospital Network efficiency. If a Local Hospital Network is able to operate more efficiently than the level of funding set by the State under the Local Hospital Network Service Agreement, the Local Hospital Network will be able to retain and reinvest the benefits accruing from efficiency in service delivery and in accordance with State policy and practice, as guided by the Service Agreement.
- A94. There will be no requirement for Local Hospital Networks to be paid the full national efficient price if the State considers that a lower payment is appropriate, having regard to the actual cost of service delivery and the Local Hospital Network's capacity to generate revenue from other sources.
- A95. To improve transparency and national comparability, States will provide to the Administrator and the IHPA:
- a. the price per weighted service they determine;
 - b. the volume of weighted services as set out by the national ABF classification scheme; and

- c. any variations to service loadings from the national ABF classification schemes.

Innovative Models of Care

- A96. It is the intention of the Parties that this Addendum facilitate exploration and trial of new and innovative approaches to public hospital funding, to improve efficiency and health outcomes.
- A97. The Commonwealth and a State(s) may agree to trial an innovative model of care for a fixed period of time through a bilateral agreement in accordance with Schedule C.
- A98. During a trial, a State would need to continue to acquit and report Commonwealth funding on an ABF or a block funded basis as appropriate, as provided for in this Addendum.
- A99. A Party can seek to trial innovative models of care, either:
 - a. as an activity based funded service with shadow pricing, reporting, and appropriate interim block funding arrangements for the trial period; or
 - b. as a block funded service, with reporting against the national model and program outcomes for the innovative funding model.
- A100. The outcomes of any trials of an innovative model of care would be provided to IHPA and the CHC. If Commonwealth and the relevant State(s) agree through the CHC, the IHPA will be advised of any decision to continue an innovative funding model. The IHPA will work with jurisdictions to facilitate the continuation of the model for a further period of trial or translation as a permanent model of care.
- A101. To support the trialling of innovative models of care the IHPA will:
 - a. develop a funding methodology for CHC approval by April 2021 that does not penalise States undertaking trials, or other parties to the Addendum. Application of this methodology in individual instances would be agreed by the relevant State(s) and the Commonwealth.
 - b. advise the Commonwealth and State(s) on the application of the methodology at (a) above and on any issues it foresees with the proposed trial, with regard to the national funding model.
 - c. provide advice to CHC on any proposal to translate an innovative funding model to the national funding model. This advice would inform CHC consideration on the matter.

Maintenance of effort

- A102. Parties agree to, at a minimum for the period of 2020-21 to 2024-25, maintain 2018-19 levels of funding for Public Hospital Services through the National Health Funding Pool, while having regard to new, appropriate models of care that may change the setting in which care is delivered.
- A103. The Administrator and AIHW will work with all Parties towards consistency and transparency of reporting to enable the Administrator to provide an annual report on maintenance of effort.

Provision of service level data and Service Agreements to the Administrator

- A104. Parties agree to improve the accuracy of NWAU estimates by allowing States to provide non-binding advice to the Commonwealth and the Administrator on expected services to be delivered, without the need to vary Service Agreements. The provision of this advice will not affect Commonwealth payments or cash flows to Local Hospital Networks (LHNs).
- A105. States will provide the Administrator with an estimate of weighted service volumes for a financial year as an aggregated total, which the Administrator will share with the Commonwealth, by the end of March in the preceding financial year.
- A106. States will provide the Administrator with confirmed aggregate weighted service volumes for a financial year, and estimated service volumes for each Local Hospital Network, by the end of May in the preceding financial year. The estimated weighted service volumes provided are to incorporate the level of disaggregation required by the Administrator in order to calculate the Commonwealth's funding contribution.
- A107. States will provide the Administrator with a copy of the Service Agreement for each Local Hospital Network once agreed between the State and the Local Hospital Network.
- A108. States will provide to the Administrator all State-reported in-scope expenditure at the Local Hospital Network level, including distribution of block funding from State managed funds.
- A109. To improve transparency, the reporting of the distribution of block funding from State managed funds at the Local Hospital Network level will separately detail the distribution of all Commonwealth block funding received by the State.

Cross-border arrangements

- A110. The treatment of cross-border hospital activities will be governed by the following principles:
 - a. the State where a patient would normally reside should meet the cost of services (exclusive of the Commonwealth contribution arrangements discussed below) where its resident receives hospital treatment in another jurisdiction;
 - b. in instances where quality and safety penalties have been applied the State funding contributions will not increase to offset the reduced Commonwealth contribution for those services;
 - c. where a patient is transferred from their resident State to another jurisdiction for treatment the referring hospital is to meet the costs of medical transfers;
 - d. where a patient is transferred from another jurisdiction to their resident State for treatment the resident State is to meet the costs of medical transfers;
 - e. patient out-of-pocket costs related to discharge home from the provider State will be met through the patient's resident State travel assistance scheme where appropriate;
 - f. payment flows (both Commonwealth and State) associated with cross-border services should be administratively simple, and where possible consistent with the broader arrangements of this Addendum;
 - g. the cross-border payment arrangements should not result in any unintended GST

distribution effects;

- h. States recognise their commitment under the Medicare principles which require medical treatment to be prioritised on the basis of clinical need;
- i. both States should have the opportunity to engage in the setting of cross-border activity estimates and variations, in the context that this would not involve shifting of risk; and
- j. there should be transparency of cross-border flows.

Funding Flows

- A111. Commonwealth funding contributions will flow to the provider jurisdiction through the National Health Funding Pool. Steps will be taken to prevent Commonwealth payments made in accordance with these arrangements being subject to equalisation by the Commonwealth Grants Commission to avoid financially disadvantaging one State.
- A112. The Administrator will release actual cross-border activity data and Commonwealth contribution advice to the States within one month of finalising reconciliation to support bilateral cross-border reconciliations.
 - a. Administrator cross-border data made available to States and Territories will include Commonwealth percentage funding rates, Commonwealth funding contributions, and activity flows for activity-based funded and block funded hospitals.
- A113. Funding contributions by the resident State will be made to the provider State through the National Health Funding Pool, either:
 - a. on a regular basis throughout the year, reflecting activity estimates between the parties as scheduled through a Cross-border Agreement with subsequent reconciliation for activity; or
 - b. within six-months of receiving activity data from the Administrator finalising reconciliation and releasing activity data and Commonwealth contribution advice to the States (subject to arrangements between jurisdictions outlined in cross-border agreements).

Agreement around Activity

- A114. Cross-border Agreements will be developed between jurisdictions which experience significant cross-border flows, where one of the parties requests a Cross-border Agreement be in place.
- A115. States and Territories will review the national cross-border agreement template for endorsement by the Australian Health Ministers' Advisory Council (AHMAC) before April 2021 (noting that final cross-border agreements will be adjusted to take into account bilateral arrangements).
- A116. States and Territories will share estimated cross-border activity levels by 31 May for the coming financial year, to provide capacity for both parties to contribute to service delivery planning.
- A117. Cross-border Agreement disputes will be dealt with as part of the IHPA dispute resolution process.

- A118. States and Territories will endeavour to finalise cross-border agreements by 31 May for the coming financial year.

Pricing

- A119. Prices will be set at the national efficient price, as determined by the IHPA including adjustments for any loadings for the provider Local Hospital Network, unless otherwise agreed by the parties to the cross-border Agreement.
- A120. Outlier patients requiring Highly-Specialised Services, not appropriately defined within the existing classification system, and where costs are not reasonably funded by the pricing of the next closest Diagnosis-Related Group, should be flagged in advance by the provider State to the resident State when possible to simplify reimbursement through cross-border arrangements.
- a. Highly-Specialised Services are defined by procedures that do not appropriately fit within a Diagnosis-Related Group classification, are provided at limited sites nationally, have low volume (generally less than 200 separations nationally), and cost significantly more than the funding provided based on pricing in the relevant year's National Efficient Price Determination
 - b. Parties recognise that referrals are often made and agreed to at the clinician level at short notice in the interests of patient well-being. Where it is not possible for States to notify the resident State prior to treatment commencing, the treating State will endeavour to communicate and notify as soon as possible thereafter.
 - c. Highly-Specialised Services will be excluded from cross-border reconciliations and subject to separate reimbursement by agreement between jurisdictions. Payments will not be made directly to the treating hospital by the resident State.
 - d. States and Territories will designate a point of contact to action this clause. If a point of contact is no longer reachable or appropriate the default point of contact will be the jurisdiction's representative for the Administrator's Jurisdictional Advisory Committee.
- A121. Capital will not be explicitly priced by the IHPA, however cross-border dispute resolution can include disputes in relation to the resident State's contribution to capital funding.
- A122. The Commonwealth and States agree that they will accept and implement any recommendations made by the IHPA in relation to cross-border disputes under clause B24(k), and will provide additional funding to the other party in a dispute if this is required.
- A123. If, three months after the IHPA has made a recommendation under clause B24(k), a State has not complied with any element of the recommendation requiring it to make payments to another State, the IHPA may at the request of the second State, advise the Commonwealth Treasurer of any adjustments to Commonwealth payments to the National Health Funding Pool required to give effect to the recommendation. States agree to fund from their own resources any reduction in Commonwealth payments to Local Hospital Networks.

Cost-shifting

- A124. Jurisdictions may make submissions to the IHPA requesting it advise whether a party to

this Addendum has shifted costs onto another jurisdiction in a manner which is contrary to the intent of this Addendum.

- A125. The IHPA will provide the other party a copy of the submission and request a responding submission to be provided within 60 days. The IHPA will provide this response to the initiating jurisdiction.
- A126. The IHPA will then assess the submissions, consult further with affected jurisdictions and publicly release its assessment should it consider that cost-shifting has occurred.

Funding Pool payments

- A127. A single National Health Funding Pool will be maintained, comprising a Reserve Bank of Australia account for each State, for the purposes of receiving all Commonwealth and activity-based State public hospital funding.
- A128. The existence and operation of the Pool in relation to a particular State owes its authority to the enabling legislation passed by both the Commonwealth Parliament and the Parliament of that State.
- A129. Pool accounts will be audited, have complete transparency in reporting and accounting, and will meet all other transparency requirements established by COAG and relevant legislation.
- A130. There will be complete transparency and line-of-sight of respective contributions into and out of Pool accounts to Local Hospital Networks, discrete State managed funds, or to State health departments in relation to public health funding and any top-up funding, and of the basis on which the contributions are calculated. There will also be complete transparency and line-of-sight of respective contributions out of State managed funds to Local Hospital Networks.
- A131. Additional streams of funding may be incorporated into the National Health Funding Pool, once agreed by COAG, with the aim of optimising transparency and efficiency of all public hospital funding flows.
- A132. Commonwealth payments into the pool will be made monthly, calculated as 1/12th of the estimated annual payment. Commonwealth payments will be made into the National Health Funding Pool in accordance with Schedule D of the IGA FFR.
- A133. States will determine when State payments are made into the Pool and State managed funds.

Payments from the National Health Funding Pool and State Managed Funds

- A134. Payments will be made from the Pool accounts to Local Hospital Networks and State managed funds in accordance with Service Agreements to be agreed between the States and Local Hospital Networks.
- A135. Payments may be made out of the Pool accounts directly to other parties on the behalf of Local Hospital Networks for the provision of shared services, as detailed in a Service Agreement between a Local Hospital Network and a State. Any subsequent reference to payments made to Local Hospital Networks in this Addendum includes a reference to payments made to other parties for the provision of shared services.
- A136. States and Local Hospital Networks can agree amendments to Service Agreements in

order to adjust service volumes or pricing to take account of such matters as changing health needs, variations in actual service delivery and hospital performance.

A137. States, as the system manager of public hospitals, can determine the frequency of alterations to Service Agreements. States will notify the Administrator, within 28 calendar days, of agreed variations to a Service Agreement.

A138. The payment arrangements for Commonwealth funding are as follows:

- a. ABF will flow directly to Local Hospital Networks through Pool accounts;
- b. funding for block grants will flow through Pool accounts to State managed funds and from there to Local Hospital Networks;
- c. funding for teaching, training and research will flow through Pool accounts to State managed funds and from there to Local Hospital Networks or other organisations (such as universities and training providers) depending upon the specific funding arrangements established in each State for the provision of those services; and
- d. public health funding and any top-up funding will flow through Pool accounts to State health departments.

A139. The payment arrangements for States' funding are as follows:

- a. ABF will flow directly through Pool accounts to Local Hospital Networks;
- b. funding for block grants will flow through State managed funds to Local Hospital Networks; and
- c. funding for teaching, training and research will flow through State managed funds to Local Hospital Networks or other organisations (such as universities and training providers) depending upon the specific funding arrangements established in each State for the provision of those services.

A140. States will direct the disbursement of State funding from Pool accounts and State managed funds to Local Hospital Networks. The frequency of State payments to Local Hospital Networks will be in accordance with Service Agreements, agreed between the State and Local Hospital Network.

A141. States are able to make exceptional payments through a Pool account or a State managed fund to Local Hospital Networks at any time.

A142. States will direct the timing of Commonwealth payments from Pool accounts and State managed funds to Local Hospital Networks. However, States will not redirect Commonwealth payments:

- a. between Local Hospital Networks;
- b. between funding streams (for example from ABF to block funding); or
- c. to adjust the payment calculations underpinning the Commonwealth's funding.

A143. States can cause Commonwealth payments to be modified by changing the relevant Service Agreements, if they wish, and by notifying the Administrator of an agreed

variation, in accordance with clause A137. These changes to Commonwealth funding will take effect in the next payment period.

- A144. To ensure that payments flowing out of the National Health Funding Pool are correct, no payment will flow from the Pool until the respective State has validated the schedule of payment and instructed the Administrator to make payment on the State's behalf.

Administrator of the National Health Funding Pool

- A145. The Administrator will calculate and advise the Commonwealth Treasurer of the monthly Commonwealth payments into the National Health Funding Pool. The States, in consultation with the National Health Funding Body, will continue to determine when State payments are made into the National Health Funding Pool and State managed funds.
- A146. The Administrator will apply the national funding cap and soft cap in calculating and delivering advice to the Commonwealth Treasurer in respect of the Commonwealth contribution to the National Health Funding Pool under the Addendum.

Reporting by the Administrator

- A147. The Administrator will provide a monthly report to the Commonwealth and States detailing the following at the Local Hospital Network level:
- a. the basis for the amount of Commonwealth funding flowing into Pool accounts;
 - b. the basis for the amount of State funding flowing into Pool accounts and State managed funds;
 - c. the number of public hospital services funded and provided as a running yearly total, in accordance with the national system of ABF; and
 - d. the delivery of other public hospital functions funded by the National Health Funding Pool and State managed funds as a running yearly total.
- A148. The same transparency arrangements that apply to the National Health Funding Pool will also apply to the State managed funds. States will provide data to the Administrator in accordance with the timeframe and format specified in the Administrator's data plan on the:
- a. flow of Commonwealth and State funds into and out of State managed funds; and
 - b. provision of public hospital services by Local Hospital Networks.
- A149. All reports produced by the Administrator will be publicly available.
- A150. Reporting undertaken by the Administrator will be structured to avoid duplication and overlap with the reporting undertaken by other bodies detailed in this Addendum.
- A151. Financial audits will be undertaken at least annually, at the completion of each financial year. Performance audits may be undertaken at any time.

A152. Further to clause B81, in publishing information on compliance with data requirements, the Administrator will publish additional information including:

- a. dates on which each State provided data under clauses A66, A79, A105 and A106;
- b. dates on which resubmissions of data were provided; and
- c. dates on which Reconciliation was completed.

A153. The Administrator will ensure that determinations, and final activity and entitlements at the Local Hospital Network level, are publicly available for all years that the Addendum has been in operation.

Data quality and integrity

A154. Consistent with clause B76, jurisdictions will work together and with the national bodies to share and work towards best practice approaches to data quality and integrity.

Data Conditional Payment

A155. The Parties agree to continue the operation of a Data Conditional Payment (DCP) to encourage the prompt provision of the required data in order to facilitate timely Reconciliation and payment of any Redistribution Amounts due to States. The DCP will be a variation to the timing of payments under clause A132.

A156. If a State has not provided the Required Data for annual Reconciliation within three months of the end of the Reconciliation period the Administrator will, in calculating the Commonwealth contribution to the National Health Funding Pool for that State, advise the Commonwealth Treasurer to defer payment of 10 per cent of the amount payable to the State in November of the current year, until the Required Data is provided.

A157. If a State has not provided the Required Data for the annual Reconciliation within four months of the end of the Reconciliation period, the Administrator will, in calculating the Commonwealth contribution to the National Health Funding Pool for that State, advise the Commonwealth Treasurer to defer a further 15 per cent of the amount payable to the States in December of the current year, until the Required Data is provided.

A158. If an amount is deferred under clauses A156 or A157:

- a. the Administrator will advise the affected State of that fact; and
- b. any funds deferred will be paid in the next available monthly payment once the Required Data is provided.

A159. The Administrator will be responsible for applying the DCP and providing advice to jurisdictions as to its operation.

Reforms to decrease avoidable demand for public hospital services

A160. All Parties commit to implement reforms to improve outcomes for patients and decrease potentially avoidable demand for Public Hospital Services. This Part does not preclude pursuing other reforms to improve health outcomes and the efficiency of public hospitals in the future.

Incorporating quality and safety into hospital pricing and funding

- A161. Australia's public hospitals deliver safe, high quality care but there remain opportunities for improvement. Reducing Sentinel Events, Hospital Acquired Complications (HACs) and Avoidable Readmissions will deliver better health outcomes, improve patient safety and support greater efficiency in the health system.
- A162. The Parties agree to continue reforms integrating safety and quality into the pricing and funding of Public Hospital Services in a way that:
- a. Improves patient outcomes;
 - b. Provides an incentive in the system to provide the right care, in the right place, at the right time;
 - c. Decreases avoidable demand for public hospital services; and
 - d. Signals to the health system the need to reduce instances of preventable poor quality patient care, while supporting improvements in data quality and information available to inform clinicians' practice.
- A163. The Parties agree that pricing and funding adjustments for Sentinel Events, HACs and Avoidable Readmissions are part of a multifaceted, system-wide approach to safety and quality, which includes national standards, accreditation, and workforce development.
- a. The Parties recognise that safety and quality reforms are connected to wider health system reforms, particularly better coordinated care.
 - b. Together, these reforms will establish better system capability and culture to support the reduction of ineffective interventions and procedures known to be harmful in the longer term, beyond the immediate focus on Sentinel Events, HACs and Avoidable Readmissions.
- A164. For the avoidance of doubt, the Parties agree that Sentinel Events and Safety and Quality adjustments will be subject to back-casting under clause A41.

Sentinel events

- A165. The Parties agree that any episode of care that gives rise to a Sentinel Event will not be funded by the Commonwealth. The episode will be assigned a NWAU of zero.
- A166. States agree to apply a digital flag to any episode that includes a Sentinel Event and report this information to IHPA as part of data submissions under clauses A8 and B72 of this Addendum.

Hospital Acquired Complications

- A167. The Parties agree to continue to develop, in consultation with the ACSQHC, IHPA and the Administrator, a comprehensive pricing and funding model, that:
- a. Is rigorous, fair and transparent;
 - b. Does not incentivise under reporting, or adversely affect service delivery; and
 - c. Is significant enough to be an effective overall price signal from the Commonwealth

through to hospitals.

A168. To confirm the suitability of the complications on the HAC List in a pricing and funding model, the Parties will use the following four criteria:

a. Preventability:

- i. Clinical evidence is available to demonstrate that the HAC can be prevented with 'best clinical practice';
- ii. Evidence supports that individual LHNs (including single campus and specialist hospitals) are able to prevent the HAC and that the causes of such condition are within the control of the hospital;
- iii. The strength of external influences (e.g. patient factors) does not unduly impact the LHN's ability to avoid the HAC;
- iv. There is sufficient evidence to inform / instruct health services on how to avoid the HAC; and
- v. The development of the HAC measure has been subjected to valid construction. The inferences used to test the HAC have been made on the basis of appropriate measurements and occurrences can be easily defined, identified and adequately measured.

b. Impact:

- i. The introduction of the financial adjustments related to specific HAC will result in a significant enough change to funding at the hospital level to drive the intended clinical practice outcome, impact appropriately on patients and improve patient outcomes;
- ii. Unintended consequences as a result of practice or reporting changes are not likely to be to the detriment of individual and hospital-wide patient care; and
- iii. The rate of HAC by LHN (giving consideration to size and type of hospital) is sufficient to warrant introduction of a financial mechanism.

c. Feasibility:

- iv. Reporting mechanisms are sufficiently robust to ensure that any benefit obtained through under reporting is minimised;
- v. Sufficient information is available to other bodies, such as the National Health Funding Body, to monitor the impact of the financial mechanism on the prevalence of the HAC across the system;
- vi. Sufficient processes, systems, policies, feedback mechanisms and data collections are in place to support the reduction of the HAC across each LHN; and
- vii. The introduction of the HAC is prioritised to obtain maximum benefit.

d. Equity:

- i. The application of pricing and funding adjustment does not unfairly impact any one, or group, of providers as a result of characteristics beyond their control (e.g. size, location and type of hospital).

Avoidable Hospital Readmissions

- A169. The Parties recognise that there is variation in the way States currently define Avoidable Hospital Readmissions, presenting challenges to the immediate development of a pricing and funding model.
- A170. The ACSQHC will develop and maintain a list of clinical conditions, subject to AHMAC approval, that arise from complications of the management of the original condition, which can be considered Avoidable Hospital Readmissions, including identifying suitable condition-specific timeframes for each of the identified conditions.
- A171. The Parties agree that the IHPA will consult with and have regard to the advice of the ACSQHC and Parties in the development of a pricing model for Avoidable Hospital Readmissions, for implementation by 1 July 2021, following approval from the CHC.

Evaluation

- A172. The Parties agree that IHPA will provide advice to CHC by April 2021 evaluating these reforms against the principles outlined at clause A168, to support COAG consideration of new or additional reforms from 1 July 2021.
- A173. In addition, IHPA, the ACSQHC and the Administrator will provide advice to CHC by April 2021 providing options for the further development of safety and quality-related reforms, including examining ways that avoidable and preventable hospitalisations can be reduced through changes to the Addendum.
- A174. IHPA will work with the Parties, national bodies and other related stakeholders to establish a framework to evaluate the reforms against the following principles:
 - a. Reforms are evidence based and prioritise patient outcomes:
 - i. Better patient health outcomes underpin the design and implementation of reform;
 - ii. The design and implementation of pricing and funding models for safety and quality, and reducing avoidable readmissions, are based on robust evidence;
 - iii. Adjustments are based on evidence of a causal link to the condition or complication, and are commensurate with the additional care required as a result of the complication;
 - iv. Adjustments relate to conditions or complications which clinicians and other health professionals are reasonably able to take action to reduce their incidence or impact; and
 - v. Pricing and funding models add to the evidence base for strategies to address safety and quality, with robust monitoring of the effectiveness of implementation and ultimately, their impact on patient outcomes.

- b. Reforms are consistent with whole-of-system efforts to deliver improved patient health outcomes:
 - i. Adjustments complement existing national and State measures to improve patient health outcomes and reduce avoidable hospital demand, including but not limited to the ACSQHC's goals, national benchmarking, data reporting, and accreditation;
 - ii. The design and implementation of pricing and funding models acknowledge that mechanisms other than pricing and funding have a role in achieving the reform intention and that complementarity of all mechanisms is desirable; and
 - iii. The design and implementation of pricing and funding models should not compromise State system financial sustainability and quality and should therefore be focused on system level performance improvement.
- c. Reforms are transparent and comparable:
 - i. As far as practicable, the financial levers are designed to ensure there is transparency between the approach and the intended outcome; and
 - ii. Pricing and funding models use an appropriate risk adjustment methodology to consider different patient complexity levels or specialisation across jurisdictions and hospitals.
- d. Reforms provide budget certainty:
 - i. Any downward adjustment to an individual State is not deducted from the available pool of funding under the overall cap of 6.5 per cent.

Transparency

- A175. States agree to implement a pricing approach for Sentinel Events and safety and quality adjustments, to give effect to the model developed by the IHPA, within their funding and purchasing arrangements (including in Service Level Agreements and Purchasing Agreements) for public hospital services at the episode of care level.
- A176. States agree to each provide an annual report to AHMAC, within nine months from the end of each financial year, on the outcomes of the implementation of the pricing approach for safety and quality. These reports will include information on:
 - a. the financial impacts at the LHN level; and
 - b. any relevant safety and quality programs.

Roles and responsibilities

- A177. CHC will oversee the continuing development, implementation and the ongoing refinement of reforms to integrate safety and quality into the pricing and funding of public hospital services, including:
 - a. advising national bodies on pricing and funding approaches, including shadow approaches, for HACs and avoidable readmissions; and
 - b. final approval of the Sentinel Events, HACs and avoidable readmissions lists for

funding and pricing purposes.

A178. States will seek to refine and improve public hospital activity monitoring and reporting capability to support the system in making safety and quality improvements.

A179. The Commonwealth will work collaboratively with States and national bodies to support pricing and funding reforms for public hospital services, and advise on how these reforms intersect with private hospital services and primary health care services.

Private or not-for-profit provision of public hospital services

A180. Where a State contracts with a private or not-for-profit provider to operate a public hospital, that hospital will be treated as a public hospital for the purposes of this Addendum, and may be, or form part of, a Local Hospital Network. This arrangement will apply to existing contracts and contracts entered into after the Addendum commences.

A181. Hospitals owned by charitable organisations which are recognised as public hospitals, whether by legislation or by other arrangements, will be treated as a public hospital for the purposes of this Addendum, and may be, or form part of, a Local Hospital Network.

A182. Other public hospital services provided by the private or not-for-profit sector can be contracted for in the following ways:

- a. the State may contract centrally and establish a notional ‘contracted services Local Hospital Network’ which is not required to meet usual Local Hospital Network governance arrangements; or
- b. Local Hospital Networks may enter into individual contracts with the private or not-for-profit sectors.

A183. For any notional contracted services Local Hospital Network, the State will provide information on forecast and actual contracted activity to the Administrator, and this will include the same type, level and specificity of data on the contracted activity as required of other Local Hospital Networks under this Addendum.

A184. The Commonwealth will provide funding in respect of the contracted activity through the National Health Funding Pool to the State. IHPA determined loadings will apply in respect of patient characteristics, and service location.

A185. Public hospital services provided under contract by the State with the private sector or not-for-profit sector will be treated as being provided by public hospitals and will be treated consistently with the approach in clauses A17 to A24 to determine eligibility for a Commonwealth funding contribution.

Veteran Entitlements

A186. Arrangements for funding and provision of health care for entitled veterans are the subject of a separate Commonwealth-State agreement. Nothing in any separate agreement will interfere with the rights of entitled veterans to access public hospital services as public patients.

Nationally Funded Centres

A187. These arrangements may have an impact on Nationally Funded Centres. This will be considered further by the CHC.

SCHEDULE B – NATIONAL BODIES

Introduction

- B1. The national bodies are:
 - a. The Independent Hospital Pricing Authority (the IHPA);
 - b. The Administrator of the National Health Funding Pool (the Administrator) and the National Health Funding Body (the NHFB);
 - c. The Australian Commission on Safety and Quality in Health Care (the ACSQHC); and
 - d. The Australian Institute of Health and Welfare (the AIHW).
- B2. The national bodies are established by relevant Commonwealth and State legislation to undertake specific functions including under this Addendum.
- B3. For avoidance of doubt, any jurisdiction that enacts or amends legislation that is inconsistent with the provisions of this Addendum relating to the new National Health Reform funding arrangements, including the establishment, appointment, powers and functions of the Administrator, will be in breach of this Addendum.
- B4. The Commonwealth and States will consult with COAG on any proposed amendments to legislation establishing the position and functions of the national bodies and the operation of the National Health Funding Pool.
- B5. Parties recognise that the national bodies are independent and expect these bodies to carry out their functions in a timely manner that advances the objectives of this Addendum and regularly consult with each other, Parties to this Addendum and other relevant stakeholders. The consultation requirements and processes set out in this Addendum are not intended to be exhaustive.
- B6. The functions and roles of national bodies relating to this Addendum may overlap from time-to-time. Where the work of one national body affects the work of another, relevant bodies are expected to work collaboratively together and keep Parties informed of their work through their relevant advisory committees.
- B7. Commonwealth and State departments of health will be the primary contact for the national bodies, and will be responsible for engaging with other government agencies in their jurisdictions (noting the Administrator's statutory role in providing advice to the Commonwealth Treasurer).

National funding bodies

Consultation and transparency

- B8. For the purposes of this Schedule, the national funding bodies are the IHPA, the Administrator and the NHFB.
- B9. The Commonwealth established the national funding bodies under the *National Health*

Reform Act 2011 on behalf of all parties to facilitate and administer the public hospital funding arrangements under the Act and this Addendum. The Commonwealth Minister must consult and have regard to the views of COAG Health Council (CHC) on any direction to the IHPA.

- B10. Given the significance to all Parties of the functions discharged by the national funding bodies, the bodies will consult with CHC on changes that materially impact the application of the national funding model. Such consultation will be in addition to specific consultation requirements and processes with Parties set out in this Addendum.
- B11. The national funding bodies must consult with affected Parties and provide relevant analysis and documentation on decisions that could materially impact Parties before releasing draft or final advice on the matter.
- B12. When a Party has raised a matter formally in writing with a national funding body through a consultation process under this Addendum or otherwise, the relevant body is to provide a written statement explaining how the matter has been considered and addressed on request from a Party. The request and statement must be timely in relation to the matter raised.
- B13. The Commonwealth or two or more States may request that the national funding bodies present for Health Ministers' consideration a final or draft business rule, decision or determination that affects the national funding model or the calculation of the Commonwealth funding contribution. Such consultation will be in addition to specific consultation requirements and processes set out in the Addendum, and provide no less than 45 days for response by Health Ministers.
- B14. As per clause A42, National Bodies will develop business rules related to process and consultation related to retrospective adjustments, for consideration and unanimous agreement by CHC, by April 2021.
- B15. National Bodies will formally consult with Parties on the development of business rules and policies as per clause A42.

Resolving national funding body matters

- B16. Consistent with the principles articulated in this Addendum and prior to raising a matter under this section:
 - a. Parties should follow the consultation requirements and processes under this Addendum and work together with the relevant national funding bodies to understand the different perspectives and attempt to resolve the matter;
 - b. National funding bodies should work collaboratively and with Parties as appropriate, and have regard to advice provided by Parties; and
 - c. Parties and national funding bodies should use existing governance mechanisms including Jurisdictional Advisory Committees productively and transparently.
- B17. The Commonwealth, or a State (with the support of another party) or national funding

body can raise a dispute under this section through CHC.

- B18. Once a dispute is raised, the appropriate national body will conduct a 45 day ministerial consultation period seeking submissions from the Parties and other national bodies. Within 45 days of the close of the consultation period, the national body will provide a statement on the dispute to CHC ahead of the Administrator providing any advice to the Commonwealth Treasurer.
- a. The statement is to address submissions received during the consultation period and make recommendations on how the matter can be resolved in the context of the Addendum and on the basis of the submissions from Parties.
- B19. After the consultation period closes, a parallel report from the Australian Health Ministers' Advisory Council (AHMAC) is to be provided to CHC within 45 days. The report is to address submissions received within the consultation period and make recommendations on how the matter can be resolved in the context of the Addendum.
- B20. The process under this section is intended to be an intermediary step prior to a matter being formally referred to COAG under the dispute resolutions under clauses 26 to 28.

Independent Hospital Pricing Authority

Functions

- B21. The Independent Hospital Pricing Authority is an independent Commonwealth statutory authority established under the *National Health Reform Act 2011* (the Act) to promote improved efficiency in and access to Australian public hospital services.
- B22. In performing its functions, the IHPA must:
- a. have regard to this Addendum;
- b. follow the process and meet the conditions or requirements set out in this Addendum; and
- c. have regard to submissions made at any time by the Commonwealth, a State or a Territory.
- B23. The main functions of the IHPA are to:
- a. determine the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis;
- b. determine the national efficient cost for health care services provided by public hospitals where the services are block funded; and
- c. publish this, and other information, for the purpose of informing decision makers in relation to the funding of public hospitals.

B24. The IHPA has the following determinative functions:

- a. developing and specifying the national classifications to be used to classify activity in public hospitals for the purposes of ABF;
- b. subject to clause B67, determining the supporting data requirements and data standards to apply to data to be provided by States, including:
 - i. data and coding standards to support uniform provision of data; and
 - ii. patient demographic characteristics and other information that is relevant to classifying, costing and paying for public hospital functions;
- c. subject to clause B67, specifying costing data, methods and standards to be used in studies of the costs of delivering public hospital services, and to collect such data from Local Hospital Networks, through the States, to enable it to calculate the national efficient price and loadings;
- d. determining the national efficient price for services provided on an activity basis in public hospitals through empirical analysis of data on actual activity and costs in public hospitals, taking account of any time lag and the cost weights to be applied to specific types of services;
- e. determining the national efficient cost of services provided on a block funded basis in public hospitals through empirical analysis of data on actual activity and costs in Australian public hospitals, taking account of any time lag;
- f. developing, refining and maintaining such systems as are necessary to calculate the national efficient price, including determining classifications, costing, data elements and data collections;
- g. determining adjustments ('loadings') to the national efficient price required to take account of legitimate and unavoidable variations in the costs of service delivery, including those driven by hospital size, type and location;
- h. developing projections of the national efficient price for a four year period, updated on an annual basis and providing confidential reports on these projections to the Commonwealth and States;
- i. determining what other services provided by public hospitals are eligible for a Commonwealth funding contribution (Schedule A – Scope of 'Public Hospital Services' refers);
- j. determining the Block Funded Criteria to be applied to agreed hospitals, functions and services that would be better funded in that way every three years from 2013-14. Before this determination can be made the Block Funding Criteria must have been endorsed by COAG (clause A53 refers);
- k. resolving disputes on cross-border issues, where parties are unable to reach bilateral

agreement and either party seeks a determination from the IHPA; and

- l. determining the national efficient price that will apply to eligible private patients receiving public hospital services.

B25. The CHC may direct the IHPA to refine the determination of public hospital services eligible for a Commonwealth funding contribution (clause B24(i) refers).

B26. The IHPA has the following advisory functions:

- a. advising COAG on a nationally consistent definition and typology of public hospitals eligible for:
 - i. block funding only (including small rural and regional hospitals better funded in that way); and
 - ii. mixed ABF and block funding;
- b. making recommendations to the Treasurer to adjust Commonwealth contributions to implement cross-border recommendations under clause A123;
- c. making an assessment in relation to cost-shifting in line with clauses A124 to A126.

B27. In relation to the safety and quality reforms described in this Addendum the IHPA will:

- a. implement an approach whereby any episode of care that includes a Sentinel Event, across all care settings, will not be funded in its entirety;
- b. implement an approach whereby all HACs across every public hospital will have a reduced funding level to reflect the extra cost of a hospital admission with a HAC and will be risk adjusted; and
- c. develop a pricing and funding approach for avoidable hospital readmissions related to a prior HAC, based on a set of definitions developed by the ACSQHC.

B28. Parties may request the IHPA provide monitoring and support for the development of innovative models of care and funding for inclusion into the national funding model under clauses A96 to A101.

B29. The IHPA will improve transparency by publicly reporting on:

- a. ABF, including release of nationally consistent classifications, costing methods and data and efficient prices;
- b. its advice in respect of block funding and the basis of that advice; and
- c. its findings and supporting analysis on cost-shifting and cross-border issues raised by parties to the Addendum, following consultation with the relevant jurisdictions.

B30. The IHPA will provide all governments with draft copies of its reports before they are

released publicly. All governments will have 45 calendar days in which to comment on the reports.

- B31. The IHPA may undertake data collection and research, including by commissioning others to undertake specified studies and research.
- B32. In carrying out its functions, the IHPA will:
- a. publicly call for submissions from interested parties annually;
 - b. have regard to any submissions from governments regardless of when they are made; and
 - c. draw on relevant expertise and best practice within Australia and internationally.
- B33. Should the IHPA, in carrying out its functions, identify significant anomalies in service provision or pricing which potentially suggest activity contrary to the intent of this Addendum, the IHPA may consult with the relevant jurisdiction. If the matter is unresolved following consultation with the relevant jurisdiction, the IHPA may confidentially provide information to all jurisdictions about the matter. Should a jurisdiction consider this information evidence of cost-shifting, they can make a submission to the IHPA (as set out in clause A125).
- B34. Any information provided as a result of consultation under clause B33 by a jurisdiction to IHPA can only be used to resolve the matter in relation to which the information was provided for.

Governance

- B35. The IHPA comprises an independent board and chief executive officer, supported by officials from the Commonwealth Department of Health operating at the direction of the IHPA CEO. The ongoing costs of the IHPA will continue to be met by the Commonwealth.
- B36. In seeking to make an appointment to the position of the IHPA CEO, the IHPA Board will consult with the Parties.

Consultation

- B37. The IHPA must seek guidance from Parties, through the IHPA Jurisdictional Advisory Committee, when implementing changes to the national funding model that will impact the way services are delivered. Parties may escalate a funding policy issue to the HSPC, AHMAC or CHC for consideration.
- B38. The IHPA must provide a Statement of Impact to Parties when material changes or significant transitions are proposed to the national funding model, including changes that will have a major impact on any one party or materially redistribute activity between service streams.
- B39. The Statement of Impact must be timely in relation to the matter raised and:

- a. include a risk assessment of the proposed changes or adjustments;
- b. outline appropriate transition arrangements;
- c. be informed by consultation with the Parties; and
- d. have input from the Administrator.

B40. The IHPA will provide AHMAC with a clear understanding of IHPA's processes, governance arrangements and its committees on national funding model matters.

Administrator of the National Health Funding Pool

Functions

B41. The Administrator of the National Health Funding Pool (the Administrator) is an independent statutory office holder, distinct from Commonwealth and State and Territory governments and established by the *National Health Reform Act 2011*.

B42. The functions of the Administrator are to:

- a. calculate and advise the Commonwealth Treasurer of the Commonwealth contribution to the National Health Funding Pool under this Addendum;
- b. reconcile estimated and actual volume of service delivery, informed by the results of data checking activities conducted by other bodies on behalf of the Administrator, and incorporate the result of this reconciliation into the calculation of the Commonwealth contribution to the National Health Funding Pool;
- c. maintain accounts (established by each State) with the Reserve Bank of Australia in the name of each State, collectively known as the National Health Funding Pool;
- d. oversee payment of Commonwealth funding determined under this Addendum into State accounts established at the Reserve Bank of Australia under State legislation;
- e. oversee payments into Pool accounts of State funding provided under this Addendum;
- f. pay State funding from Pool accounts to Local Hospital Networks and other recipients in accordance with the direction of the relevant State Health Minister; and
- g. publicly report on:
 - i. funding received into the National Health Funding Pool from the Commonwealth;
 - ii. funding received into the National Health Funding Pool from the States;
 - iii. payments made from the National Health Funding Pool to Local Hospital Networks and State managed funds, and the basis on which these payments are made;

- iv. payments made, and the basis on which these payments are made, from the State managed funds to Local Hospital Networks and other providers, based on information provided by States;
 - v. payments made by the Commonwealth through the National Health Funding Pool to the States for the provision of public health services;
 - vi. top-up payments made by the Commonwealth through the National Health Funding Pool to the States;
 - vii. the volume of public hospital services provided by Local Hospital Networks; and
 - viii. the delivery of other public hospital functions funded by the National Health Funding Pool and State managed funds.
- h. calculate Commonwealth Funding Entitlement of States with reported Sentinel Events;
 - i. calculate Safety and Quality Adjustments to be made using the pricing and funding models nominated for this purpose by the Parties; and
 - j. advise the Commonwealth Treasurer of h) and i) during annual Reconciliation and a) during six monthly assessment reporting.

Governance

- B43. As per the *National Health Reform Act 2011*, the Chief Executive Officer of the National Health Funding Body is appointed by the Commonwealth Minister.
- B44. In seeking to make an appointment to the position of the NHFB CEO, the Commonwealth Minister will consult with the States.

Consultation

- B45. The Administrator must have regard to intent and objectives of the Addendum and avoid unnecessary administrative burden for Parties when considering implementation of the Addendum.
- B46. The Administrator will provide AHMAC with a clear understanding of the Administrator's processes, governance arrangements, its committees on national health funding matters and changes to these arrangements.

Australian Commission on Safety and Quality in Health Care

Functions

- B47. The Australian Commission on Safety and Quality in Health Care is a Commonwealth statutory authority established under the *National Health Reform Act 2011*. The ACSQHC is a body corporate subject to the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

- B48. The role of the ACSQHC is to:
- a. lead and coordinate improvements in safety and quality in health care in Australia by identifying issues and policy directions, and recommending priorities for action;
 - b. disseminate knowledge and advocate for safety and quality;
 - c. report publicly on the state of safety and quality including performance against national standards;
 - d. recommend national data sets for safety and quality, working within current multilateral governmental arrangements for data development, standards, collection and reporting;
 - e. provide strategic advice to CHC on best practice thinking to drive quality improvement, including implementation strategies; and
 - f. recommend nationally agreed standards for safety and quality improvement.
- B49. The ACSQHC will expand its role of developing national clinical standards and strengthened clinical governance. These arrangements will be further developed in consultation with Parties to this Addendum via AHMAC.
- B50. The ACSQHC will:
- a. formulate and monitor safety and quality standards and work with clinicians to identify best practice clinical care, to ensure the appropriateness of services being delivered in a particular health care setting; and
 - b. provide advice to CHC about which of the standards are suitable for implementation as national clinical standards.
- B51. The ACSQHC does not have regulatory functions.
- B52. In relation to the safety and quality reforms described in this Addendum, the ACSQHC will:
- a. curate the Sentinel Events and HAC lists for the purposes of ensuring they remain robust and relevant for clinical improvement purposes, within its existing governance arrangements and in conjunction with IHPA Technical Advisory Committee advice;
 - b. maintain a HAC Curation Clinical Advisory Group (HCCAG) to advise on new and existing complications on the HAC list. The HCCAG will have regard to the recommendations of specialty Clinical Panels established by the ACSQHC where necessary;
 - c. assess rates of preventability for each HAC to inform a risk adjustment methodology developed by IHPA;
 - d. maintain a nationally consistent definition for avoidable hospital readmissions

associated with a HAC;

- e. consult with ACSQHC committees to ensure proposals forwarded to AHMAC and CHC best represent matters that are supported by the relevant committees; and
- f. advise on clinician engagement.

Consultation

- B53. The Parties expect that, in performing its functions, the ACSQHC will provide advice to the CHC on best practice thinking to drive quality improvement, including implementation strategies.
- B54. The Parties expect that, in performing its functions, the ACSQHC will collaborate with Parties via AHMAC.
- B55. The ACSQHC is expected to liaise with AHMAC to provide a clear understanding of the ACSQHC's processes, governance arrangements, its committees on national safety and quality matters and any changes to these arrangements.

Australian Institute of Health and Welfare

Functions

- B56. The Australian Institute of Health and Welfare is a Commonwealth statutory authority established under the *Australian Institute of Health and Welfare Act 1987* (the Institute Act). The AIHW is a body corporate subject to the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).
- B57. The AIHW is an independent agency that provides reliable, regular and relevant information on Australia's health and welfare. The AIHW's broad health-related functions are set out in section 6 of the Institute Act and include:
 - a. collecting and producing health-related information and statistics; coordinating and assisting the collection and production of such information by other bodies;
 - b. developing methods and undertaking studies designed to assess the provision, use, cost and effectiveness of health services and health technologies;
 - c. conducting and promoting research into health and health services; developing statistical standards and classifications; and
 - d. subject to confidentiality requirements in the Institute Act, providing access to health information and statistics.
- B58. The AIHW, in accordance with the Australian Health Performance Framework, will:
 - a. provide clear and transparent annual public reporting of the performance of every Local Hospital Network, the hospitals within it, every private hospital and every Primary Health Network;

b. develop additional performance indicators, when asked by the Commonwealth Health Minister at the request of CHC; and

c. maintain the MyHospitals website and MyHealthyCommunities website.

B59. In undertaking its work, the AIHW will provide comparative analysis across Local Hospital Networks and Primary Health Networks.

B60. The AIHW will carry out work designed to facilitate jurisdictions' understanding of service performance in line with implementation of the Australian Health Performance Framework, as agreed from time to time by CHC.

B61. The AIHW will develop specifications for performance indicators to be reported under the Australian Health Performance Framework that align with AHMAC's intentions for health sector performance reporting (see Schedule D).

B62. The AIHW will continue to develop the National Integrated Health Services Information Analysis Asset which will comprise linked health services data to inform contemporary health policy development and the planning and monitoring of health and residential aged care service delivery (see clause C44(d) in Schedule C). The AIHW will do this in consultation with key stakeholders, including jurisdictions, clinicians and consumer representatives, and through established committee processes.

B63. The AIHW will establish a 'national front door' as a reporting platform for performance information, to assist Australians to make informed decisions about the performance of the health system.

Consultation

B64. The Parties expect that, in performing its functions, the AIHW will collaborate with Parties via AHMAC.

B65. The AIHW will provide AHMAC with a clear understanding of the AIHW's processes, governance arrangements and its committees on national health information matters and changes to these arrangements.

Data requirements for the national bodies

B66. The national bodies will develop rolling three year data plans indicating their future data needs, in line with the following process:

- a. each national body will develop a data plan that takes into account the objectives of this Addendum and the requirements in clause B67;
- b. each national body will provide its data plan to the CHC; and
- c. the plan will be considered final and complete 30 calendar days after release, unless the process referred to in clause B70 is invoked.

- B67. In determining data requirements, each body must:
- a. seek to meet its data requirements through existing national data collections, where practical;
 - b. conform with national data development principles and wherever practical use existing data development governance processes and structures, except where to do so would compromise the performance of its statutory functions;
 - c. allow for a reasonable, clearly defined, timeframe to incorporate standardised data collection methods across all jurisdictions;
 - d. support the concept of ‘single provision, multiple use’ of information to maximise efficiency of data provision and validation where practical, in accordance with privacy requirements;
 - e. balance the national benefits of access to the requested data against the impact on jurisdictions providing that data; and
 - f. consult with the Commonwealth and States when determining its requirements.
- B68. AHMAC will periodically review the three-year data plans of the national bodies for the effectiveness and appropriateness of data requested from jurisdictions. The review will consider the administrative burden of non-essential data requests:
- a. The review will check the three-year data plans conform with the data requirements of clause B67; and
 - b. The review of three-year data plans will be conducted at least once every three years.
- B69. Privacy of individual healthcare users is paramount and will be protected at all times. The national bodies will collect, secure and use information in accordance with relevant legislation and Australian Privacy Principles, ethical guidelines and practices in order to protect the privacy of individuals. To give effect to this commitment, the Commonwealth will consult with relevant privacy stakeholders on Commonwealth-related data aspects of this Addendum.
- B70. The CHC may direct the national bodies in respect of specific elements of their data plans or interim data plans:
- a. if it determines that a plan does not meet the requirements set out at clause B67; and
 - b. provided that such a direction would not diminish the achievement of transparency, comparability or other objectives of this Addendum or materially delay implementation.
- B71. If a jurisdiction intends to request CHC to consider changes to the data plan under clause B70, the following procedure will be used:

- a. within 45 calendar days of the release of the plan, the jurisdiction must lodge a submission with CHC, setting out its reasons for seeking the direction;
 - b. the jurisdiction must provide the body that developed the data plan with a copy of the submission; and
 - c. within 21 calendar days of receiving the submission, CHC will consider the matter out of session and agree its response.
- B72. Subject to clauses B67 and B69, the Commonwealth and States will provide the national bodies outlined above with the data the national bodies determine is required to carry out their functions in accordance with their data plans. This data will be provided to each agency as required, with the exception of patient identified data which will be provided to the Services Australia (formerly the Commonwealth Department of Human Services) for the purpose of de-identifying the data (as set out in clause B74). This de-identified data will then be used by the IHPA and NHFB in the calculation of the national efficient price and ensure appropriate Commonwealth payments for public hospital services.
- B73. Data requested by a national body from a jurisdiction, additional to the requirements of the published three year data plan, can only be used to resolve the matter in relation to the which the information and/or data was provided, or other purposes agreed by the Parties.
- B74. Where patient identified data is required, States will provide that data with patients identified by a Medicare Card Number to Services Australia. Services Australia will then de-identify that data and provide it to the relevant national body. Where patient identified data is required it will be subject to relevant Commonwealth and State statutory protections of individuals' privacy.
- B75. The Commonwealth Department of Health will be able to access relevant matched data to allow it to perform Medicare compliance activities and State health departments will be able to access a copy of the matched data relevant to their jurisdiction for verification purposes.
- B76. The Commonwealth and the States will take responsibility for the data integrity within their systems and agree to establish appropriate independent oversight mechanisms for data integrity, to provide certainty to the Australian public about the actual performance of hospitals and other parts of the health system.
- B77. As set out in clause B67(d), data provided to the national bodies may be shared between agencies as set out by the following principles:
- a. the national bodies will be able to access data to allow them to meet their functions as set out by this Addendum;
 - b. the Australian Bureau of Statistics will be able to access relevant data required to meet its legislative and contractual reporting requirements;
 - c. the Australian Institute of Health and Welfare (AIHW) will be able to access relevant

data to allow the AIHW to meet its statutory and contractual reporting requirements;

- d. Services Australia will be able to access data to perform its role of de-identifying patient level data to allow the Administrator to perform their functions; and
- e. the Commonwealth Department of Health, the Commonwealth Department of Veterans' Affairs, the Commonwealth Treasury, State health departments and State treasuries will be able to access all de-identified data for the purposes of policy analysis and planning.

- B78. To ensure that States are able to effectively fulfil their responsibilities in public hospital management and health planning, the Commonwealth will provide reasonable access to Local Hospital Network level and PHN level health and ageing data about Commonwealth programs in accordance with arrangements under Schedule C (see Enhanced health data). CHC will agree appropriate protocols and procedures to govern the operation of this arrangement, including compliance with Commonwealth legislative obligations.
- B79. With regard to clause B77(e), those agencies will not publish, or use in any way publicly, or provide data to a third party without the express written approval of the originating jurisdiction in writing, except where there is a legislative basis to do so.
- B80. In using the data available, agencies listed in clause B77 will have regard to the caveats and limitations of the collected data.
- B81. Each body will publish details of Commonwealth and State compliance with the data requirements of the national bodies on a quarterly basis.

Statement of Assurance

- B82. States will provide the IHPA with a Statement of Assurance from a senior health department official on the completeness and accuracy of approved data submissions provided under clauses A66, A79, B76 and B77 of this Addendum:
- a. consistent with clause B77, the IHPA will provide statements of assurance to the Administrator;
 - b. jurisdictions will use the Statement of Assurance template agreed by AHMAC; and
 - c. the provision of the Statement of Assurance does not prevent a State from resubmitting data to improve previous submissions, subject to the requirements in clause A78. Each approved submission or resubmission of data will be accompanied by a Statement of Assurance.
- B83. Data provided to the Administrator by the Commonwealth under clauses A8 and A9 will also require a statement of assurance on completeness and accuracy of data submitted by the relevant Divisional Data Steward.

SCHEDULE C – LONG-TERM HEALTH REFORM PRINCIPLES

- C1. Shared action on long-term health system reform is essential to achieve the agreed critical priorities of:
- a. Improving efficiency and ensuring financial sustainability
 - b. Delivering safe, high-quality care in the right place at the right time; through
 - i. Nationally cohesive health technology assessment
 - ii. Paying for value and outcomes
 - iii. Joint planning and funding at a local level
 - c. Prioritising prevention and helping people manage their health across their lifetime; through
 - i. Empowering people through health literacy
 - ii. Prevention and wellbeing
 - d. Driving best practice and performance using data and research; through
 - i. Enhanced health data
- C2. The Parties acknowledge that a genuine commitment to shared action on long term health system reform with clearly identified approaches will contribute to improved patient outcomes, reducing emergency department demand, avoidable hospital admissions and extended stays. Actions to improve the interfaces with the health system will also be essential in addressing this demand (see Schedule F).
- C3. Facilitation of innovative approaches will be critical. The Parties agree funding pools and models must have sufficient flexibility to enable the testing and trialling of these approaches. The Parties will also work collaboratively on the fundamental enablers of the reform such as strengthened governance arrangements, including for sharing and developing data simplifying processes to support long term health system reform objectives.
- C4. The Parties agree to jointly develop detailed implementation plans for each of the six long-term reforms outlined above, to be considered by COAG Health Council (CHC). Once approved, the implementation plans will be appended to this Addendum. The implementation plans will include steps and timelines for delivery of activities, objectives, expected outcomes and evaluation.
- C5. The Parties agree that activities included as part of this schedule and in the implementation plans will be delivered within existing resources and programs, unless specific budget authority or agreement by jurisdictions has been sought and granted.
- C6. The Parties also:
- a. Commit to regular progress reports to CHC on implementation of reforms and progress against key outcomes, including reducing emergency demand, avoidable hospital admissions and extended stays in public hospitals;

- b. Agree that a common approach to evaluation is required to assess reform outcomes and inform CHC considerations to refine, further scale or apply reforms nationally; and
- c. Recognise that reforms should be tested in a range of circumstances to ensure they meet the needs of all Australians, including rural and remote areas, as well as vulnerable populations.

Nationally cohesive health technology assessment

- C7. Australia requires a strategic, systematic, cohesive, efficient and responsive national framework for health technology assessments (HTA). The current approach to the use of HTA to inform investment and disinvestment decisions in Australia is fragmented and does not facilitate coordinated and timely responses to rapidly changing technologies.
- C8. Separate processes exist across all levels of the health system, which has the potential to duplicate effort, create inefficiencies and inconsistent advice, and delay access to innovative and emerging technologies. Proactive planning will optimise financial and organisational access to innovative and emerging technologies.
- C9. The Parties agree that:
 - a. HTA is an important means of delivering value to patients and the broader health system;
 - b. the Commonwealth and States must determine how to prioritise spending on health technologies within the constraints of limited budgets, and do so in a way that is consistent, equitable and efficient; and
 - c. the development and implementation of a nationally cohesive approach to HTA is an opportunity for governments to make informed decisions to deliver safe, effective and efficient care that is financially viable and improves population health.
- C10. The Parties further agree to jointly develop a federated approach to health technology assessment, with a view to towards a unified framework in the longer term. The goal is to increase the impact of HTA on policy, funding (investment and disinvestment) and service delivery decision making at all levels of the health system. The Parties acknowledge that a unified framework is ambitious and commit to testing and trialling this strategy within an initial narrow and defined scope.
- C11. The Parties agree that funding arrangements for new high cost, highly specialised therapies (HSTs), recommended for delivery in a public hospital setting by the Medical Services Advisory Committee, will be determined on the basis of hospital funding contributions specified in Schedule A with the following exceptions for the term of this Addendum:
 - a. the Commonwealth, for these types of therapies, will provide a contribution of 50 per cent of the growth in the efficient price or cost (including ancillary services), instead of 45 per cent; and
 - b. they will be exempt from the funding cap at clause A56 for a period of two years from the commencement of service delivery of the new treatment.
 - c. Upon commencement of service delivery of the new treatment in a State, the State

may request advice from the Administrator on the operation of the cap exemption for that treatment in that State.

- C12. The Parties agree that there will be joint decision making by Chairs of MSAC and PBAC and a nominated representative of CHC, on the referral for HTA of applications for a new HST likely to be offered within public hospitals. This decision will consider potential impact on other public hospital clinical services, as well relevant legislation guiding the HTA process. This decision will occur within 30 days of the application so that HTA is not unreasonably delayed by early consideration of implementation. The governance process for these arrangements is outlined at Appendix B.
- C13. The reform will also include the following components:
- a. establishment of a process to facilitate a consistent approach to HTA nationally, identify and prioritise technologies that would benefit from national level HTA;
 - b. development of a national HTA framework, including processes for HTA to inform advice on implementation, investment and disinvestment opportunities at Commonwealth and State levels;
 - c. establishment of an information sharing platform to enable collaboration between relevant jurisdictional and national bodies;
 - d. Production of public and stakeholder guidance; and
 - e. Review and support of HTA workforce.
- C14. The Parties agree that the Australian Health Ministers' Advisory Council (AHMAC) and its relevant authorised committees will oversee the design and delivery of the HTA federated approach.
- C15. The Parties jointly agree to ensure that other relevant agencies and committees directly or partially engaged in HTA remain informed of and consulted on the progress of this long term health reform.
- C16. The Parties agree to continue to work together to improve the engagement with, and transparency of, HTA processes where the item under assessment is likely to be delivered in a public hospital setting.

Paying for value and outcomes

- C17. While Australia's health system performs comparatively well, current models for commissioning and funding health care are fragmented and do not reward providers for planning, coordination, and integration of care across a treatment journey. Policies and programs are designed in isolation from one another, even though patients access services across boundaries between programs. This has widespread impacts on people, providers and funders, and jeopardises the sustainability of the health system.
- C18. Responding to the challenges the Australian health system will face in the future demands a financing system that is proactive, value-based and focused on individual and community needs. The current system does not afford the necessary funding flexibility and governance arrangements to address these challenges, provide best patient care and support contemporary models of care.

- C19. The Parties agree that the Paying for Value and Outcomes reform will explore funding and payment mechanisms to create stronger incentives for providers to:
- a. focus on the outcomes that matter to patients, including through the utilisation of Patient Reported Measures;
 - b. improve patient equity, namely inequities in health care provision, access to health care, and health outcomes;
 - c. improve clinical outcomes, including the outcomes that matter to patients, and experiences of health care;
 - d. deliver best-practice clinical care; and
 - e. focus on the entire patient journey, not just individual parts of it.
- C20. The Parties agree that reform to funding and payment mechanisms should be sustainable and holistic, and aim to improve the extent to which funding is:
- a. needs based, with funding distributed to patient and population need; and
 - b. flexible with funding conditions giving providers the necessary discretion to provide care in the right place, at the right time, by the right workforce.
- C21. Further, the Parties agree the reform plan for Paying for Value and Outcomes may include, but not be limited to, the following activities and commitments:
- a. develop a National Health Funding and Payments Framework to guide and evaluate trials and inform future implementation of health system reform across all levels of government;
 - b. identify and support removal of legislative, regulatory and technical barriers to the implementation of innovative funding and payment approaches, at the national and State and Territory levels;
 - c. develop and progress trials of funding and payment reforms at a:
 - i. program level – options may include bundled payments, refinements to ABF, capitation models, and outcomes-based payments, among others; and
 - ii. system level – options may include blended funding models and pooling of payment streams across programs and providers; and
 - d. A common approach to evaluation of trials and knowledge sharing, to inform further decisions about scaling of trials and future reform directions.
- C22. Successful delivery of reform objectives will be supported by the exploration and trial of new and innovative approaches to public hospital funding under this Addendum, as outlined in clauses A96 to A101.

Joint planning and funding at a local level

- C23. The current health system in Australia is fragmented, making it difficult for people to get well-coordinated care. There is a complex split between the Commonwealth and State governments, and the not-for-profit and private sectors, regarding who is responsible for planning, funding and delivering different services.
- C24. While these mixed funding and accountability arrangements have benefits, they do not create strong incentives for providers to plan, work together and co-ordinate care for patients. Current models of commissioning and funding health care do not compensate or reward providers for planning, coordination, and integration of care across a treatment journey. Patients with chronic and complex conditions are particularly at risk of receiving fragmented and variable quality of care because they often use a wide range of health services.
- C25. The Parties recognise that they need to work together to better plan and co-ordinate health services at the local level, and that this will benefit them both as population outcomes improve. This can only be achieved if there is greater collaboration across care settings, clinicians are engaged and supported to adopt new practices, accountabilities are clear, and there is a joint commitment across all agencies and governments that span the continuum of care.
- C26. As part of this shared commitment, the Parties will:
- a. encourage local health organisations, such as Primary Health Networks, Local Hospital Networks, as well as primary and community health services, to collaborate when planning health services and making investment decisions;
 - b. develop commissioning arrangements that provide stronger incentives for local health organisations to co-ordinate care, pool funding and integrate health services; and
 - c. establish shared reporting and accountability arrangements to effectively measure the impact on population health outcomes, quality of health services and value at the local level.
- C27. Further, the Parties agree the reforms aim to:
- a. reorient the health system around individuals and communities and improve patient outcomes and experiences while considering the impacts on patients, carers and their families;
 - b. achieve better integrated patient-centred care that is evidence-based and incentivises innovation;
 - c. emphasise patient empowerment, particularly through co-design of services, collaboration with providers and expanded use of new and existing technologies; and
 - d. promote equitable access to high quality health care and reduce disadvantage for all Australians, including for Aboriginal and Torres Strait Islander people and those living in regional and remote areas.

- C28. The reform plan for Joint Planning and Funding at a Local Level will include, but not be limited to, the following activities and commitments:
- a. nationally agreed principles for local-level commissioning;
 - b. identifying and supporting removal of barriers to joint governance, needs assessment, service integration, evaluation and funding, at a national and State and Territory level;
 - c. progressively trialling, evaluating, refining and scaling up joint planning and funding arrangements of increasing levels of ambition;
 - d. addressing workforce matters, including capability gaps for effective health services commissioning, and exploration of innovative workforce models and potential new roles to support better care coordination; and
 - e. ongoing monitoring and evaluation of joint planning and funding arrangements, including the development of shared outcome measures to determine the effectiveness of jointly planned and funded services.

Empowering people through health literacy

- C29. Health literacy is a system issue. It involves interactions between individual consumers, communities, healthcare professionals, and healthcare organisations. Creating health literacy-friendly systems and organisations through a co-design approach will better equip and empower people to manage their own health, engage effectively with health services, and achieve better health outcomes. People with low health literacy are less well equipped to take appropriate action to prevent and manage disease and ill health. As a result, they may have higher rates of hospitalisation, emergency care and adverse outcomes.
- C30. The Parties recognise that a significant proportion of adult Australians have low health literacy and that supporting health literacy can help to address the social determinants of health. Low health literacy compounds the disadvantage already experienced by marginalised groups. As a result, the Parties recognise the need to prioritise disadvantaged groups in the design of health literacy interventions because this will help to reduce inequity in access to care and health outcomes.
- C31. The Parties agree the reforms will aim to:
- a. improve population health outcomes;
 - b. make the health system and organisations more health literacy-friendly, so it is easier for people to get appropriate health information, support and services;
 - c. empower people to become informed and active participants in their own health care;
 - d. increase the uptake of health promoting behaviours, particularly among population groups at high risk of ill health;
 - e. develop providers' capacity to engage consumers in co-designing health services around patients' needs; and
 - f. improve the efficiency, effectiveness and equity of health service delivery.

- C32. The Parties will provide strategic leadership for the health sector to raise awareness of health literacy needs and build capacity within the workforce to meet these needs. Patient reports of their health outcomes and care experiences will be measured systematically to drive a transition towards more person-centred care.
- C33. Government-funded information resources and digital platforms will be better aligned, culturally appropriate and evidence-based. Information on the performance of the health system and services will be more accessible. These resources will support people to manage their own health and actively engage with their health service providers in making decisions about their care.
- C34. Evidence of the effectiveness of health literacy initiatives will be shared between governments and with the health workforce, researchers and the community.

Prevention and wellbeing

- C35. The Parties recognise the benefits of supporting Australians to live healthier lives by reducing the proportion of people living with preventable chronic conditions and delaying the onset of these conditions. Reducing the burden of chronic disease and addressing the underlying drivers to ill health will significantly reduce avoidable hospital admissions and make our health system more sustainable.
- C36. The risk of a person developing a preventable illness or condition is affected by social, economic and environmental factors, as well as their lifestyle. Prevention needs to work at several levels, beginning with a healthy start to life and targeting approaches at critical stages throughout a person's life, as well as impacting on the broader environment to create healthier places where people spend their time. It should include a focus on population groups and areas with the greatest need.
- C37. Despite consensus on the need to intervene earlier to prevent the onset of poor health and wellbeing, investment has historically been targeted towards treating ill health. Currently, there are few incentives for the health workforce to build prevention into practice, and there are ongoing difficulties measuring impacts, outcomes, and returns on investment for preventive health activities.
- C38. The Parties acknowledge that all governments currently invest in primary prevention of disease in various ways, and that the Prevention and wellbeing reform will complement existing activities.
- C39. The Parties agree that the key objectives of the reform is to:
 - a. increase investment in primary prevention;
 - b. reduce the prevalence of chronic disease;
 - c. support coordinated, cross-sector investment including from non-government sectors;
 - d. address the underlying drivers of ill-health, including social, economic and environmental determinants;
 - e. develop sustainable, innovative mechanisms for financing preventive health activities, including the adoption of cohort-specific and risk-based approaches to planning and prioritisation; and

- f. improve the sustainability of the health system.

C40. The Parties agree to the following actions:

- a. a national prevention monitoring and reporting framework, with a focus on shared priorities;
- b. a commitment to increase investment in primary prevention over time;
- c. developing innovative, fit-for-purpose financing mechanisms for scaling primary prevention initiatives;
- d. exploring evidence-based regulatory prevention measures; and
- e. reviewing and addressing health system barriers to prevention.

Enhanced health data

C41. The Parties recognise that timely access to data is critical to support shared patient-clinician decision making, improved service delivery, policy development and system planning.

C42. Parties acknowledge that enhanced health data is a critical enabler for all the long-term health reforms and commit to working together to harness data and analytics to drive meaningful improvements in the health system.

C43. The Parties are committed to achieving comprehensive health data access, usage and sharing, while at the same time maintaining data security and preserving individuals' privacy.

C44. The Parties agree the key objectives of the reforms are to achieve better patient outcomes and incentivise and support integrated patient centred care by:

- a. establishing a national standard approach to govern the creation, access and sharing of data from all Australian governments;
- b. providing data access to support shared patient-clinician decision making, improved service delivery and system planning;
- c. working together to better harness data, analytics and evidence in order to drive meaningful improvements in the health system; and
- d. progressing mechanisms and interoperable systems for secure and comprehensive integration of data across patient journeys, such as the National Integrated Health Services Information Analysis Asset, and a dynamic cyber security framework to ensure security and ethical management of personal health information.

C45. Further, in achieving comprehensive health data access, usage and sharing it will:

- a. facilitate bona fide research;
- b. protect individual privacy in line with relevant legislation, community expectations and values;

- c. make data available in a timely manner based on the purpose for which the data is intended to be used;
- d. collect data once for multiple uses;
- e. build capacity, capability and innovation in collecting and applying data; and
- f. allow all jurisdictions to identify priority reforms and timing of trials that best suit local needs and readiness.

C46. The Parties agree to the following national actions:

- a. scale up a national approach to data governance arrangements, structures and processes, to facilitate clear and efficient mechanisms for sharing and developing data in a sustainable, purpose-based and safe way;
- b. establish Commonwealth-State patient-level primary and community health care datasets to inform the development of quality indicators that support shared decision making and service planning across the primary, community and acute sectors;
- c. develop a health data workforce capability framework that defines roles and standards, identifies necessary skills, competencies and mechanisms to build capacity;
- d. develop a risk-based framework and standards to provide the capacity for the effective collection, sharing and security of data;
- e. develop and implement a consistent approach to the collection and use of Patient Reported Measures, to build national-level evidence and improve care across the health system; and
- f. review relevant legislation and regulations across Australia to provide recommendations on ways to support better data linkage while ensuring appropriate protections for patient privacy.

C47. The Parties agree to the following bilateral activities:

- a. share information about current data systems, processes and guidelines to help inform solutions for data sharing; and
- b. pilot projects for local implementation and feedback to all participants.

SCHEDULE D – TRANSPARENCY AND PERFORMANCE

- D1. While the Australian health system performs well, access to timely, fit-for-purpose information, which is needed to make informed decisions about health care is not consistently available. Expanding public reporting on quality, safety and value of health services will drive improvements in the health system and make providers more accountable for outcomes.
- D2. Health Ministers have agreed to the Australian Health Performance Framework (AHPF) which will provide a single framework to support system-wide reporting on Australia's health and health care performance, support research for policy and planning purposes, and inform the identification of priorities for improvement and development.
- D3. Past agreements have committed to improving public reporting on performance and outcomes and this Addendum will build on them.
- D4. All Parties will be accountable to the community for their progress towards achieving the outcomes outlined in the AHPF and articulated in this Addendum, as well as any prior commitments to performance indicators, public reporting and data provision.
- D5. The Parties agree that the following will be provided to COAG Health Council (CHC) for approval including:
 - a. A consolidated set of whole of system performance indicators that are drawn from the AHPF (with priority given to reporting already agreed indicators). This will include:
 - i. A review of the performance indicators outlined in the National Healthcare Agreement 2012 (NHA) and other relevant health performance frameworks;
 - ii. A detailed plan for developing new performance indicators to measure progress and impact against the whole AHPF, including the impact on the health of other sectors that intersect with the health system; and
 - iii. Timeframes for regular public reporting and updating indicators ensuring information is current and relevant;
 - b. Revised performance benchmarks to demonstrate improvement in performance over time. This will replace the performance benchmarks in the NHA;
 - c. A mechanism of governance for the:
 - i. review and revision of indicator set utility and relevance to the AHPF;
 - ii. rationalisation of reporting by data providers, including moving over time to single provision, multiple use; and
 - iii. accurate analysis and interpretation of shared data; and
 - d. A proposed approach to measuring value in the health system that encompasses Commonwealth, State, private sector and individual funding sources and aligns with the definition in this Addendum.

- D6. Progress on work outlined in clause D5 will be reported to the Health Services Principal Committee in consultation with the Australian Institute of Health and Welfare (AIHW), the Australian Commission on Safety and Quality in Health Care (ACSQHC), the Independent Hospital Pricing Authority (IHPA), the Productivity Commission (PC), the Australian Digital Health Agency (ADHA), the National Aboriginal and Torres Strait Islander Health Standing Committee (NATSIHSC) and other bodies as required.
- D7. The Parties will work to harmonise reporting arrangements on health system performance information and data and rationalise where appropriate. This includes Parties agreeing to:
- a. a list of reports for inclusion as part of the reporting arrangements under the AHPF; and
 - b. ongoing monitoring of the list of AHPF reports.
- D8. Further to clause D5, the Parties agree to work collaboratively with relevant national agencies in accordance with their roles and responsibilities outlined in Schedule B to:
- a. Review and revise the National Health Information Agreement (consistent with the principles outlined in this Addendum) by April 2021;
 - b. Manage a central repository for the AHPF performance information and national reporting, leveraging the existing infrastructure and platforms;
 - c. Ensure fit for purpose public reporting of performance information is accessible, understandable and timely for stakeholders, based on the data provided by all sources in accordance with this Addendum; and
 - d. Develop and provide, in collaboration with relevant stakeholders, tiered, fit for purpose reporting at the lowest meaningful level of granularity, in line with best practice and subject to any applicable privacy legislation. This could include:
 - i. Individual providers and facilities, local (PHN, LHN), State/Territory, national and international;
 - ii. Priority population groups including Aboriginal and Torres Strait Islander populations;
 - iii. Comparisons across local (PHN, LHN), State/Territory regions and population groups;
 - iv. Funding sources;
 - v. Different health conditions;
 - vi. Demographic and socio-economic groups; and
 - vii. Public and private health care providers and funders.

- D9. The Parties agree that transparent performance reporting should be based on the following:
- a. flexibility to evolve over time to support the long term objectives of this Addendum;
 - b. ability to progressively expand to cover the AHPF domains focused on health system performance;
 - c. apply measures across the range of private sector and primary care settings;
 - d. providing timely and regular information to the public on the performance, safety and quality of the health system and health facilities;
 - e. provide data once through a single source with multiple use by national agencies and Commonwealth departments;
 - f. use agreed data supply pathways;
 - g. strong governance protocols which limit unauthorised access and protect privacy;
 - h. prioritise additional data sources for development and expansion over time; and
 - i. States and Territories remain responsible for jurisdictional reporting of performance information outside the scope of national reporting.
- D10. Whole of system reporting will include all facets of the health system including primary, secondary and tertiary services in the public, private and community settings:
- a. The Parties agree to align their individual performance frameworks with the AHPF to the greatest extent;
 - b. The Parties agree to develop and implement enhanced performance reporting across the whole care pathway including:
 - i. Health system outcomes including: health outcomes, clinical outcomes, safety and quality, workforce outcomes and health system sustainability;
 - ii. Patient-centred outcomes by embedding Patient Reported Measures and moving towards linkage with other data sets;
 - iii. Increased coverage and reporting of primary care activity;
 - iv. Specific consideration of the representation of Aboriginal and Torres Strait Islander peoples' experience including: the choice of outcomes; patient centred outcomes; the presentation and interpretation of reporting; and any other factors;
 - v. Increased coverage and reporting of private hospital sector activity and performance; and
 - vi. The interface between health and other sectors, such as the disability or aged

care sectors.

- D11. The Productivity Commission will continue its role of reporting the progress towards the COAG's key commitments, including reviewing progress against a set of agreed national performance indicators defined through the AHPF.

SCHEDULE E – LOCAL GOVERNANCE

Local Hospital Networks

- E1. The Commonwealth and the States agree that the role of Local Hospital Networks is to decentralise public hospital management and increase local accountability to drive improvements in performance. Local Hospital Networks are accountable for treatment outcomes and responsive to patients' needs and make active decisions about the management of their own budget. They have the flexibility to shape local service delivery according to local needs.
- E2. Local Hospital Networks are required to engage with the local community and local clinicians, incorporating their views into the day-to-day operational planning of hospitals, particularly in the areas of safety and quality of patient care.
- E3. Local Hospital Networks are required to directly manage public hospital services and functions and may at the discretion of States also have responsibility for delivery of other health services. Local Hospital Networks are required to work with Primary Health Networks to integrate services and improve the health of local communities.
- E4. Local Hospital Networks are responsible for:
 - a. managing their own budget, in accordance with State financial and audit requirements;
 - b. managing performance of functions and activities specified in Service Agreements;
 - c. receiving Commonwealth and State funding contributions for delivery of services as agreed under the Service Agreement entered into with the State government;
 - d. local implementation of national clinical standards to be agreed between the Commonwealth and States on the advice of the Australian Commission on Safety and Quality in Health Care (ACSQHC);
 - e. local clinical governance arrangements;
 - f. providing information to States at their request, for the purpose of enabling the relevant State to provide information and data to the national bodies and the Commonwealth;
 - g. maintaining accountability under, and subject to, State financial accountability and audit frameworks; and
 - h. collaborating with Primary Health Networks and private providers to meet the health needs of the community and minimise service duplication and fragmentation.
- E5. Local Hospital Networks are required to 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.
- E6. Local Hospital Networks are required to engage with the following stakeholders to enable

their views to be considered when making decisions on service delivery at the local level, or service and capital planning at the State level:

- a. other Local Hospital Networks to collaborate on matters of mutual interest;
- b. local primary health care providers, Primary Health Networks and aged care services; and
- c. the local community and local clinicians, particularly in the area of safety and quality of patient care.

E7. The Local Hospital Network Service Agreement are required to include at a minimum:

- a. the number and broad mix of services to be provided by the Local Hospital Network, so as to inform the community of the expected outputs from the Local Hospital Network and allow the Administrator to calculate the Commonwealth's funding contribution (clause B42(a) refers);
- b. the quality and service standards that apply to services delivered by the Local Hospital Network, including the Performance and Accountability Framework (2011 NHRA) and Australian Health Performance Framework (Schedule D);
- c. the level of funding to be provided to the Local Hospital Networks under the Service Agreement, through ABF, reported on the basis of the national efficient price, and block funding; and
- d. the teaching, training and research functions to be undertaken at the Local Hospital Network level.

E8. Service Agreements are required to be publicly released by States within fourteen calendar days of finalisation or amendment and are required to then also be made available through relevant national bodies. States may agree additional matters with Local Hospital Networks (such as the delivery of additional programs).

E9. The Commonwealth is not a party to Local Hospital Network Service Agreements and has no role, directly or indirectly, in the negotiation or implementation of Local Hospital Network Service Agreements.

E10. States are accountable for financial management and audit of Local Hospital Networks and are required to ensure that stringent independent oversight and financial accountability is put in place.

E11. Local Hospital Networks are required to have separate bank accounts able to receive funding from the National Health Funding Pool independent of State treasuries or health departments and are required to be audited as separate entities.

E12. Local Hospital Networks are required to have a professional Governing Council and Chief Executive Officer, unless otherwise agreed by the Health Ministers of the Commonwealth and an individual jurisdiction. The professional Governing Council and Chief Executive Officer are responsible for:

- a. delivering agreed services and performance standards within an agreed budget, based on annual strategic and operating plans, to give effect to the Local Hospital Network Service Agreement;

- b. ensuring accountable and efficient provision of services and producing annual reports, subject to State financial accountability and audit frameworks;
- c. monitoring Local Hospital Network performance against the agreed performance monitoring measures in the Local Hospital Network Service Agreement, including the Performance and Accountability Framework (2011 NHRA) and Australian Health Performance Framework (Schedule D);
- d. improving local patient outcomes and responding to system-wide issues; and
- e. maintaining effective communication with the State and relevant local stakeholders, including clinicians and the community.

E13. Local Hospital Network Governing Councils are responsible for:

- a. negotiating and agreeing with the relevant State government a Local Hospital Network Service Agreement and any necessary adjustments; and
- b. developing a strategic plan for the Local Hospital Network, and implementing an operational plan to guide the delivery of the services, within the budget agreed under the Local Hospital Network Service Agreement.

E14. Local Hospital Network Governing Councils are required to comprise members with an appropriate mix of skills and expertise to oversee and provide guidance to large and complex organisations, including:

- a. health management, business management and financial management;
- b. clinical expertise, including expertise external to the Local Hospital Network wherever practicable;
- c. cross-membership with Primary Health Networks wherever possible;
- d. where appropriate, people from universities, clinical schools and research centres; and
- e. where appropriate, people with other skills and experience.

E15. The overall makeup of Local Hospital Network Governing Councils are required to be determined taking into account the need to ensure local community knowledge and understanding.

E16. Local Hospital Network Governing Councils are required to be recruited through a process conducted publicly, transparently and in accordance with due process principles, and are required to be remunerated at rates determined by the relevant State.

E17. Local Hospital Network Governing Council members are required to be appointed under State legislation by State Health Ministers. Each Local Hospital Network's Chief Executive Officer (CEO) is required to be appointed by the Governing Council, with the approval of the State Health Minister or their delegate, and are required to be accountable to the Governing Council.

E18. Local Hospital Network Governing Councils are required to establish a formal engagement protocol with local Primary Health Networks.

Local Hospital Network Structure

- E19. Local Hospital Networks are required to comprise single or small groups of public hospitals with a geographic or functional connection, large enough to operate efficiently and to provide a reasonable range of hospital services and small enough to enable the Local Hospital Networks to be effectively managed to deliver high quality services.
- E20. Types of Local Hospital Networks include:
- a. metropolitan Local Hospital Networks, which are required to comprise at least one hospital, but could comprise a small group of hospitals, and should be built around principal referral hospitals or specialist hospitals;
 - b. specialist Local Hospital Networks, which are required to have a functional focus without any particular geographic focus and are required to operate with whole-of-State coverage, for example specialist hospitals or the largest most complex tertiary hospitals; and
 - c. other Local Hospital Networks, bringing together an individual or groups of hospitals operated by third parties as public hospitals, including those operated by religious orders.
- E21. In regional Australia, a flexible approach is required to be adopted to determine the regional, rural and remote Local Hospital Network structure that best meets the needs of these communities and best takes into account the challenges of managing multiple small hospitals.
- E22. If over time States identify that significant changes are needed to roles and structures for Local Hospital Networks, they are required to work with Local Hospital Networks to deliver the adjustments necessary to respond to these changes, including the number and location of staff.
- E23. States are required to work cooperatively with the Commonwealth to ensure, wherever possible, common geographic boundaries with Primary Health Network boundaries, including where States introduce arrangements for cross-border Local Hospital Networks.
- E24. In respect of performance assessment, reporting and management of Local Hospital Networks:
- a. States, as system managers of the public hospital system, are required to agree and adopt the Performance and Accountability Framework (2011 NHRA) and Australian Health Performance Framework (Schedule D), and are required to be responsible for ensuring Local Hospital Network performance in accordance with this framework; and
 - b. States, as system managers of the public hospital system, are required to decide on the nature and timing of actions to remediate ongoing poor performance.

Primary Health Networks

- E25. Primary Health Networks will be the GP and primary health care partners of Local Hospital Networks, responsible for supporting and enabling better integrated and responsive local GP and primary health care services to meet the needs and priorities of patients and communities.

- E26. Primary Health Networks and State-funded health and community services will cooperate to achieve these objectives.
- E27. The strategic objectives for Primary Health Networks are:
- a. identifying the health needs of their local areas and development of relevant focused and responsive services;
 - b. commissioning health services to meet health needs in their region;
 - c. improving the patient journey through developing integrated and coordinated services;
 - d. providing support to clinicians and service providers to improve patient care;
 - e. facilitating the implementation of primary health care initiatives and programs; and
 - f. being efficient and accountable with strong governance and effective management.
- E28. Primary Health Networks have, among other functions, responsibility for assessing the health needs of the population in their region, for identifying gaps in GP and primary health care services and working with other funders and key stakeholders to put in place strategies to address these gaps.
- E29. Primary Health Networks are independent legal entities (not government bodies) with strong links to local communities, health professionals and service providers, including GPs, allied health professionals and Aboriginal and Torres Strait Islander Community Controlled Health Services. Primary Health Networks will reflect their local communities and health care services in their governance arrangements.
- E30. The Commonwealth and States will work together on system-wide policy and State-wide planning for GP and primary health care. The Commonwealth will consult with States and Primary Health Networks to ensure that:
- a. Primary Health Networks are taken into account in system-wide policy and State-wide planning for primary health care; and
 - b. plans required to be developed by Primary Health Networks take account of State-wide plans.
- E31. Primary Health Networks and Local Hospital Networks will be expected to share some common membership of governance bodies where possible. Primary Health Networks will be expected to work closely, and establish a formal engagement protocols, with Local Hospital Networks.
- E32. The Commonwealth will monitor performance for Primary Health Networks.
- E33. States will not establish duplicate GP or primary health care planning and integration organisations. To the extent that such organisations already exist, the Commonwealth and the relevant State will work together to agree a transition plan, including timing, for the organisation then to become part of Primary Health Network arrangements.
- E34. The Commonwealth and States will work together to create linkages and coordination mechanisms, where appropriate, between Primary Health Networks and other State

services that interact with the health system, for example services for children at risk, people with serious mental illness and homeless Australians.

- E35. The Commonwealth will work co-operatively with States to ensure, wherever possible, Primary Health Networks have common geographic boundaries with Local Hospital Networks. These boundaries may be reviewed over time by the Commonwealth in consultation with States.
- E36. Primary Health Networks will engage with the following stakeholders to enable their views to be considered when making decisions on service delivery at the local level, or service and capital planning at the State level:
 - a. other Primary Health Networks to collaborate on matters of mutual interest;
 - b. Local Hospital Networks, particularly to improve planning and delivery of services to coordinate and integrate care for patients; and
 - c. the local community and local clinicians, particularly in the area of safety and quality of patient care.

Commonwealth and State engagement to support local care delivery

- E37. GP and primary health care services are integral to an effective and efficient Australian health system. The Commonwealth will renew its efforts to improve GP and primary health care services in the community to improve care for patients. The Commonwealth will take lead responsibility for the system management, funding and policy development of GP and primary health care with the objective of delivering a GP and primary health care system that meets the health care needs of Australians, keeps people healthy, prevents disease and reduces demand for hospital services.
- E38. The Commonwealth and the States will work together on system-wide policy and local, regional and State level planning and funding for GP and primary health care given the impact on the efficient use of hospitals and other State funded services, and because of the need for effective integration across Commonwealth and State-funded health care services at the local level to improve patients' outcomes through early intervention and better coordination of care.
- E39. Commonwealth and States will work together to trial and test better approaches to accountability and funding that supports more integrated service delivery for communities. States will work cooperatively with the Commonwealth in the implementation and ongoing operation of the Commonwealth's primary health care initiatives.

Reforms to primary care to reduce potentially avoidable hospital admissions

- E40. The Commonwealth will continue to invest in programs designed to minimise the impact of potentially preventable hospital admissions arising from shortcomings in areas within its own direct policy control including:
 - a. integrating the planning, co-ordination and commissioning of services at a regional level through Primary Health Networks, with a specific focus on the interface between primary health care, and hospital services;
 - b. investments in national implementation of co-ordination of care models for persons

with complex, chronic conditions, and flexible funding models to better support persons with severe mental health conditions, consistent with the November 2015 response to the National Mental Health Commission Report - Contributing Lives, Thriving Communities;

- c. continued national rollout of My Health Records with legislative change to enable opt out provisions, with ongoing patient safety and efficiency benefits;
- d. implementation of the Community Pharmacy Agreement to enhance primary health care management of medications and avoidance of errors; and
- e. partnering with jurisdictions, where appropriate, in relation to primary health care, for example in remote and Aboriginal and Torres Strait Islander communities.

SCHEDULE F – INTERFACES BETWEEN HEALTH, DISABILITY AND AGED CARE SYSTEMS

- F1. Many Australians have increasingly complex care needs that require services from across the health, primary care, disability and aged care systems. This growing complexity requires better coordination between these systems to ensure positive outcomes for people through access to appropriate services, and reductions in avoidable hospital admissions, time spent in hospital and premature residential care admissions. Parties will develop meaningful and transparent mechanisms to monitor and report on system interface performance, and agree appropriate escalation pathways to ensure issues are identified and addressed proactively in a timely manner, to optimise consumer access and care outcomes.
- F2. The Parties recognise:
- a. that the disability, aged care, acute care, primary care and community health systems, including the Aboriginal and Torres Strait Islander Community Controlled Health sector, are part of a whole care and support system and are a collective responsibility;
 - b. all governments have a shared responsibility to improve people's health outcomes, by supporting consumers, carers and their families to better navigate the health, primary care, aged care, and disability support systems, with the aim of optimising care and support and reducing avoidable hospital admissions;
 - c. the interoperability of the health, primary care, aged care and disability systems, their interfaces, and that policy changes in one system can have an impact on other systems particularly in resource constrained environments.
 - d. that people who regularly move between and interact with the health, aged care and/or disability systems may be more vulnerable, so it is important to have clear and effective mechanisms in place to effectively co-ordinate care across systems;
 - e. that the outcomes of people living with a disability can be improved by supporting their continued access to mainstream health services and the National Disability Insurance Scheme (NDIS), where eligible; and
 - f. that the outcomes for older people can be improved by continued co-ordination between hospital, aged care and mainstream health services, including primary care services.

Roles and responsibilities

- F3. The roles and responsibilities of the Parties where they relate to the interface between health, primary care, aged care and disability support systems, including community and residential aged care, and the NDIS should be read together with the NDIS Bilateral Agreements, the National Psychosocial Supports Measure, relevant legislation and supporting documents including the:
- a. *Aged Care Act 1997*;
 - b. *the Aged Care Safety and Quality Commission Act 2018*;
 - c. *the National Disability Insurance Scheme Act 2013*;

- d. the National Disability Agreement;
 - e. the National Disability Strategy;
 - f. the NDIS Rules; and
 - g. the 'Principles to Determine the Responsibilities of the NDIS and other Service Systems - Applied Principles and Tables of Support (APTOS)' agreed by COAG.
- F4. In addition to the role and functions of the Australian Commission on Safety and Quality in Health Care (ACSQHC) (see Schedule B), the roles and functions of other relevant bodies including the Aged Care Quality and Safety Commission and the NDIS Quality and Safeguards Commission should also be considered.
- F5. The Parties acknowledge the need to build on the activities set out in the 2017 Bilateral Agreements on Coordinated Care, which were designed to improve people's health outcomes and reduce avoidable demand for health services.
- F6. The Commonwealth is responsible for:
- a. policy and regulation of community and residential aged care delivered under Commonwealth-funded aged care programs for all people;
 - b. funding of community and residential aged care delivered under Commonwealth-funded aged care programs for people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people);
 - c. providing continuity of support, where required, for clients of Commonwealth programs that support people who are aged under 65 years with a disability but are not eligible for the NDIS;
 - d. regulating the provision of services under the NDIS via the NDIS Quality and Safeguards Commission, once established in each State; and
 - e. policy and funding to support timely and appropriate access to general practitioners regardless of where people live, through benefits paid for services listed on the Medicare Benefits Schedule (MBS).
- F7. States are responsible for:
- a. policy, funding and regulation of relevant disability supports and services for people aged under 65 years (and Aboriginal and Torres Strait Islander people aged under 50 years) with a disability who are not eligible for the NDIS;
 - b. continuing to fund and provide access to mainstream public hospital and State owned and run community health services, regardless of a person's NDIS participation;
 - c. funding of Commonwealth residential aged care or Home Care Packages for people aged under 65 years, except Indigenous Australians aged 50 years and over, who are not eligible for the NDIS; and
 - d. providing continuity of support, where required, for clients of State specialist disability programs who are found to be ineligible for the NDIS, to assist them to achieve similar outcomes.

- F8. The Parties will share responsibility for:
- a. providing continuity of care across the health, primary care, aged care, and disability systems to ensure smooth client transitions and reduce avoidable hospital admissions, and avoidable disability and aged care admissions; and
 - b. providing direction and strategic guidance through the Disability Reform Council on the NDIS, that funds disability supports and services for people who are eligible.
- F9. Where applicable, the Parties will share program responsibility for their respective community care and residential care services for Aboriginal and Torres Strait Islander clients aged 50 to 64 years, who will be eligible to receive services from an appropriate provider under programs of either level of government. There will be no 'wrong door' for Aboriginal and Torres Strait Islander people in this age group seeking community or residential care services. Where care services are provided under a State funded program to an Aboriginal or Torres Strait Islander person aged 50 years or older the Commonwealth will meet the cost of the service.

Interface between systems

- F10. This work builds on activities agreed in the Bilateral Agreements on Co-ordinated Care that aim to improve care coordination, particularly for people with chronic conditions and a disability, and transitions between residential aged care and primary and acute settings.
- F11. The Parties are committed to working across service systems to ensure legislative and regulatory changes, changes to service types, eligibility, and methods and mechanisms of service delivery avoid a negative impact on the interoperability of health, primary care, aged care and disability systems and people's wellbeing and outcomes, by:
- a. ensuring that changes with anticipated impacts on interfacing systems are managed in a timely and collaborative manner;
 - b. using a range of clearly defined, existing governance mechanisms (including relevant Ministers' forums) to manage, escalate and report on significant interface issues in a timely and sustainable way.
- F12. The Parties agree that the AIHW, in consultation with States, Territories and the Commonwealth, will develop health, primary care, aged care and disability interface performance indicators and an associated data collection and reporting for COAG Health Council (CHC) consideration by June 2021. The indicators will monitor the impact of interface performance on client outcomes (with a focus on priority population groups), in domains including, but not limited to:
- a. responsiveness of assessment and decision making processes;
 - b. equity of access to primary care, aged care, and disability care systems;
 - c. public hospital efficiency, including access to public hospital services, avoidable admissions, and appropriate discharge.
- F13. The Parties recognise that issues may arise at the interface between the health, primary care, aged care and disability systems from time to time. To appropriately identify and understand such issues, Parties agree to:

- a. monitor and report on the effect of any policy or significant service change in one system, on services in other systems;
- b. support the health, primary care, aged care and disability systems to operate together effectively;
- c. monitor and analyse interface performance using performance indicators and data developed and collected under clause F12 to identify new issues and manage known issues;
- d. proactively address identified service gaps in a timely manner that minimises risk to individuals; and
- e. measure effectiveness of system and interface improvement strategies.

F14. The following governance arrangements will apply for resolving system interface issues:

- a. The Australian Health Ministers' Advisory Council (AHMAC) will monitor interface issues that arise between the health system, and primary care or aged care systems, and make recommendations to CHC to resolve those issues. AHMAC will report to CHC on issues and resolution strategies and seek endorsement for any action that requires Ministerial approval. Aged Care Ministers will be included in any decisions relating to the aged care system.
- b. AHMAC and the NDIS Senior Officials Working Group will monitor interface issues that may arise between the health system and the NDIS. Either party can raise an issue to be resolved with outcomes or recommendations to be provided to the Disability Reform Council and/or CHC, as appropriate.
- c. Ministerial Councils will update COAG on any consequential decisions or activity.
- d. COAG will determine appropriate governance arrangements which are not addressed by the above arrangements.

F15. Parties agree to explore the impact of housing security, provision and assistance on people's health outcomes, and report to CHC by December 2021.

F16. The Parties will jointly:

- a. recognise that the principles agreed by COAG in the APTOS will be used to determine the funding and delivery responsibilities of the NDIS and that the interactions of the NDIS with other service systems will reinforce the obligations of other service delivery systems to improve the lives of people with disability, in line with the National Disability Strategy, noting the APTOS does not intend to place additional obligations on other systems;
- b. work together with the NDIA to improve outcomes for people with a disability;
- c. work towards the consistent application and interpretation of data across the systems to assist understanding of the linkages between data sets, establish sharing practices, and explore the viability of a disability identifier in health data;
- d. improve data sharing for serious incident/missed care across systems to provide early warning flags for all regulators; and

- e. work towards sustainability and improved coordination of health, primary health, aged care and disability services particularly in regional, rural and remote communities with progress to be reported to CHC and the Disability Reform Council.

SCHEDULE G – BUSINESS RULES

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

Public patient charges

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

Charges for patients other than public patients

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

Pharmaceutical Reform Arrangements

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

in the Arrangements.

Public health services

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

Public patients' charter and complaints body

- G7. States agree to:
- a. continue the commitment under the previous health care agreements to preparing and distributing a Public Patients' Hospital Charter (the Charter), in appropriate community languages to users of public hospital services; and
 - b. maintaining complaints bodies independent of the public hospital system to resolve complaints made by eligible persons about the provision of public hospital services received by them.

Public Patients' Hospital Charter

- G8. States agree to:
- a. review and update the existing Charter to ensure its relevance to public hospital services. The review should be conducted with the Australian Commission on Safety and Quality in Health Care (ACSQHC);
 - b. develop the Charter in appropriate community languages and forms to ensure it is accessible to people with disabilities and from non-English speaking backgrounds;
 - c. develop and implement strategies for distributing the Charter to public hospital service users and carers; and
 - d. adhere to the Charter.
- G9. States agree to the following minimum standards:
- a. the Charter will be promoted and made publicly available whenever public hospital services are provided; and
 - b. the Charter will set out:
 - i. how the principles included in this Addendum are to apply to the provision of public hospital services in States;
 - ii. the process by which eligible persons can lodge complaints about the provision of public hospital services to them;
 - iii. that complaints may be referred to an independent complaints body;
 - iv. a statement of the rights and responsibilities of consumers and public hospitals in the provision of public hospital services in States and the mechanisms available for user participation in public hospital services; and

- v. a statement of consumers' rights to elect to be treated as either public or private patients within States' public hospitals, regardless of their private health insurance status.

Independent Complaints Body

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

Patient arrangements

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

services; and

- c. referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services.

G18. An eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit. On admission, the patient will be given the choice to elect to be a public or private patient in accordance with the National Standards for Public Hospital Admitted Patient Election processes (unless a third party has entered into an arrangement with the hospital or the State to pay for such services). If it is clinically appropriate, the hospital may provide information about alternative service providers, but must provide free treatment if the patient chooses to be treated at the hospital as a public patient. However:

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

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

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

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

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

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

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

Data provision to private health insurers

G24. Hospitals will continue to provide data on privately insured patients treated in a public hospital to insurers, consistent with the agreed private patients claim form (clause G30).

G25. Consistent with the principle of single provision, multiple use, Local Hospital Networks and the AIHW will work towards providing data on privately insured patients treated in a public hospital to insurers as required under the Private Health Insurance (Health

Insurance Business) Rules made under the *Private Health Insurance Act 2007*.

- G26. The Commonwealth will consult with States on any changes to the Private Health Insurance (Health Insurance Business) Rules made under the *Private Health Insurance Act 2007* that impact on the practices of public hospitals. Any changes to data provision requirements to private health insurers should avoid creating undue additional administrative burden on public hospitals.

Certification documentation

- G27. Consistent with the Private Health Insurance (Health Insurance Business) Rules, private health insurers are not to:
- a. request certification documentation from public hospitals beyond those requirements prescribed in the National Private Patient Hospital Claim Form; or
 - b. delay or refuse payments of claims for eligible hospital treatments.
- G28. Where there is insufficient or incorrect information in certification documentation, private health insurers should, in the first instance, work with the public hospital providing the certification documentation and seek further information.
- G29. As regulators of private health insurers, the Commonwealth will review compliance with the minimum standards set out in this Addendum, the Private Health Insurance (Health Insurance Business) Rules and the *Private Health Insurance Act 2007* annually, report any relevant findings to the COAG Health Council (CHC), and publish the review.

Public hospital admitted patient election forms

- G30. States agree that while admitted patient election forms can be tailored to meet individual State or public hospital needs, as a minimum, all forms will include:
- a. a statement that all eligible persons have the choice to be treated as either public or private patients. A private patient is a person who elects to be treated as a private patient and elects to be responsible for paying fees of the type referred to in clause G1 of this Addendum;
 - b. a private patient may be treated by a doctor of his or her choice and may elect to occupy a bed in a single room. A person may make a valid private patient election in circumstances where only one doctor has private practice rights at the hospital. Further, single rooms are only available in some public hospitals, and cannot be made available if required by other patients for clinical reasons. Any patient who requests and receives single room accommodation must be admitted as a private patient (note: eligible veterans are subject to a separate agreement);
 - c. a statement that a patient with private health insurance can elect to be treated as a public patient;
 - d. a clear and unambiguous explanation of the consequences of public patient election. This explanation should include advice that admitted public patients (except for care and accommodation type patients as referred to in clause G2):
 - i. will not be charged for hospital accommodation, medical and diagnostic services, prostheses and most other relevant services; and

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

- I. where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election, or actual election, these patients will be treated as public patients and the hospital will choose the doctor until such time as a valid election is made. When a valid election is made, that election can be considered to be for the whole episode of care, commencing from admission.

Multiple and frequent admissions election forms

- G31. A State or hospital may develop a form suitable for individuals who require multiple or frequent admissions. The form should be for a specified period, not exceeding six months, and nominate the unit where the treatment will be provided. Further, the form should be consistent with the national standards and provide patients with the same information and choices as a single admission election form.

Other written material provided to patients

- G32. Any other written material provided to patients that refers to the admitted patient election process must be consistent with the information included in the admitted patient election form. It may be useful to include a cross reference to the admitted patient election form in any such written material.
- G33. All parties agree that written material provided to patients by public hospitals or private health insurers on the choice to elect to be treated privately will:
- a. be appropriate, robust and best support the consumer to make an informed choice; and
 - b. refrain from directing the patient to a particular choice.

Verbal advice provided to patients

- G34. Any verbal advice provided to admitted patients or their legally authorised representatives that refers to the admitted patient election process must be consistent with the information provided in the admitted patient election form.
- G35. Admitted patients or their legally authorised representatives should be referred to the admitted patient election form for a written explanation of the consequences of election.
- G36. To the maximum extent practicable, appropriately trained staff should be on hand at the time of election, to answer any questions admitted patients or their legally authorised representatives may have.
- G37. Verbal advice provided to patients by public hospitals or private health insurers on the choice to elect to be treated privately will:
- a. be appropriate, robust and best support the consumer to make an informed choice; and
 - b. refrain from directing the patient to a particular choice.
- G38. Through the provision of translation/interpreting services, hospitals should ensure, where appropriate, that admitted patients, or their legally authorised representatives, from non-English speaking backgrounds are not disadvantaged in the election process.

APPENDIX A – DEFINITIONS

- A. A reference in this Addendum to the *Health Insurance Act 1973* or the *National Health Act 1953* is a reference to the Acts as at 1 July 2020 or as amended thereafter.
- B. Words and phrases which are not defined in this Addendum or defined in the *Health Insurance Act 1973* are to be given their natural meaning.
- C. In this Addendum, unless otherwise specified, words and phrases are to be interpreted as follows.

Activity Based Funding (ABF)	Refers to a system for funding public hospital services provided to individual patients using national classifications, cost weights and nationally efficient prices developed by the Independent Hospital Pricing Authority.
ABF Service	Means a Public Hospital Service funded under ABF.
Administrator	Means the Administrator of the National Health Funding Pool, who is appointed in accordance with section 232 of the <i>National Health Reform Act 2011</i> , and performs the functions set out in Schedule B.
Admitted patient	Means “Admitted patient” as defined in the National Health Data Dictionary.
Australian Commission on Safety and Quality in Health Care	Means the authority performing the functions set out in Schedule B.
Australian Health Performance Framework	Means the framework established in accordance with Schedule D.
Avoidable Hospital Readmission	Means a clinical condition identified by the Australian Commission on Safety and Quality in Health Care for the purpose of clause A170 of Schedule A.
Block Funding	Means funding provided to support: • Public hospital functions other than patient services; and • Public patient services provided by facilities that are not appropriately funded through ABF.
Blended funding models	Means payments that use multiple mechanisms e.g. fee-for-service and pay-for-performance.
Bundled payment	Means a single payment for multiple services.
COAG	Refers to the Council of Australian Governments, being the peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association (ALGA).

COAG Health Council	Means the forum established to facilitate provision of advice by Health Ministers to COAG.
Compensable patient	Means an eligible person who is: • receiving public hospital services for an injury, illness or disease; and • entitled to receive or has received a compensation payment in respect of an injury, illness or disease; or if the individual has died.
Commissioning	Means a continual and iterative cycle involving the development and implementation of services based on needs assessment, planning, co-design, funding, monitoring and evaluation. Operational commissioning (or service commissioning) involves applying the design and governance principles of commissioning to a service, group of services or activities to create better service integration and community outcomes. Commissioning is undertaken at the regional level by organisations such as Local Hospital Networks, Primary Health Networks and the community health sector. A range of approaches can be used in commissioning of health care services. In the context of the National Health Reform Agreement, these could include co-commissioning arrangements between health agencies and agencies and organisations from other service sectors such as Human Services, Education, Justice), to develop joined-up and co-ordinated service responses to complex service needs. Joint commissioning arrangements, which often involve the use of a pooled or aligned budget, may also be used.
Commonwealth Funding Entitlement	Means, in respect of a State, its Uncapped Commonwealth Funding Entitlement, adjusted for the imposition of the Soft Cap and any Redistribution Amount that may be payable. It may be expressed on an estimated basis prior to annual Reconciliation or a final basis after annual Reconciliation and Redistribution.
Complaints body	Means an independent entity established or commissioned to investigate complaints and/or grievances against providers of States' public hospital services.
Cultural safety	Means that health consumers are safest when health professionals have considered power relations, cultural differences and patients' rights. Part of this process

requires health professionals to examine their own realities, beliefs and attitudes.

Cultural safety is not defined by the health professional, but is defined by the health consumer's experience—the individual's experience of care they are given, ability to access services and to raise concerns.

The essential features of cultural safety are:

- a. An understanding of one's culture
- b. An acknowledgment of difference, and a requirement that caregivers are actively mindful and respectful of difference(s)
- c. It is informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point
- d. An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on First Nations people's living and wellbeing, both in the present and past
- e. Its presence or absence is determined by the experience of the recipient of care and not defined by the caregiver.

[definition sourced from AHMAC's *Cultural Respect Framework 2016-2026*]

Data Conditional Payment (DCP)	Means the mechanism described at clause A155 in Schedule A to provide an incentive for the prompt provision of hospital activity data to enable timely Reconciliation.
Default bed day rate	Means the rate set by the Commonwealth Minister under the <i>Private Health Insurance Act 2007</i> .
Eligible admitted private patient	Means an eligible patient who is admitted and chooses to be treated as a private patient, and excludes compensable patients and other patients funded by third parties.
Eligible person	Means, as defined in subsection 3(1) (6) (6A) and (7) of the <i>Health Insurance Act 1973</i> , excluding compensable patients.
Emergency department	Means admission level three or above emergency service under the Australian College for Emergency Medicine guidelines, or as otherwise recommended by the IHPA and agreed by the COAG Health Council.
Entitled veteran	Means a Department of Veterans' Affairs patient referred to in the <i>Veterans' Entitlements Act 1986</i> .

Federated approach (related to Health Technology Assessment)	Means an overarching centralised framework, within which the Commonwealth and each State and Territory keeps some internal autonomy.
HAC List	Means the Hospital Acquired Complication List maintained by the Australian Commission on Safety and Quality in Health Care, as amended from time to time.
Health Technology Assessment (HTA)	Means the systematic evaluation of the properties and effects of a health technology, addressing direct and intended effects, as well as its indirect and unintended consequences, and aimed mainly at informing decision making. Health technologies include tests, devices, medicines, vaccines, procedures, programs and systems.
High cost, highly specialised therapies	Means TGA approved medicines and biologicals delivered in public hospitals where the therapy and its conditions of use are recommended by MSAC or PBAC; and the average annual treatment cost at the commencement of funding exceeds \$200,000 per patient (including ancillary services) as determined by the MSAC or PBAC with input from the IHPA; and where the therapy is not otherwise funded through a Commonwealth program or the costs of the therapy would be appropriately funded through a component of an existing pricing classification.
Highly-specialised services	Means high cost, low volume services that require a highly skilled and specialised workforce and require a national population catchment to ensure quality and safety is maintained.
Hospital Acquired Complication (HAC)	Means a condition set out on the HAC List and approved by the COAG Health Council.
Implementation principles	Means the principles that should underpin National Health Reform as set out in clauses 17 to 19.
Independent Hospital Pricing Authority (IHPA)	Means the authority established under the <i>National Health Reform Act 2011</i> to perform the functions set out in Schedule B.
Individual health literacy	Means the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action.
Ineligible person	Means any person who is not an eligible person.
Informed financial consent	Means the provision of cost information to patients, (including any likely out-of-pocket expenses), by a doctor or other health service provider, preferably in writing, about a proposed treatment or admission to hospital.

Local Hospital Network	Means an organisation established in accordance with Schedule E and providing public hospital services.
Medicare Benefits Schedule (MBS)	Means the Commonwealth government's scheme to provide medical benefits to Australians established under part II, IIA, IIB and IIC of the <i>Health Insurance Act 1973</i> together with relevant Regulations made under the Act.
Medicare Principles	Means the principles set out in clause 8 of this Addendum.
National efficient cost	Means the model that underpins funding for services that are not suitable for activity based funding, such as small rural hospitals. The national efficient cost determines the Commonwealth Government contribution to block funded hospitals.
National efficient price	Means the base price(s) which will be determined by the IHPA and applied to those services funded on the basis of activity for the purpose of determining the amount of Commonwealth funding to be provided to Local Hospital Networks. The IHPA may determine that there are different base prices for discrete categories of treatment, for example admitted care, sub-acute care, non-admitted emergency department care and outpatient care. In the event that there are multiple national efficient prices, the IHPA will determine which national efficient price applies.
National bodies	Means the functions and bodies established and existing from time to time for the purposes of the Addendum, including, without limitation, the Administrator, the National Health Funding Body, the Independent Hospital Pricing Authority and the Australian Commission on Safety and Quality in Health Care.
National Funding Cap	Means the limit in growth in Commonwealth funding for Public Hospital Services for all States of 6.5 per cent per annum and where the context so requires includes the operation of the Funding Cap as provided in this Addendum.
National Funding Model	Means the calculation, payment and reconciliation of Commonwealth national health reform funding entitlements for health services, by the Administrator of the National Health Funding Pool (Administrator) applying the agreed methodology, business rules and policies. This is calculated from activity based funding based on National Weighted Activity Units and the Independent Hospital Pricing Authority's (IHPA) National

	Efficient Price determination, and block funding calculated from the IHPA's National Efficient Cost determination.
	The agreed methodology, business rules and policies include the activity based funding formula, the Administrator's Calculation of Commonwealth National Health Reform Funding and associated operational documents, IHPA's Pricing Framework and National Pricing Model specifications, classification systems, counting rules, data, coding and costing standards.
National Health Data Dictionary	Means the publication (in hard copy and/or the internet) containing the Australian National Standard of Data Definitions recommended for use in Australian health data collections; and the National Minimum Data Sets agreed for mandatory collection and reporting at a national level.
National Health Funding Body	Means the body established under the <i>National Health Reform Act 2011</i> to assist the Administrator in carrying out his or her functions under Commonwealth and State legislation, in accordance with Schedule B of this Addendum.
National Health Funding Pool	Means the pool established by enabling Commonwealth and State legislation in accordance with Schedule B of this Addendum.
Non-admitted patient services	Means services of the kind defined in the National Health Data Dictionary, under the data element "Non-Admitted Patient Service Type".
Outpatient department	Means any part of a hospital (excluding the emergency department) that provides non-admitted patient care.
Parties	Means the signatories to this Addendum, being the Commonwealth and each State and Territory.
Patient election status	Means the status of patients according to the National Standards for Public Hospital Admitted Patient Election Processes in Schedule G.
Patient Reported Measures	Means information collected about the experience of health services, and the outcomes of health services, as described by patients. • Patient-reported experience measures (PREMs) include patients' views and observations on matters such as the accessibility and physical environment of services and aspects of the patient–clinician interaction. • Patient-reported outcome measures (PROMs) are used to obtain information from patients on their

	health status such as overall health and wellbeing, the severity of symptoms such as pain, measures of daily functioning and psychological symptoms.
Pharmaceutical Benefits Scheme (PBS)	Means the Commonwealth government's scheme to provide subsidised pharmaceuticals to Australians established under part VII of the <i>National Health Act 1953</i> (the Act) together with the National Health (Pharmaceutical Benefits) Regulation 1960 made under the Act.
Pharmaceutical Reform Arrangements	Means arrangements which provide for public hospitals that are Approved Hospital Authorities under Section 94 of the <i>National Health Act 1953</i> to supply pharmaceuticals funded by the PBS for specific categories of patients including: • admitted patients on separation; • non-admitted patients; and • same day admitted patients for a range of drugs made available by specific delivery arrangements under Section 100 of the <i>National Health Act 1953</i>.
Population health	Means activities aimed at benefiting a population, with an emphasis on prevention, protection and health promotion as distinct from treatment tailored to individuals with symptoms. Examples include the conduct of anti-smoking education campaigns, and initiatives to increase accessibility and promotion of healthier food and drink. Can also refer to the health of particular sub-populations, and comparisons of the health of different populations.
Private Health Insurance Rebate	Means the Commonwealth Government's scheme to provide private health insurance rebates established under the <i>Private Health Insurance Act 2007</i> together with relevant Regulations and rules made under that Act.
Public Hospital Services	Means the services, functions and activities funded by the Commonwealth under this Addendum, including service subject to Activity Based Funding, Block Funding or public health activities.
Public patient	Means an eligible person who receives or elects to receive a public hospital service free of charge.
Public patients' hospital charter	Means the document outlining how the principles of this Addendum are to be applied; the process by which eligible persons might lodge complaints about the provision of public hospital services; a statement of rights and responsibilities of consumers and public hospitals; and a statement of consumers' rights to elect

	to be treated as either public or private patients.
Reconciliation	Means the Reconciliation of actual ABF Service delivery volume undertaken within a State to the estimate of ABF Service delivery volumes provided by a State in accordance with clauses A63 to A76 of Schedule A of this Addendum.
Redistribution	Means the allocation of remaining funding under the National Funding Cap to States whose Uncapped Commonwealth Funding Entitlement exceeded their respective Soft Funding Cap in accordance with clause A77 of Schedule A of this Addendum.
Redistribution Amount	Means an amount paid by the Commonwealth to a State that is entitled to additional funds as a result of the Redistribution.
Relevant financial year	Means a specific financial year for which data is submitted by the Parties so that the Administrator can calculate the Commonwealth funding and payments for that financial year.
Required Data	Means each of: a. the data specified as being required for Reconciliation in the data plan issued by the Administrator for the relevant financial year; b. data necessary to enable the Administrator to operate the pricing and funding models agreed by the Parties to calculate Safety and Quality Adjustments; c. data necessary to identify Sentinel Events; and d. the duly completed Statement of Assurance.
Risk/reward share payment	Means payments where the provider/s share in the financial risk and reward.
Safety and Quality Adjustment	Means a reduction in funding payable to a State by the Commonwealth for Public Hospital Services, funded either under ABF or Block Funding, following the occurrence of a HAC or an Avoidable Hospital Readmission in accordance with the pricing and funding models to be developed by the Parties for this purpose.
Sentinel Event	Means an event set out on the Sentinel Events List.
Sentinel Events List	Means events set out on the Australian Sentinel Events List maintained by the Australian Commission on Safety and Quality in Health Care and approved by the COAG Health Council.
Service Agreement	Means an agreement between a State and a Local Hospital Network consistent with this Addendum.

Soft Cap	Means the limit in growth in Commonwealth funding for Public Hospital Services in a State of 6.5 per cent per annum.
Statement of Assurance	Means the statement as to the completeness and accuracy of data submitted, issued in accordance with clauses B82 and B83 in Schedule B of this Addendum.
State managed fund(s)	Means a fund(s) or account(s) established by State legislation for the purpose of receiving funding for block grants, teaching, training and research.
States	Means States and Territories.
Uncapped Commonwealth Funding Entitlement	Means in respect of a State in a relevant financial year, its entitlement to Commonwealth funding for Public Hospital Services in that State under the Addendum, excluding the impact of the National Funding Cap or any relevant Soft Cap.
Value	Means maximising patient experience and outcomes, improving population health and high quality, evidence-based clinical care, relative to the cost of delivery. This definition of value-based health care involves the alignment of incentives for all stakeholders (including patients, families, providers and governments) in order to obtain the best possible health outcomes for all Australians.
Weighted services	Means services of a particular ABF category where each service may count as more or less than one service as determined by the cost weight determined by the IHPA to be applicable to that service.

APPENDIX B – GOVERNANCE PROCESS FOR HIGHLY SPECIALISED THERAPIES

- A. The Medical Services Advisory Committee (MSAC) and Pharmaceutical Benefits Advisory Committee (PBAC) Chairs, together with a COAG Health Council (CHC) representative will jointly decide on which committee should assess the application for a new drug or therapy, where the HCT is likely to be delivered in a public facility.
 - I. The rules for PBAC assessment are set out in the National Health Act 1953. Where the matter does not fall within the definition for consideration by PBAC it is assessed by MSAC.
 - II. The Chair of CHC will nominate one representative on behalf of all states and territories to participate in this meeting. This representative is to have the same clinical expertise as the MSAC and PBAC Chairs.
- B. For therapies that will be assessed by MSAC and delivered in a public hospital, the Commonwealth will write to states and territories advising them that an application has been received and invite them to make a submission to MSAC for consideration, noting that the states and territories will need to abide by the same confidentiality requirements as MSAC members.
 - I. The terms of reference of MSAC will be amended to ensure that MSAC is obliged to consider any submission from a state or territory where it is relevant to comparative safety, clinical effectiveness and/or cost-effectiveness of the therapy.
- C. For therapies that will be assessed by MSAC and delivered in a public hospital, states and territories will be invited to send a representative to observe the meeting where the application will be considered.
 - I. This will enable states and territories to ensure all submissions are considered and to have an early heads up that the MSAC has recommended a therapy for public funding.
- D. States and territories will be notified on the same day that the company agrees to the recommendations of MSAC.
 - I. This is usually 6-8 weeks after the MSAC recommendation, depending on the approach of the company.
- E. Once the company agrees to the recommendations of MSAC, the decision of MSAC is published on the public website.
 - I. States and territories will be notified before this occurs.
- F. States and territories decide when and where the therapy will be provided.