ADDENDUM TO THE NATIONAL HEALTH REFORM AGREEMENT

2026-2031

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/agreements/national-health-reform-agreement***

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PRELIMINARIES

Vision

1. The Australian healthcare system should be person-centred, equitable, responsive, and sustainable. This means an integrated healthcare system that:

   a. is shaped around and responsive to the health needs of individual people, their families and communities, including through best practice coordination of people's journeys across the care continuum

   b. provides safe, high quality, contemporary care that delivers optimal patient outcomes and experiences by ensuring the right care is provided in the right place, at the right time, regardless of where people live

   c. is focused on evidence-based preventive health action to deliver improved population health and wellbeing, health equity and health system preparedness for emerging public health threats and rising chronic diseases

   d. is responsive to the needs and aspirations of Aboriginal and Torres Strait Islander people to ensure they enjoy the highest attainable standard of health and wellbeing and experience a health system that is culturally safe and free of racism

   e. is supported by a sufficient and skilled health workforce

   f. is agile, innovative and efficient, able to effectively and sustainably respond to needs of individuals and communities, emerging technologies and models of care

   g. is financially sustainable

   h. is environmentally sustainable and climate resilient, with a national trajectory to net zero emissions

   i. is adaptive in forecasting and planning for current and future challenges.

Principles

2. The Parties agree that people should be at the core of our health system and will work in partnership to deliver an effective, integrated health system that reduces service duplication and fragmentation. This Addendum amends the National Health Reform Agreement (NHRA) for the period 1 July 2026 to 30 June 2031, and confirms ongoing commitment to person centred, culturally safe, trauma-informed, and place-based care.

3. All governments 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.

4. The Parties re-affirm their responsibility and shared commitment to work in partnership with Aboriginal and Torres Strait Islander people to operationalise the National Agreement on Closing the Gap. Health system reform under this Addendum will be in line with the four Priority Reforms: formal partnerships and decision making, building the community-controlled sector, transforming government organisations and their institutions, and shared access to data and information at the regional level.

5. Consistent with the National Aboriginal and Torres Strait Islander Health Plan 2021-2031, Parties agree the health system must recognise and embed Aboriginal and Torres Strait Islander holistic health and wellbeing, the cultural determinants of health, the social determinants of health and a life course approach.

6. Activities under this Addendum will also help embed preventive health in services delivered to those already receiving care in the health system for existing conditions (secondary prevention), as well as alignment with and support for strategies and policies designed to keep people healthy and well in the community (primary prevention).

7. All governments and bodies described in this Addendum will make use of the best available information, will foster innovation and share approaches to continuously improve and reflect best-practice service delivery in the system, to benefit the health of all Australians.

8. The Parties commit to taking a learning system approach to implementing commitments outlined in this Addendum, including undertaking evaluation to assess progress on outcomes described below, and an evidence-based approach to scaling up successes.

9. The Parties recognise the importance of community and clinician engagement and the role of the Aboriginal and Torres Strait Islander community-controlled, private, and not-for-profit sectors in supporting and delivering health system outcomes. Parties commit where appropriate to engaging providers, clinicians and communities in the design and delivery of services under this Addendum, such as new models of care.

10. In progressing shared national priorities agreed under this Addendum, States and Territories will have flexibility to prioritise service delivery reforms according to local needs and priorities.

Objectives and outcomes

11. The Parties recognise this Addendum provides an opportunity for all governments to work together to ensure their collective investments in healthcare can advance reform that delivers:

    a. better health outcomes and experiences for all Australians and better value for patients

    b. stronger shared stewardship of the whole health system

    c. a simpler, more equitable public hospital and health services funding model.

12. The Parties commit to working in partnership to implement arrangements to achieve the following health system outcomes:

    a. Appropriate care

        i. People access optimal models of care that encourage a shift to community care (Outcome 1.1)

        ii. Demand for care is efficiently managed across public hospital and health services and alleviated by adjacent health and care systems[1] (Outcome 1.2)

[1] Adjacent systems include primary, disability and aged care sectors.

iii. Prevention and health promotion strategies are used to keep people well and reduce the burden of disease (Outcome 1.3)

b. Quality care

i. People receive continuity of care across health and other care systems (Outcome 2.1)

ii. Public hospitals and health services consistently provide safe, high-quality care (Outcome 2.2)

c. Equitable access and health outcomes

i. People have equitable access to care and equitable health outcomes (Outcome 3.1)

ii. Aboriginal and Torres Strait Islander people, regardless of where they live, have access to health care that is effective, culturally safe and appropriate, equitable, and free of racism (Outcome 3.2)

d. Value

i. Innovation and continuity of care are incentivised to generate value for patients and the system (Outcome 4.1)

ii. Care delivered across public hospitals and health services is efficient, cost-effective, and priced appropriately (Outcome 4.2)

e. Governance

i. Robust governance enables innovation and collective stewardship across the continuum of care, particularly across adjacent care systems including primary, acute, aged and disability care settings (Outcome 5.1).

13. Monitoring and assessing progress against these outcomes will be through the health system performance assessment framework described below and in Schedule H.

Scope

14. This Addendum sets out the shared commitments and actions of the Commonwealth and the States and Territories (States) to work in partnership to deliver on the vision, principles and outcomes described above.

15. The Schedules of the Addendum set out the Parties' commitments in relation to:

a. financial arrangements for Australian public hospital and health services, including the appropriate use of payment models spanning Activity Based Funding (ABF), capitation, bundled payments and block methods. The financial arrangements will also support developing other payment methods as required to enable and scale optimal models of care and set out cross-border service delivery arrangements (Schedule A)

b. reforms to embed Aboriginal and Torres Strait Islander leadership and decision-making and address the inequity experienced by Aboriginal and Torres Strait Islander people across the health system through specific actions and increased focus on operationalising Closing the Gap, the National Aboriginal and Torres Strait Islander Health Plan 2021-2031, and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 across the Addendum (Schedule B)

c. providing better coordination between care sectors, supported by reforms at the interfaces between hospitals, primary and community care services, aged care, disability, mental health and suicide prevention, and across both the public and private health system (Schedule C)

d. delivering more contemporary service models and pathways that increasingly provide care in community settings, supported by flexible funding models, incentives for reform and dedicated resources to evaluate, scale and embed best practice (Schedule D)

e. supporting an integrated health and care system through joined up local governance arrangements (Schedule E)

f. ensuring improved access to care in rural and remote areas (Schedule F)

g. maintaining a sustainable and resilient health workforce (Schedule G)

h. providing transparency, accountability and quality of care supported by a whole-of-health system performance assessment framework, a National Health Data System and digitally enabled health care (Schedule H)

i. reaffirming roles of key bodies in supporting and implementing reform, including the Independent Health and Aged Care Pricing Authority, Administrator of the National Health Funding Pool, National Health Funding Body, Australian Commission on Safety and Quality in Health Care and the Australian Institute of Health and Welfare (Schedule I).

16. The Parties commit to progressing reforms in each of these Schedules to achieve the objectives of this Addendum. This includes continued efforts to implement reform commitments agreed in the 2011 National Health Reform Agreement and subsequent Addenda, including the six long-term health reforms identified in the 2020-2025 Addendum.

National Health Reform Strategy

17. To support clear governance, accountability and stewardship, the Parties will develop a National Health Reform Strategy (the Strategy) for Health Ministers' agreement by 30 September 2026. The Strategy will guide cohesive implementation of the Addendum as outlined above, and:

a. be developed and amended as needed in collaboration with Aboriginal and Torres Strait Islander stakeholders as set out in Schedule B

b. describe the objectives and outcomes and how Parties will measure the success of the Addendum and its reforms

c. outline an implementation plan to deliver and monitor reforms and commitments, complemented by the Service Model and Funding Reform Framework detailed in Schedule D

d. describe an annual process for Parties to review progress against Addendum objectives and recalibrate direction if necessary (as per clause H16)

e. consider how to position reforms for scaling or adjustment in the next Addendum.

Stewardship, roles and responsibilities

18. This Addendum recognises that responsibility for health care is shared between the Commonwealth and the States and Territories, and that governments must ensure all parts of the health system and other care systems work together effectively and efficiently to deliver the best outcomes for all Australians, including to fulfil the roles outlined in the National Agreement on Closing the Gap.

19. The Commonwealth is the market steward of the aged care, primary care and NDIS systems. States are the stewards of the public hospital and health system. Effective stewardship ensures that services are accessible and sustainable, creating incentives that shape behaviour towards desired outcomes and addressing service accessibility issues and service gaps.

20. Parties recognise that these are all part of a whole care and support system, and all governments play a collective stewardship role. Parties agree that key principles of stewardship include:

    a. a systematic, evidence-informed approach to planning, designing, regulating and funding systems to support equitable, and sustainable access to care and health outcomes

    b. transparency and regular monitoring of service demand, supply, utilisation, access and quality, in line with policy objectives

    c. early identification and proactive intervention to support appropriate and timely collaborative action to address service delivery gaps

    d. regular review and adjustment of regulatory, policy and program settings, funding and service delivery models informed by evidence and changing conditions

    e. supporting capability and innovation including tailored solutions in local or regional/remote areas to promote long term market sustainability

    f. collaboration between the Parties to support alignment across all care systems (primary care, aged care, disability, and public hospitals) and proactively address any barriers to coordinated care.

21. All Parties affirm their commitment to deliver health services under this Addendum based on the following Medicare Principles and will adhere to the Business Rules and other requirements set out in Schedule J.

    a. Eligible persons must be given the choice to receive public hospital services free of charge as public patients.

b. Access to public hospital services is to be based on clinical need and within a clinically appropriate period.

c. Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

22. This Addendum describes how Parties, including governments and national bodies, will work together and in partnership with Local Hospital Networks (LHNs), Primary Health Networks (PHNs), Aboriginal Community Controlled Health Organisations (ACCHOs) including peak and professional bodies, and aged care and disability services to enact the vision, principles, objectives and outcomes described above.

Shared responsibilities

23. Under this Addendum the Parties will be jointly responsible for:

a. funding public hospital and health services using a range of approaches, including Activity Based Funding, block, capitation, bundling and other contemporary and alternative funding models based on agreed frameworks and shared decision-making criteria

b. determining funding policy and exploring the potential to introduce optimal models of care into the national funding model with support of the Independent Health and Aged Care Pricing Authority. This includes reviewing and broadening the scope of public hospital services to incorporate those that are provided beyond the hospital door, including virtual services, in-reach/out-reach services and other new models of care that replace or avoid hospital admissions, enabled by contemporary funding arrangements

c. improving the health of Aboriginal and Torres Strait Islander people through specific actions and increased accountability by:

i. operationalising commitments to the National Agreement on Closing the Gap, particularly the Priority Reforms

ii. implementing the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 and National Aboriginal and Torres Strait Islander Workforce Strategic Framework and Implementation Plan 2021-2031

iii. embedding Aboriginal and Torres Strait Islander co-design, leadership and decision making in governance structures

iv. recognising the ACCHO sector as legitimate partners in the health system

v. addressing racism with the long-term goal of eliminating racism across the health system

vi. ensuring cultural safety in health service delivery with agreed measurement and reporting

vii. improving processes and capacity to collect, share and use data at the regional level with active recognition of Aboriginal and Torres Strait Islander people's data sovereignty and aligned with the APS Framework for Governance of Indigenous Data principles

viii. ensuring the health system is accountable to Aboriginal and Torres Strait Islander people through improved reporting and transparency.

d. working together to improve mental health and suicide prevention outcomes by re-affirming commitments in the National Mental Health and Suicide Prevention Agreement, including through improving system integration and new reforms under this Addendum

e. establishing and maintaining nationally consistent standards for healthcare and reporting to the community on the performance of health services

f. collecting and providing patient-level data to support delivering and evaluating services

g. working together on policy decisions or areas of the system that impact on each other's responsibilities, including across primary health care, mental health and suicide prevention, and disability and aged care sectors

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

i. maintaining and improving efforts in population health, public health and health promotion

j. ensuring maintenance of effort across health sectors, acknowledging ongoing reforms.

Commonwealth responsibilities

24. The Commonwealth affirms its commitment to:

a. funding the Medicare Benefits Schedule (MBS) to ensure equitable and timely access to affordable primary health care and specialist medical services

b. funding the Pharmaceutical Benefits Scheme (PBS) to ensure timely and affordable access to safe, cost-effective, and high-quality medicines

c. affordable aged care services so that people needing this care can access it when required, regardless of geographic location

d. ensuring that Aboriginal and Torres Strait Islander people have choice and control in accessing culturally safe and appropriate mainstream primary care services.

25. The Commonwealth is responsible for system management, support, planning and policy for general practice (GP) and primary health care, including:

a. maintaining and enabling PHNs to commission a range of activities that promote coordinated GP and primary health care service delivery, collaboration and integration

b. funding and support for ACCHOs and other organisations to deliver comprehensive, culturally safe primary health care services for Aboriginal and Torres Strait Islander people (noting contributions of the States)

c. collaborating with each State and their PHNs and ACCHOs on system-wide policy and State-wide planning for GP and primary health care

d. continuing to focus on reforms in primary care that are designed to improve patient outcomes and experiences and reduce avoidable hospital presentations and admissions

e. regulation for the primary care workforce to support working to full scope of practice, collaboration across care systems, and innovation in workforce models at scale.

26. In addition, the Commonwealth is responsible for:

a. supporting and regulating private health insurance to enable an effective private health sector and patient choice, including access to private specialist medical services

b. system management, policy and planning for the national aged care system

c. national health workforce planning and governance oversight to drive workforce priorities, based on shared responsibility and commitment of all jurisdictions to meaningfully engage in collaborative reform efforts

d. maintaining the legislative basis and governance arrangements for the key independent national bodies outlined in Schedule I.

State and Territory responsibilities

27. States will provide health and emergency services through their public hospitals and health services, based on the Medicare Principles at clause 21.

28. Under this Addendum, the States will be responsible for system management of public hospitals and health services, including:

a. ensuring the legislative basis and governance arrangements for LHNs are consistent with the objectives of this Addendum

b. system-wide public hospital, health service and LHN planning and performance

c. purchasing of public hospital services and monitoring delivery of services purchased

d. planning, funding and delivering capital works and adequate infrastructure for public hospitals and community health facilities to meet future needs

e. delivering teaching, training (including cultural safety), and research in public hospitals

f. State-wide public hospital industrial relations functions, including negotiation of enterprise bargaining agreements and establishment of remuneration and employment terms and conditions to be adopted by LHNs

g. ensuring Aboriginal and Torres Strait Islander people have access to culturally safe and appropriate public hospital and health services.

29. States are responsible for:

    a. delivering public health, community health and health promotion programs, including a lead role in managing public health activities

    b. providing public patients with access to all services provided to private patients in a public hospital

    c. ensuring that eligible persons who have elected to be treated as private patients have done so based on informed financial consent

    d. providing and funding pharmaceuticals for public and private inpatients and for public non-admitted patients in public hospitals (except where Pharmaceutical Reform Arrangements are in place)

    e. maintaining a Public Patients Hospital Charter and an independent complaints body and ensuring that people are aware of how to access these provisions.

30. In providing these services States will adhere to the Business Rules and other requirements set out in Schedule J.

National bodies

31. The Parties acknowledge that national bodies play a key enabling role in informing a dynamic and sustainable health system which meets emerging healthcare challenges and evolving patient and community needs.

32. National bodies will support reform directions and Ministerial priorities to help deliver outcomes under this Addendum and incorporate their expertise and data insights into national policy development processes, including through relevant governance forums outlined in clause 42.

33. The roles and responsibilities of the following national bodies and organisations under this Addendum are outlined in Schedule I, in addition to those set out in relevant legislation:

    a. the Independent Health and Aged Care Pricing Authority (IHACPA) – independent national price and cost setting

    b. the Administrator of the National Health Funding Pool and the National Health Funding Body (NHFB) – independent Commonwealth NHRA funding calculation and administration

    c. the Australian Commission on Safety and Quality in Health Care (ACSQHC) – supporting national health system safety and quality service provision

    d. the Australian Institute of Health and Welfare (AIHW) – collection, analysis, and reporting of health performance data (including social and cultural determinants).

34. The Parties acknowledge the role and contribution of other national agencies and bodies in advancing and enabling health reform under this Addendum, including but not limited to the Australian Digital Health Agency.

35. The Parties acknowledge that to enact their obligations under the National Agreement on Closing the Gap national bodies must embed Aboriginal and Torres Strait Islander leadership and decision-making in their operations. This includes through:

    a. employing and retaining Aboriginal and Torres Strait Islander staff throughout their organisations

    b. having teams to lead their Aboriginal and Torres Strait Islander projects and priorities, as well as embed Aboriginal and Torres Strait Islander perspectives across their organisation

    c. including Aboriginal and Torres Strait Islander representation and decision making on boards and/or committees

    d. engaging in partnership with Aboriginal and Torres Strait Islander people and organisations to inform policy development and the use of data.

Transparency and performance

36. All Australians are entitled to access simple, timely and nationally comparable performance data and information on hospitals, GP and primary health care, aged care, disability and other care systems that meaningfully measures progress against agreed accountabilities.

37. The Parties will implement a performance assessment framework incorporating quantitative and qualitative indicators to accurately report on the performance of the whole health system, and its interactions with other care and support systems. The framework will help measure progress of health programs, strategies and agreements, including this Addendum.

38. The Parties agree to actively address gaps in performance assessment including establishing and implementing data development plans should appropriate data and indicators not be available.

39. Reporting should enable performance assessment by Ministers and other stakeholders with responsibility for effecting change within and across systems. This includes measures of whether the health system is working as a whole and together with adjacent care systems to achieve better health outcomes. Performance reporting should galvanise action to improve services and prepare for future challenges.

40. The Parties and national bodies will comply with all applicable privacy legislation and principles during implementation of this Addendum, including for data collection, sharing and provision.

    a. As part of this commitment all Parties agree to uphold Aboriginal and Torres Strait Islander data governance and sovereignty principles in line with the Framework for Governance of Indigenous Data, increasing public reporting and transparency.

41. Performance monitoring, assessment and reporting arrangements, including enhanced accountability, are outlined in Schedule H.

Governance

42. The Addendum will be implemented through the following mechanisms.

    a. National Cabinet will provide overall leadership and facilitate joint decision making, supported by Health Ministers and other Ministerial Councils as needed.

    b. The Health Ministers Meeting (HMM) will have delegated authority from National Cabinet to agree and lead implementation of commitments under this Addendum, including through:

        i. annual priority setting in line with objectives and performance assessment framework outcomes, including to guide the Service Model Reform Funding stream

        ii. seeking input from national bodies, other stakeholders and other Ministerial Councils to support priority reforms

        iii. regular strategic dialogue on progress of priorities and reforms informed by performance dashboards

        iv. use of separate and joint levers to address priority strategic issues or solve specific problems

        v. agreeing amended or new schedules to this Addendum as per clauses 45 and 46.

    c. The Health Chief Executives Forum (HCEF) will provide strategic advice and support to Health Ministers, including through:

        i. oversight of the Addendum work program, responding to emerging issues in a timely manner, and collaboratively developing solutions to improve health outcomes

        ii. providing authority for decisions on resourcing and policy direction to achieve the Addendum's objectives and HMM priorities

        iii. resolving contested policy issues.

    d. A time-limited System Reform Deputies Group for the period 2026-2031 will lead collaboration across governments to implement the Addendum and will be supported by a limited number of existing and new HCEF-established Collaborations and Taskforces specified in relevant Schedules.

        i. The System Reform Deputies Group will include a non-government Aboriginal and/or Torres Strait Islander representative as a standing member with decision-making authority equal to other members (detailed in Schedule B).

        ii. Specific Collaborations and Taskforces referenced in Schedules refer to those in operation at the time of signing and may change during this Addendum.

General provisions

Alignment with other agreements

43. This Addendum:

    a. amends the National Health Reform Agreement (NHRA) for the period 1 July 2026 to 30 June 2031

    b. builds on and re-affirms the high-level service delivery principles, objectives, roles and responsibilities in the National Healthcare Agreement 2012 for the period of this Addendum

    c. is subject to the Intergovernmental Agreement on Federal Financial Relations overseen by the Council on Federal Financial Relations and should be monitored and read in conjunction with that Agreement and subsidiary schedules.

44. The Parties recognise the Addendum does not function in isolation but sits within a wider set of national and bilateral Agreements, including the National Mental Health and Suicide Prevention Agreement, strategies, and legislation. The Parties will strive to ensure new and existing Agreements have shared visions, principles and reform goals for the health system where possible and that objectives and actions are mutually reinforcing across Agreements.

Amendment

45. Subject to clause 46, the NHRA and this Addendum may be amended at any time in writing with the agreement of all Parties and with terms and conditions as agreed by all Parties.

46. The schedules to the Addendum 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.

    a. Changes relevant to Aboriginal and Torres Strait Islander people must first be made in partnership with Aboriginal and Torres Strait Islander stakeholders, as outlined in Schedule B.

Review

47. An independent mid-term review of the Addendum commissioned by Health Ministers will be completed by 30 June 2029 to enable any recommendations to be considered, agreed, and included in the future Agreement.

48. The review will assess if the Addendum is meeting its stated vision, objectives and outcomes, and report on the sustainability, efficiency, and effectiveness of reforms across the health system. The review may consider other matters as agreed by Health Ministers or National Cabinet, and include but not be limited to, assessing:

    a. the impacts of reforms on Aboriginal and Torres Strait Islander people, with this component to be led by Aboriginal and Torres Strait Islander people

b. whether reforms in this Addendum, including governance and funding arrangements, are delivering on the objectives and changing individual and system outcomes, informed by the National Health Reform Strategy at clause 17

c. any unintended consequences such as cost-shifting, perverse incentives, or other inefficiencies that impact on patient outcomes, and the capacity of Parties to adopt and deliver innovative models, as a result of financial and other arrangements in this Addendum

d. performance of the national bodies against their functions, roles, and responsibilities under this Addendum

e. all other intergovernmental health agreements to determine how they relate to this Addendum's objectives, with the intent to cross-reference, subsume or replace those agreements, as appropriate (for example, the National Healthcare Agreement 2012 and National Mental Health and Suicide Prevention Agreement).

49. A separate independent review of the National Efficient Price methodology (NEP) will be undertaken in consultation with all jurisdictions and completed by no later than 30 June 2029. The terms of reference for the review will be agreed by Health Ministers and will include a review of methodology including timing of data provision, data quality, and other inputs. Any agreed options for improvement based on the review findings will be implemented in the next Addendum, or earlier if deemed appropriate.

Dispute resolution

50. Any Party may give notice to other Parties of a dispute to under this Addendum.

51. 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 jurisdictions' Ministers, and if necessary, to all Health Ministers.

52. If a dispute cannot be resolved at Ministerial level, it may be referred to National Cabinet for consideration.

SCHEDULE A – MORE EFFECTIVE FUNDING AND PAYMENT MODELS

A1. This Schedule details the funding arrangements for public hospitals and health services agreed between the Parties for the period 1 July 2026 to 30 June 2031.

A2. This Schedule intends to deliver sustainable and effective funding for public hospitals and health services. This schedule has been informed by recommendations from the 2023 NHRA Mid-Term Review to improve the core funding arrangements and drive reform in service and care delivery models, by:

a. improving Commonwealth funding contributions, including through a commitment to an increasing share over time, higher growth caps compared to the previous 2020-2025 Addendum, and a minimum funding guarantee for the States

b. dedicated reform funding to better support optimal care pathways and payment models to improve the system's allocative efficiency and greater productivity

c. expanding incentives for services to deliver safe, high quality, high-value care

d. greater funding transparency through improved reporting, classification and data sharing.

A3. The Parties agree the Commonwealth's contribution to health services in respect of this Addendum will comprise funding relating to:

a. hospital and health services provided to public patients in a range of settings and funded on an activity basis, as appropriate

b. hospital and health services provided to eligible private patients in public hospitals

c. hospital and health services provided to patients in public hospitals through block funding, including relevant services in rural and remote communities and trialling of alternative payment models

d. teaching and training functions facilitated by States and undertaken in public hospitals or other organisations (such as universities and training providers)

e. research facilitated by States and undertaken in public hospitals

f. public health activities as determined by clause A25 and A26

g. activities undertaken through the Service Model Reform Funding (SMRF) stream, including capitation and bundled payment trials.

A4. The Parties agree the States' contribution to public hospital and health services in respect of this Addendum will comprise funding relating to the delivery of services within their jurisdiction consistent with the activities described in clause A3 and in line with processes described in Part 5.

A5. As the National Funding Model evolves over time, funding arrangements will be implemented in accordance with the following principles, so States have financial predictability and sustainability.

a. Information and data 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, activity and funding calculations should be accurate, based on the most complete data available, transparent, accountable, and in accordance with the National Funding Model.

c. Data reporting from jurisdictions and advice from national bodies should be provided as early as possible to facilitate timely payments to Local Hospital Networks (LHNs) and determine Commonwealth funding entitlements.

d. Commonwealth funding entitlements should be determined in a timely manner.

e. Activity and cost data will progressively be incorporated into the development of the National Pricing Model (including the National Efficient Price and the National Efficient Cost), and the National Funding Model.

f. In continuously improving the pricing and classification of public hospital and health services, the national funding bodies will endeavour to ensure that changes from one year to another do not result in unintended volatility in National Health Reform (NHR) funding.

g. Where an error or unexpected outcome in activity, funding, pricing or cost data has been identified, national bodies must consult with jurisdictions before taking any further action.

h. Parties, the Administrator of the National Health Funding Pool (the Administrator), and the Independent Health and Aged Care Pricing Authority (IHACPA) will seek to resolve any disputes in a timely and transparent manner.

A6. Parties agree to replace the previous base plus growth funding model with a new glide path funding model, commencing from 1 July 2026. Details on the operation of the glide path funding model are outlined in clauses A22, A24, and A31 to A37.

A7. The Commonwealth's total annual funding contribution to health services for each State under this Addendum will be subject to a funding cap. Details on the operation of the state-based, cumulative funding cap are outlined in clauses A38 to A47.

A8. The Parties agree that the Commonwealth's annual funding contribution will encompass the streams listed below, with distinct rules for calculating the funding amount under each stream:

a. Activity Based Funding (ABF) (clauses A20 to A22)

b. Block Funding (clauses A23 and A24)

c. Public Health Funding (clauses A25 and A26)

d. Service Model Reform Funding (SMRF) (clauses A27 to A29).

A9. The IHACPA will consult with all Parties to develop the first version of a Funding Models Framework by 30 June 2027 for HCEF consideration. The IHACPA will be responsible for ongoing updates to the Funding Models Framework as necessary to support and contribute to reform implementation (refer clauses D16 and D17). The framework will:

a. collate advice on IHACPA processes to increase transparency of IHACPA decision making related to pricing, classification, scope, and funding stream criteria

b. outline principles and criteria for determining when each funding stream is most appropriate and practicable, consistent with the objectives of this Addendum

c. describe the pathways to transition service categories between funding streams, and their treatment within the General List

d. describe processes for scaling and embedding successful SMRF and alternative payment model trials

e. include guidance for Parties on how to request pricing, classification, or stream changes (either through the Service Model and Funding Model Framework described in Schedule D or direct request).

A10. Commonwealth funding will be provided for in-scope health services through the most appropriate and practicable funding stream in line with clauses A8 and A9. Funding will only be provided through the Block Funding stream where other streams are not appropriate or practicable.

a. Parties agree to progress work to incorporate Public Health Funding into the Block Funding stream in line with clause A80.

A11. HCEF will review the funding arrangements after the first annual reconciliation to ensure it is operating in accordance with the model's intentions: to simplify funding arrangements, increase the CCR, and improve equity in the model.

a. The terms of reference of this review will be agreed by Health Ministers (HMM), and adjustments may be agreed by HMM in accordance with Preliminaries clauses 45 and 46 for implementation in the term of this Addendum.

b. If unintended outcomes from implementing the new funding arrangements are identified prior to the review, Parties may raise them with HMM, and adjustments may be agreed as per clauses 45 and 46.

A12. Subject to any exceptions specifically made in this Addendum or through variation to the Addendum (such as those described at clause A13), the Commonwealth will not fund services through the NHRA if the same service, or any part of the same service, is funded through any of the benefit programs listed in clause A17(a), any other Commonwealth program or another NHRA stream.

A13. The Parties agree the following Commonwealth benefits and other programs constitute exceptions to clause A12:

a. Medicare Benefits Schedule (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. Pharmaceutical Benefits Schedule (PBS) benefits dispensed under Pharmaceutical Reform Arrangements agreed between the Commonwealth and the relevant State (in accordance with clauses A245 to A250), or under relevant Section 100 special arrangements established under the *National Health Act 1953*

d. The payment (which could be the default, the gazetted or an equivalent payment) received for daily bed fees for eligible admitted private patients in public hospitals supported through the private health insurance rebate

e. activities through the SMRF stream that are partly funded outside the NHRA, where explicitly agreed by the Commonwealth Health Minister and one or more State Health Ministers.

A14. To enact the principle set out in clause A12:

a. States will ensure that any practitioner privately billing services at a public hospital operates under a rights of private practice agreement, made in accordance with the minimum standards of this Addendum

b. Commonwealth NHR funding for admitted and non-admitted patient services will be contingent on valid patient elections, made in accordance with the minimum standards of this Addendum set out in Schedule J.

A15. The Parties agree to the principle that both the Commonwealth's and States' funding models will not incentivise hospitals to treat public or private patients differently.

A16. 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.

A17. 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.

a. The Commonwealth will continue to support private health services through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and Private Health Insurance Rebate.

Part 1 – The National Funding Model

A18. This Addendum is to be used for calculating the Commonwealth's funding contribution to the States for the five financial years of 2026-27 to 2030-31. The calculation of the Commonwealth's funding contribution for 2025-26 will be undertaken according to arrangements and processes in Schedule K – Addendum to the National Health Reform Agreement: Revised public hospital funding and health reform arrangements for 2025-26.

A19. The Administrator is responsible for performing the calculations contained in this Part and advising all Parties on the outputs of those calculations.

a. Where the calculations contained in this Part rely on an input or parameter that is not available, or is not finalised, the Administrator will calculate and apply an approach consistent with the intent of this Schedule and Schedule I.

Activity Based Funding calculation

A20. The Commonwealth will fund ABF service delivery at an increasing rate, as determined by the glide path (clause A36).

A21. The Commonwealth's funding of ABF service delivery will be calculated and reported on discrete categories of service as defined by the Administrator, known as ABF service categories.

A22. The Commonwealth's funding contribution for each ABF service category will be calculated individually for each State by multiplying:

a. activity – the volume of weighted ABF services provided in the current year for that ABF service category as measured in National Weighted Activity Units (NWAUs)

b. price – the National Efficient Price for that year as determined by the IHACPA

c. input contribution rate – the rate for that financial year as determined by clauses A34 to A36.

Block Funding calculation

A23. The Commonwealth's funding of Block service delivery will be calculated and reported on discrete categories of service as defined in the Block Funding Criteria, known as block service categories.

A24. The Commonwealth's funding contribution for each block service category will be calculated for each State by multiplying:

a. cost – the National Efficient Cost for each State in the current year for that block service category as determined by the IHACPA

b. input contribution rate – the rate for that financial year as determined by clauses A34 to A36.

Public Health Funding calculation

A25. The Commonwealth's funding contribution to public health will continue to grow by the former National Healthcare Specific Purpose Payment (SPP) growth factor until the process for incorporating Public Health Funding in the Block Funding stream is resolved and adopted by unanimous agreement of the Parties through HMM (see clause A80).

A26. Until Public Health Funding is included in the Block Funding stream:

a. the Commonwealth's funding contribution for public health activities will be equal to the previous year's funding indexed by the former National Healthcare SPP growth factor

b. States will continue to have full discretion over application of the Public Health Funding to achieve the outcomes set out in the National Healthcare Agreement 2012.

Service Model Reform Funding calculation

A27. The Service Model Reform Funding (SMRF) stream is a new dedicated funding stream to be established under this agreement from 2027-28 as a mechanism to foster system-wide innovation and improved productivity (refer Schedule D).

a. For each year of the Addendum from 2027-28, States can opt in to the SMRF stream for a designated amount in line with clause A28.

A28. From 2027-28, the Commonwealth's funding contribution for approved projects within the SMRF stream, for each State that opts in will be within the State's annual funding cap (refer A41) and will be equal to the lesser of:

a. the advised value of the approved projects multiplied by 50.0 per cent, or

b. a designated amount up to 0.50 per cent of that State's funding cap for the relevant financial year plus any SMRF rollover amounts from prior years (refer clause A29).

A29. For a given financial year, if a State opts in for a designated amount but does not fully expend this amount against approved projects, the unexpended amount may be rolled over into the following financial year, only within the SMRF stream.

a. For the avoidance of doubt, up to 100 per cent of a State's SMRF designated opt in amount can be rolled over into the following year within the SMRF stream.

b. Unspent Commonwealth SMRF amounts do not contribute to the redistribution of unspent cap funding in 2030-31 set out in clauses A48 to A52.

Private patient funding neutrality adjustment

A30. The IHACPA and the Administrator, in consultation with the Parties, will review the methodology for calculating funding adjustments for private patient neutrality established by clause A44 of the 2020-2025 Addendum.

a. The intent of review is to ensure that funding models do not incentivise public hospitals to treat private or public patients differently as per clause A15. The terms of reference for the review will be agreed by HMM.

b. The completed review will be provided to HMM by December 2027 and include an assessment of the existing methodology and recommendations for alternative processes for future private patient neutrality adjustments.

c. Until this review is completed and actioned, the existing private patient neutrality funding adjustment methodology will apply.

Commonwealth contribution rate

A31. The Commonwealth Contribution Rate (CCR) is an output metric. Previously the CCR has been defined only for the ABF stream as:

$$State\ Y's\ CCR\ (2020\text{-}25\ Addendum) = \frac{\text{ABF entitlement for Year X in State Y}}{\text{Total volume of weighted services for Year X in State Y} \times \text{NEP for Year X}}$$

A32. The new funding model requires a separately defined Commonwealth Contribution Rate for each of ABF and Block Funding. Each State's Commonwealth Contribution Rates for these funding streams will be calculated in each year as follows:

a. ABF Commonwealth Contribution Rate (ABF CCR):

$$State\ Y's\ ABF\ CCR = \frac{\text{ABF entitlement for Year X in State Y}}{\text{Total volume of weighted services for Year X in State Y} \times NEP \text{ for Year X}}$$

i. Tasmania's 2025-26 ABF CCR, accounting for the Transfer of the Mersey Community Hospital, will be calculated instead as follows:

$$TAS\ \text{2025-26}\ ABF\ CCR = \frac{\text{ABF entitlement for TAS in 2025/26} + \$32{,}858{,}722}{\text{Total volume of weighted services for TAS in 2025/26} \times NEP \text{ for 2025/26}}$$

where $32,858,722 is the 2025-26 funding adjustment as set out in Table 1 of the National Partnership on Transfer of the Mersey Community Hospital.

b. Block Commonwealth Contribution Rate (Block CCR):

$$State\ Y's\ Block\ CCR = \frac{\text{Block Funding entitlement for Year X in State Y}}{\text{National Efficient Cost for Year X in State Y}}$$

A33. To avoid confusion, Parties agree that updated terminology for ABF CCR and Block CCR are defined as per clause A32.

A34. An Input Contribution Rate (as required by clauses A22(c) and A24(b)) will be determined separately for each funding stream for each State, except for the Public Health Funding stream.

A35. The Input Contribution Rate for the ABF and Block Funding streams for each year of this Addendum is the greater of:

a. the rate specified in clause A36, or

b. the State's 2025-26 ABF or Block CCR respectively, as calculated as per clause A32, or

c. if a service category is moved from one funding stream to another, the input contribution rate to be paid for that service category will be that of the higher funding stream (up to a maximum of 45.0 per cent) – that is, there will be no inherent funding disadvantage due to a change of input contribution rate caused by a change in funding stream, or

d. any otherwise specified rate for particular service types described in this Addendum for example, High-Cost, Highly Specialised Therapies (refer clause A235(a)).

A36. The minimum value for the Commonwealth Input Contribution Rate for both ABF and Block Funding streams is specified in the table below:

2026-27	2027-28	2028-29	2029-30	2030-31
40.5%	41.0%	41.5%	42.0%	42.5%

A37. As the 2025-26 annual reconciliation will not be completed until after the commencement of this Addendum, each State's ABF and Block CCR for 2025-26 will be provisionally calculated based on the most recent payment advice provided by the Administrator to the Commonwealth Treasurer. The ABF and Block CCRs will be recalculated once the 2025-26 annual reconciliation is completed.

Funding cap

A38. The Commonwealth's combined annual funding contribution to each State for all funding streams under this Addendum (as described in clause A8) will be subject to a funding cap.

A39. In applying the funding cap each year, no State will be entitled to more than its capped Commonwealth contribution, except for:

a. exemptions described at clauses A45 and A46

b. the provision of the redistribution of unspent cap funding in 2030-31 as outlined in clauses A48 to A52

c. the provision of any Service Model Reform Funding rollover, as outlined in clause A29.

A40. The funding cap amount for each State for each year of the Addendum will be calculated as a percentage of the State's funding entitlement for 2025-26, with the 2025-26 funding entitlement, or funding base, being determined as:

$$\text{2025-26 NHRA entitlement} + \text{2025-26 additional amount}$$

Where 2025-26 additional amount refers to the additional funding of States under Schedule K – Addendum to the National Health Reform Agreement: Revised public hospital funding and health reform arrangements for 2025-26, FFA payment amount (as per clause K7(c)), and the 2025-26 NHRA entitlement is determined as follows:

a. prior to completion of the 2025-26 annual reconciliation process, for the purposes of estimation to inform payments for 2026-27, estimated as the Administrator's estimated soft cap for each state in 2025-26, as per December 2025

b. following completion of the 2025-26 annual reconciliation process as set out in the 2020-25 Addendum, for all purposes the final entitlement for 2025-26 as determined by the Commonwealth Treasurer.

For the avoidance of doubt, the 2025-26 additional amount is as per the table below:

State	2025-26 additional funding ($ millions)
NSW	407.000
Vic	402.000
Qld	414.000
WA	158.134
SA	169.198
Tas	50.000
ACT	50.000
NT	51.000
National	1,701.332

A41. The funding cap amount will be calculated individually for each State by multiplying the funding cap from the prior year (to the nearest dollar) by the relevant formula as specified in the table below:

Year	Cap value calculation
2026-27	$(2025\text{-}26\ \mathit{total\ NHRA\ entitlement}\ + 2025\text{-}26\ \mathit{additional\ amount}) \times 110.25\%$
2027-28	$(2026\text{-}27\ \text{cap}) \times 108.00\%$
2028-29	$(2027\text{-}28\ \text{cap}) \times 108.00\%$
2029-30	$(2028\text{-}29\ \text{cap}) \times 108.00\%$
2030-31	$(2029\text{-}30\ \text{cap}) \times 108.00\%$

This is equivalent to the following cumulative cap increases relative to the total 2025-26 NHRA entitlement and 2025-26 additional amount, rounded to two decimal places:

Year	2026-27	2027-28	2028-29	2029-30	2030-31
All States	110.25%	119.07%	128.60%	138.88%	149.99%

A42. The application of clause A40 to determine Tasmania's funding cap base will be modified as follows: for the financial years 2027-28, 2028-29, 2029-30 and 2030-31, Tasmania's funding cap base will also include the 2025-26 funding adjustment as set out in Table 1 of the National Partnership on Transfer of the Mersey Community Hospital.

A43. For each year from 2027-28 once the calculation at clause A41 is performed, States that opt in to receive their SMRF entitlement will have a designated amount up to 0.5 per cent of their funding cap reserved for SMRF. This funding will not be available for other funding streams and will not represent unspent cap funding.

A44. The funding cap amounts reserved for Service Model Reform Funding in clause A43 can be rolled over to subsequent financial years as per the conditions set out in clause A29.

a. Rollover amounts from prior year entitlements will be calculated separately to the current year's entitlement calculation.

b. For the avoidance of doubt, SMRF rollover amounts do not affect each State's remaining available funding for other funding streams and do not contribute to redistribution of unspent cap funding in 2030-31.

A45. The following services will not be included in funding cap calculations:

a. High Cost, Highly Specialised Therapies as specified in clause A235(b)

b. Cross-border arrangements provided in accordance with clause A195(c)(iii)

c. SMRF rollover amounts from prior years.

A46. In clause A45, excluding these services from funding cap calculations means that:

a. the total value of "2025-26 total NHRA entitlement + Additional Funding Support for Hospital and Related Health Services FFA payment amount", used in clause A41 to calculate funding caps for this addendum, includes the Commonwealth entitlement for services of the types in clause A45(a) and A45(b)

for each year of this Addendum, these amounts in clause A45(a) and A45(b) will not be counted for the purpose of determining whether a state has reached or exceeded its annual funding cap amount.

A47. For the avoidance of doubt, the reduction required to Tasmania's NHRA ABF stream by the National Partnership on Transfer of the Mersey Community Hospital will continue for 2026-27 only. There will be no reduction to Tasmania's funding for the Mersey Community Hospital from 2027-28.

Redistribution of unspent cap funding in 2030-31

A48. An amount equivalent to any unspent cap funding over the five years of this Addendum will be pooled by the Commonwealth and made available for redistribution in 2030-31, initially on an individual State basis.

A49. A State's unspent cap funding will be calculated as:

a. for each year from 2026-27 to 2029-30 the difference between a State's final entitlement and their funding cap, where their final entitlement is less than their funding cap

b. for 2030-31, the difference between a State's preliminary uncapped funding entitlement and their funding cap, where their preliminary uncapped funding entitlement is less than their funding cap.

A50. Where a State has an ABF CCR of less than 42.5 per cent in 2030-31 due to the operation of the funding cap and has unspent cap funding (not including unspent SMRF), the Commonwealth will provide a one-off top up payment in line with clause A51.

A51. The one-off top up payment in 2030-31 will be:

a. equal to the lower of:

i. the State's funding shortfall in 2030-31, or

ii. the State's total sum of unspent cap funding amounts over the five years (not including unspent SMRF)

b. at maximum, the amount required to lift the state to an ABF CCR of 42.5 per cent.

A52. If individual States have reached an output ABF CCR of 42.5 per cent in 2030-31 using their unspent cap funding, any remaining unspent cap funding amounts for all States will be pooled and made available nationally for redistribution to other States who have not reached an ABF CCR of 42.5 per cent. The top up amount for any remaining States will be calculated as an amount equivalent to the lower of:

a. the State's remaining funding shortfall in 2030-31, or

b. a proportionate share of the national total of unspent cap funding amounts over the five years, to be calculated as:

$$\text{National unspent cap funding amount} \times \frac{\text{Individual State's funding shortfall in 2030-31}}{\text{National funding shortfall in 2030-31}}$$

Where:

i. the 'National unspent cap funding amount' is the sum of all the individual States' remaining unspent cap funding amounts for the five years 2026-27 to 2030-31

ii. the 'individual State's funding shortfall' is the amount by which a State's own remaining uncapped Commonwealth funding entitlement exceeds the cap in 203031

iii. the 'national funding shortfall' is the sum of all the remaining 'individual States' funding shortfall' in 2030-31.

Minimum funding guarantee

A53. The Commonwealth will provide a minimum additional $15.0 billion in NHR funding over the period 2026-27 to 2030-31 when compared to the maximum amount that States would have received if the 2020-2025 Addendum funding arrangements applied.

a. The intent is that a minimum amount of NHR funding across all States over this Addendum period is guaranteed on an annual, state-specific basis.

A54. The annual State allocation of the MFG for the 2026-27 to 2030-31 period will be calculated by the Administrator according to the following steps:

a. Step 1: Calculate the maximum amount that all States would have received if the 2020-2025 Addendum funding arrangements applied to the 2026-27 to 2030-31 period as follows:

$$\text{Total National Final Entitlement 2025-26} \sum_{k=1}^{5} (1.065)^k + \text{Mersey adjustment 2026-27} \sum_{k=1}^{4} (1.065)^k$$

Where:

i. the 'Total National Final Entitlement 2025-26' is the sum of all the individual States' Final Entitlements for 2025-26

ii. the 'Mersey adjustment 2026-27' is the funding adjustment for 2026-27 as set out in Table 1 of the National Partnership on Transfer of the Mersey Community Hospital

b. Step 2: Calculate the total national MFG amount over the 2026-27 to 2030-31 period as follows:

$$\text{Max payable under the 2020-25 Addendum arrangements (Step 1)} + \$15{,}000{,}000{,}000.00$$

c. Step 3: Calculate the annual State cumulative funding cap percentage for each State for each year as follows:

$$\frac{\text{Funding cap amount for that State for that year (i)}}{\text{Five year total funding cap for all States (ii)}}$$

Where:

i. the funding cap amount for each State for each year of the Addendum will be calculated as per clauses A41

ii. the five-year total funding cap will be calculated as the sum of all the individual States' funding cap amounts for each of the five years from 2026-27 to 2030-31

iii. the sum of the annual state funding cap per cent for all States over the five years equals 100 per cent

d. Step 4: Calculate the annual state-specific MFG as follows:

$$\text{Total national MFG 2026-27 to 2030-31 (Step 2)} \times \text{Annual State funding cap \% (Step 3)}$$

A55. As part of the annual reconciliation process, if the final NHR funding entitlement for a State is less than that State's MFG entitlement for that same year, the Commonwealth will pay the difference between these amounts in the next feasible financial year (clause A114 refers).

Part 2 – The National Pricing Model

A56. The IHACPA has determinative authority under the *National Health Reform Act 2011* to develop and specify classification systems through which public hospital and health services are to be priced, costed and funded under this Addendum. In doing so, the IHACPA will have regard to the requirements set out in this Part, and Schedule D and Schedule I where relevant.

A57. In line with clause A9, the IHACPA's role in developing and specifying classification systems will follow the principles and criteria of the Funding Models Framework once agreed by HCEF.

Activity Based Funding - Principles for determining the National Efficient Price

A58. The role of the National Efficient Price (NEP) is to:

a. form the basis for calculating the Commonwealth's funding contribution

b. provide a relevant price signal to States and Local Hospital Networks (LHNs) that will improve patient access to services, public hospital and health service efficiency, funding effectiveness, and quality and safety.

A59. In determining the NEP, the IHACPA must:

a. have regard to ensuring reasonable access to public hospital and health services, clinical safety and quality, efficiency and effectiveness and financial sustainability of the public hospital system

b. consider value for patients and the system

c. consider the actual cost of delivery of public hospital and health services in as wide a range of hospitals as practicable

d. consider the actual and expected changes in costs from year to year when making projections

e. have regard to the need for continuity and predictability in prices

f. 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

g. develop methods, including sampling, which allow consideration of reasonable and likely growth in cost inputs, so that the NEP can be projected into the future in a predictable and transparent manner

h. ensure that movements in weights, adjustments, and price from one year to another do not result in unintended volatility in NHR funding.

A60. In determining adjustments to the NEP, the IHACPA must have regard to evidence of legitimate and unavoidable variations in wage costs and other inputs that affect the costs of service delivery, including:

a. hospital type and size

b. hospital location, including remoteness

c. patient complexity

d. Indigenous status, noting the review at clause A64

e. smaller jurisdictions, noting the review at clause A64.

A61. In determining the NEP, IHACPA must also have regard to developing and maintaining specific adjustments and considerations to incentivise improvements in safety, quality, and value. This is to be done in close consultation with the ACSQHC and the Parties. These adjustments and considerations should include, but not be limited to:

a. safety and quality adjustments, including:

i. Sentinel Events

ii. Hospital Acquired Complications (HACs)

iii. Avoidable Hospital Readmissions (AHRs)

b. value-based pricing approaches, including:

i. High-Value Care

ii. Low-Value Care

iii. Normative Pricing, Priority Care Loadings and other approaches as described in Schedule D.

A62. The IHACPA must provide sufficient data to the Commonwealth Grants Commission (CGC) on adjustments to the NEP to assist the CGC in determining GST relativities for the States.

A63. Parties acknowledge the national pricing model underpinning the NEP26 and NEC26 Determinations will be based on the requirements set out in the *National Health Reform Act 2011* and the Addendum to the NHRA 2020–25. The NEP methodology may be updated by the IHACPA to reflect this Addendum, as well as after the NEP review at Preliminaries clause 49 is finalised.

Reviews of pricing adjustments

A64. The IHACPA will undertake a review of the NEP and NEC price weights for Indigeneity, regionality, and smaller jurisdictions, as per the Terms of Reference agreed prior to the start of this Addendum under the remit of HCEF. This will include consideration of:

a. Indigenous status, and rural and remote status, both individually and as they interact. This will include considering the cost drivers that contribute to cost variations associated with these cohorts

b. baseline financial viability of smaller jurisdictions, including factors contributing to a lack of viability, and develop appropriate adjustments to the pricing model to ensure financial sustainability of existing health services.

A65. The IHACPA will consult with the Parties and relevant stakeholder groups such as Aboriginal and Torres Strait Islander stakeholders (set out in Schedule B), in undertaking these reviews, and identifying policy issues that may not be addressed through an adjustment but have impacts on the costs of public hospitals, as per the agreed Terms of Reference.

A66. The IHACPA will provide HCEF with the reviews and consider HCEF's response when incorporating the findings into the setting of the NEP.

Private patient arrangements

A67. Any payments for eligible private patients must use the same classification system used 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 that are covered by:

a. Commonwealth funding sources other than ABF

b. all patient charges, whether or not funded by private health insurance, including:

i. prostheses

ii. accommodation and nursing related components/charge equivalent to the payment (which could be the default, the gazetted or an equivalent payment) received for daily bed fees for eligible admitted private patients in public hospitals supported through the private health insurance rebate.

Block Funding - Principles for determining the National Efficient Cost

A68. Block-funded services will be classified and costed via the National Efficient Cost, which will be determined by the IHACPA, taking account of changes in utilisation, the scope of services provided, and the cost of those services.

A69. As part of the National Efficient Cost, the IHACPA, in consultation with Parties, will maintain and publish Block Funding Criteria and identify whether hospital and health services and functions are eligible for block funding only, or a mix of block funding and other types of funding.

A70. The IHACPA will, in consultation with Parties, publish the Block Funding Criteria on an annual basis as soon as practicable during the term of this Addendum, for implementation in the next feasible National Efficient Cost Determination.

A71. In determining the Block Funding Criteria as part of the National Efficient Cost Determination, IHACPA must have regard to:

a. criteria for determining whether a service is eligible for block funding only, or mixed ABF and block funding, or neither

b. identifying those services eligible for block funding only or mixed funding and assigning them to block service categories

c. defining nationally consistent scope of the cost, and type of activities, for those services eligible for block-funding, including providing definitions for sub-components and sub-functions, in line with requirements for scope of services, clauses A100 to A105

d. specifying the evidence States will be reasonably required to provide for block-funded services to demonstrate the estimated in-scope service delivery

e. making allowance for the Commonwealth and one or more States to enter into bilateral agreements to trial alternative payment models (as per the processes described in Schedule D and in clauses A76 to A79)

f. describing processes that allow for bilateral arrangements between the Commonwealth and one or more State(s) to fund services under the Block Funding stream where they do not otherwise fall within the IHACPA's Determination.

A72. In developing the release of the Block Funding Criteria, the IHACPA will have regard to updating existing block-funded services and their categorisation and classification in line with clause A103, including considering:

a. appropriate categories for block-funded hospitals (for example, small rural hospitals and standalone hospitals)

b. developing a suitable category (or categories) to capture Public Health activities in the Block Funding stream as set out in clause A80 (for example, cancer screening programs)

c. including other programs as agreed by the Parties

d. developing a timeline and plan to classify and move categories that are best suited to other funding streams

e. developing an approach on progressing improvements to the classification of the Australian Teaching and Training Classification (ATTC) for teaching and training, including implementation options

f. developing a process for adding new categories.

A73. In determining the Block Funding Criteria as part of the National Efficient Cost Determination, the IHACPA will have further regard to the need to set criteria for block-funded hospitals so that activity or expenditure thresholds are aligned to the current list of block-funded hospitals.

a. These criteria will apply to block-funded, non-fixed-plus-variable hospitals categories as listed in the National Efficient Cost Determination, including:

i. standalone hospitals providing specialist mental health services

ii. standalone major city hospitals providing specialist services, and

iii. other standalone hospitals that are not appropriately funded by the fixed-plus-variable small rural hospital National Efficient Cost model.

b. The IHACPA will continue to set the expenditure and activity threshold for small rural hospitals and apply the National Efficient Cost model for calculating Commonwealth block-funding contributions for small rural services.

c. If hospitals are listed as block-funded hospitals but funded by States through activity-based funding, these hospitals will be removed from the list.

A74. In developing the Block Funding Criteria, the IHACPA will have regard to the limitations States have in providing data for block-funded eligible services and should not seek to duplicate the level of data requirements needed for ABF.

A75. As part of the annual National Efficient Cost Determination process, States will provide advice to the IHACPA on how their hospitals, health services and functions meet the Block Funding Criteria, and reference Service Agreements, State Budget Papers, or other sources to substantiate estimates of in-scope funding for those services.

Alternative payment model trials

A76. Parties may bilaterally agree to trial alternative payment models not otherwise described in this Addendum, including where funding or pricing methodologies are planned to be implemented but not yet available in the formal National Funding Model or National Pricing Model, through the processes outlined in Schedule D. Commonwealth contributions to these trials will be through the Block Funding stream arrangements.

A77. Where an alternative payment model trial proposal has been agreed between the Commonwealth and one or more States, the proposal will be referred to IHACPA and ACSQHC who will support the nominating Party to:

a. develop an appropriate costing or pricing model

b. confirm details of the trial parameters, including, but not limited to, time, number of locations, and scope of costing or pricing.

A78. The IHACPA will:

a. work with the nominating State(s) to develop a costing or pricing methodology that does not penalise States undertaking trials, or other States. Application of this methodology in individual instances would be agreed by the nominating State(s) and the Commonwealth

b. advise the Commonwealth and State(s) on application of the methodology and on any issues it foresees the proposed trial will have for the National Funding Model.

A79. During a trial, a State will need to continue to acquit and report Commonwealth funding on an ABF or block basis to verify that the payment arrangement is operating as intended.

Public Health Funding - Principles for determining the cost/price

A80. During the term of this Addendum, the IHACPA and the Administrator will provide to HMM for consideration, an approach to incorporate the Public Health Funding stream into the Block Funding stream. HMM will advise on implementation and next steps based on the advice given. In developing an approach, the IHACPA and the Administrator will have regard to:

a. a definition of in-scope Public Health activities that will receive a Commonwealth funding contribution through this Addendum will be developed by IHACPA

i. the IHACPA and the Administrator will consider the work of the Australian Centre for Disease Control and the National Preventive Health Strategy 2021-2030, consult closely with the Parties, and have regard to the activities historically funded through the Public Health Funding stream

b. the need for the new block-funded Public Health activities to undergo a shadow pricing period, as outlined in accordance with the principles and processes set out in clauses A98 and A99

c. the intent for Public Health activities to be categories within the Block Funding stream to operate in line with Block Funding Criteria processes (clauses A68 to A75).

A81. Parties acknowledge this process may find that the cost of, and the Commonwealth funding contribution for, Public Health activities through other funding streams differs significantly from the historical Public Health Funding stream contribution currently paid via clauses A25 and A26. In these circumstances:

a. the Administrator will develop an implementation plan to accompany HMM's approach to incorporate Public Health Funding into the other funding stream for the delivery of this clause and its components. If the Administrator identifies any changes required to the funding model, amendments to the Addendum may be made on agreement by all Parties according to Preliminaries clauses 45 and 46

b. Parties agree that at a minimum, this process should ensure that overall annual Commonwealth funding entitlement amounts for Public Health activities in other funding streams will not be less than that provided to each jurisdiction in the base year (year prior to the implementation year)

c. details on how to maintain the level of funding at (b) will need to be addressed as part of the Administrator's implementation plan.

Service Model Reform Funding

A82. States will estimate the price or cost for relevant aspects of proposed projects in line with SMRF operation procedures in Schedule D (refer clause D26).

a. Approval of projects will be as per the process set out in clauses D30.

b. When requested by the nominating State, the IHACPA will provide advice on the development of pricing or costing for relevant components of proposed projects.

A83. As part of developing the Funding Models Framework (clause A9), the IHACPA will determine a process for incorporating changes into the National Pricing Model that are proven through SMRF projects. The IHACPA's process may include price and/or scope changes.

Safety, quality and value pricing adjustments

A84. Pricing adjustments for safety, quality and value are part of a multifaceted, system-wide approach to improving care, which also includes national standards, accreditation, continuous quality improvement programs and workforce development.

A85. The Parties agree to continue integrating safety, quality and value into the pricing and funding of public hospitals and health services in a way that:

a. improves patient outcomes

b. incentivises the right care, in the right place, at the right time

c. decreases avoidable demand for health services

d. signals the need to reduce instances of preventable poor quality patient care, while supporting improvements in both data quality and information available to inform practice

e. improves measurement and reporting of racism and cultural safety, and incentivises addressing inequities, especially for Aboriginal and Torres Strait Islander people (aligned with the National Aboriginal and Torres Strait Islander Health Plan objectives 8.1 and 8.4).

A86. The Parties agree that comprehensive safety, quality and value pricing and funding arrangements should:

a. be rigorous, fair, and transparent

b. not incentivise under-reporting or over-reporting, or adversely affect service delivery

c. be significant as an effective overall price signal from the Commonwealth through to LHNs, hospitals and other health services

d. not result in inequity or poorer outcomes for any group.

Sentinel events, Hospital Acquired Complications and Avoidable Hospital Readmissions

A87. The Parties agree to retain existing pricing adjustments for Sentinel Events, Hospital Acquired Complications (HACs) and Avoidable Hospital Readmissions (AHRs) noting:

a. a review will be completed by the ACSQHC by 30 June 2027 (described in clauses D51 to D55), and the adjustments will be retained for the full term of the Addendum if they are found to be fit-for-purpose and effective

b. following the review, Parties may consider introducing appropriate mechanisms for reinvesting pricing adjustments in safety and quality improvement activities

c. modifications to pricing adjustments may be implemented by IHACPA following recommendations of the review.

A88. The Parties agree the ACSQHC will continue to maintain and curate the Sentinel Events, HACs, and AHRs lists, based on the relevant criteria in Appendix B.

A89. The Parties agree the IHACPA will continue to manage the pricing model for HACs and AHRs, in consultation with the ACSQHC.

A90. The Parties agree that while the ACSQHC is undertaking the review of clause A87(a), absolute pricing penalties for HACs and AHRs will not be applied to states. These will be shadow priced only during this time. However, Parties agree that pricing penalties will be considered as part of a long-term solution to drive higher quality, safer care in public hospitals, and pricing adjustments will be reintroduced if the review finds they are effective. This short-term pause will allow the ACSQHC to review the existing pricing adjustments, and the IHACPA to complete the work outlined below.

a. In order to retain and strengthen the existing safety and quality pricing adjustments, IHACPA will investigate and determine a new methodology that gives effect to a pricing adjustment for HACs and AHRs. This methodology will consider how to apply pricing adjustments that create effective incentives for LHNs and states, accounting for the operation of the funding cap and the funding model. IHACPA will undertake this work in consultation with the ACSQHC and Parties.

b. The IHACPA will report to HCEF with preliminary advice on this approach within six months of the ACSQHC review referred to in clause A87(a).

A91. The Parties agree that any episode of care that gives rise to a Sentinel Event will not be funded by the Commonwealth. For each state, total NWAU associated with Sentinel Events will be calculated each year.

a. Where states are below the funding cap in any given year, the episode will be assigned a NWAU of zero.

b. Where states are over the funding cap in any given year, the total Commonwealth contribution for this number of NWAU will be applied as an absolute funding penalty, after the funding cap.

c. For the avoidance of doubt, any penalties associated with Sentinel Events will not affect future funding caps outlined at clause A41.

A92. States agree to apply a digital flag to any episode that includes a Sentinel Event and report this information to IHACPA as part of data submissions under clauses A222 and I84 of this Addendum.

High-value and low-value care

A93. The Parties agree that pricing adjustments should be introduced to better incentivise provision of higher quality care in the public hospital and health care system.

A94. The Parties agree that the ACSQHC will establish the low-value and high-value care list by 30 June 2028, based on the relevant principles in Schedule D.

A95. The IHACPA will develop pricing models and adjustments for the high-value and low-value care approaches the first set of which will be shadow priced by 1 July 2029. The IHACPA will consult with and have regard to the advice of the ACSQHC, Parties, and Aboriginal and Torres Strait Islander stakeholders.

A96. In developing these pricing models, the IHACPA will have regard to:

a. incorporating low-value care using an agreed list that has negative pricing adjustments, similar to existing safety and quality adjustments

b. incorporating high-value care using an agreed list that has positive pricing adjustments

c. developing pricing mechanisms, size of adjustments, and the scope of low-value and high-value care based on the principles in Schedule D

d. ensuring low-value and high-value care pricing adjustments are broadly balanced by delivering more high-value care and less low-value care.

A97. Prior to implementing low-value and high-value care pricing adjustments, the Parties agree to shadow-price these adjustments for one year in 2029-30, ahead of their introduction to the pricing model. This shadow-pricing will inform development of pricing adjustments described above and be incorporated into health system performance reporting (Schedule H refers).

a. Introduction of these changes will be subject to HMM consideration and the results of the shadow pricing.

b. In addition to the shadow-pricing, States will also report rates of low-value care events, procedures and pathways to the IHACPA and the ACSQHC for financial year 2028-29, which will be used to inform the development and maintenance of price adjustments.

Transitional pricing and retrospective change arrangements

A98. The Parties acknowledge that the IHACPA must determine a National Efficient Price and National Efficient Cost for the forthcoming year; that changes cannot be made to these within the course of that year or retrospectively; and, that such a retrospective change would be undesirable given the need for sustainability and certainty in public hospital and health service funding.

a. The IHACPA will use transitional arrangements including shadow pricing when developing significant new funding streams, classification systems or pricing methodologies. Shadow pricing will be undertaken for a period of up to two years or a shorter period agreed with the Commonwealth and a majority of States.

A99. Notwithstanding the principle at A98, Parties acknowledge that in some cases a retrospective or in-year change to the National Funding Model – but not the National Pricing Model – may be required. Business rules for retrospective adjustments to the National Funding Model will be maintained by the Administrator and National Health Funding Body (NHFB). These will address the significance of changes, processes, and consultation requirements.

a. If the Administrator and NHFB consider there is a potential need for a retrospective adjustment to the National Funding Model, Administrator and NHFB will communicate, consult, and collaborate with Parties. The Administrator and NHFB will hold a consultation period of 45 days to allow Parties an opportunity to provide submissions on the matter.

b. Within 45 days following the 45-day consultation period, the Administrator and NHFB will prepare a report for HMM, advising them of the Administrator and NHFB's decision, and the nature and circumstances of the recommended adjustment to the National Funding Model.

c. Once the report is provided to HMM, the Administrator and NHFB will incorporate the decision on the retrospective adjustment into the National Funding Model and provide Parties with an updated report on funding entitlements.

d. When providing payment advice to the Commonwealth Treasurer following the annual reconciliation, the Administrator will include a section that notes any matters or concerns raised by State Ministers in the 45-day consultation period.

Part 3 – Scope of services and other activities that receive a Commonwealth contribution

General list of services eligible to receive a Commonwealth funding contribution

A100. As part of the National Pricing Model, the IHACPA will be responsible for determining and publishing the scope of public hospital and health services eligible to receive a Commonwealth funding contribution through this Addendum, known as the general list. In making and maintaining this determination and list, the IHACPA will have regard to this Part of Schedule A and clauses D14 to D17 in Schedule D.

A101. Services specified on the general list will attract a Commonwealth funding contribution if provided by or on behalf of any LHN as agreed between a State and a LHN as per clauses A155 to A157.

A102. The IHACPA will maintain and publish criteria for assessing services for inclusion on this general list or a subcomponent thereof, and for reviewing whether services should remain. In establishing the criteria for inclusion and review, the IHACPA will have regard to the need for consistency and equity across all jurisdictions when implementing changes to scope, including in terms of funding stability and predictability.

A103. In making this determination, and maintaining and publishing the criteria for the general list, IHACPA will have regard to both:

a. the primary scope of public hospital and health services eligible for a Commonwealth funding contribution, which will include:

   i. all admitted services, including hospital in the home programs, forensic mental health inpatient services, and virtually provided care

   ii. all emergency care services provided by a recognised emergency department service, including virtually provided care, or other emergency care service (excluding ambulance services)

   iii. specialist outpatient clinic services

   iv. other non-admitted patient services, including new models of care or service delivery, outpatient care, mental health, subacute services or other services that directly substitute or directly reduce demand for hospital services, regardless of setting, provider, or mode of delivery

b. the primary consideration of a service eligible for a Commonwealth funding contribution, which will include reasonable evidence that it is:

   i. a contemporary health service being delivered by public hospitals and health services, or

   ii. a public hospital-like service, or

   iii. another service that directly substitutes or reduces demand, for hospital-like services.

A104. In determining the scope of services and maintaining the general list, the IHACPA will consider recommendations from Parties to amend the general list against the IHACPA's published criteria. If the IHACPA considers the service should continue to be included or excluded, it will publicly release its determination and rationale.

A105. HMM may request the IHACPA to review the services included or excluded from the general list, including in relation to clauses D14 to D17. The IHACPA will implement its desired changes in the following determination.

Other services eligible to receive a Commonwealth funding contribution

A106. As part of the National Pricing Model, the IHACPA will maintain and publish a subset of the general list of conditional services, that sets out those services that are only eligible to receive a Commonwealth funding contribution under specified criteria (such as only in certain jurisdictions and/or LHNs), as determined through this Part.

A107. A service can be included in the subset list if one or more State Health Minister(s) and Treasurer(s), and the Commonwealth Health Minister and Treasurer enter into an agreement to do so, and either:

a. the IHACPA deems that a service would ordinarily be suitable for being placed on the general list according to the considerations set out in A106, but decides that it is not suitable or appropriate for that service to be provided on a nationally consistent basis, or

b. the IHACPA deems that a service meets the intent of reforms outlined in this Addendum but requires further evidence, classification or pricing development before determining whether it is appropriate for listing on the general list.

A108. Additionally, at the commencement of this Addendum, services eligible to receive a Commonwealth funding contribution under implementation of clause A17 of the 2011 National Health Reform Agreement (NHRA) will be included in the subset.

A109. By December 2027, the IHACPA and the Administrator will report to HMM outlining an approach for incorporating the grandfathered services from the A17 list at A108 into the general list.

a. IHACPA will consult with Parties to assess the feasibility of individual services being made available as public hospital and health services in each State, and the process for assigning ABF or block categories and classifications for these services.

b. The report will include advice on which services are deemed to be in-scope and out-of-scope, with regard given to clause A103; services that should transfer to the general list and those that should remain in the subset; and identify an appropriate funding mechanism for each service to receive a Commonwealth contribution.

c. Once HMM endorses the approach, the IHACPA and the Administrator will make necessary changes to the National Funding Model.

A110. Where the Commonwealth agrees to make a funding contribution under this Addendum for non-patient services specified in clause A3 (for example research funded by States undertaken in public hospitals), these services will be included in the subset of the general list.

Part 4 – Commonwealth payment arrangements

A111. Overall funding of public hospital and health services delivered under this Addendum, and all Parties' contribution to those services, should be transparent, accountable and sustainable. This is facilitated by the Administrator's oversight of NHR funding and payment arrangements.

a. NHR funding occurs when a Party pays into the National Health Funding Pool or State Managed Fund.

b. NHR payments occur when NHR funding is paid out of the State Pool Account by the Administrator, or is paid out of the State Managed Fund by the State. NHR payments can be made to Local Hospital Networks (LHNs), third parties (on behalf of a LHN), or other States.

A112. The Administrator will calculate and advise the Commonwealth Treasurer of the annual and monthly Commonwealth payments into the National Health Funding Pool, in accordance with this Part.

a. In calculating and delivering this advice to the Commonwealth Treasurer, the Administrator will apply the funding cap (clauses A38 to A47), including relevant adjustments to the funding cap.

A113. The States, in consultation with the National Health Funding Body and in accordance with this Part, will continue to determine when State payments are made into the National Health Funding Pool.

Process to pay the Commonwealth's funding contribution

A114. The process to pay the Commonwealth's contribution to funding public hospital and health services set out in this section is summarised as follows:

a. for all relevant funding streams, States and relevant entities provide estimates to the Administrator of expected service delivery (and other relevant factors) before the start of each financial year. Other relevant entities are those that provide input to inform the formal forecast at subclause (b)

b. the Administrator calculates and provides a formal forecast to the Commonwealth and States of each State's preliminary Commonwealth funding entitlement, including future amounts owing and prior amounts owed from reconciliations and other adjustments

c. the Parties make monthly payments into the National Health Funding Pool based on the Administrator's calculation

i. As set out in clause A226, the Commonwealth's monthly payment may be subject to the Data Conditional Payment (refer clauses A222 to A229)

d. the Administrator makes payments from the National Health Funding Pool based on State estimates, at the discretion and direction of the relevant State

e. adjustments may be made throughout the year if necessary, for example to reflect updated activity estimates, finalised reconciliation processes for prior years, or final activity data

f. following the end of financial year, a reconciliation process is undertaken by the Administrator based on States' actual activities delivered and other adjustments applied at this time

g. the Administrator provides advice to the Commonwealth Treasurer regarding States' post-reconciliation entitlement amounts

h. the Treasurer determines each State's final entitlement amounts

i. the Administrator makes the relevant adjustments to future payment advice arising from the Treasurer's Determination.

Calculating preliminary Commonwealth funding entitlements

A115. The Administrator will provide the Commonwealth and States with a formal forecast of the Commonwealth's funding contribution for each funding stream, including, where relevant, each 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 (LHNs) within a State, which will be aligned to Service Agreements provided in accordance with the timing set out in clause A169

i. If Service Agreements are not finalised within these timeframes, a service volume statement signed by the State's relevant authorising agent will be provided to the Administrator that contains the minimum detail specified in clause E7 for each LHN

b. the published National Efficient Price and National Efficient Cost from the IHACPA.

A116. If States do not provide Service Agreements or service volume statements by the agreed timeframes set out in clause A169, or do not meet the requirements as set out in this Schedule and Schedule E, the Administrator may use the previous financial year's Service Agreement to calculate the formal forecast, increased by the growth in the published National Efficient Price for the relevant year.

A117. The formal forecast will include estimated SMRF for approved projects (refer clause A145).

A118. The Administrator will calculate a State's preliminary entitlement in accordance with the application of the funding cap as per clauses A38 to A47.

A119. The Administrator will provide information to jurisdictions about progress against the funding caps when the preliminary entitlement is calculated, or when the Commonwealth funding entitlement is adjusted.

A120. The Administrator will provide informal estimates of the Commonwealth funding entitlement to States when requested.

Adjustments to preliminary entitlements

A121. Preliminary Commonwealth funding entitlements can be updated throughout the year as outlined in clause A122. Adjustments to payments remain subject to funding cap arrangements.

A122. For the Administrator to make in-year funding adjustments to the ABF stream, States must provide the Administrator updated Service Agreements or amended service volume statements (as per clause A115).

a. States and LHNs can agree updates or amendments to adjust service volumes or pricing to take account of such matters as changing health needs, variations in actual service delivery, and hospital and health service performance.

b. States, as the system managers of public hospitals and health services, can determine the frequency of alterations to Service Agreements or signed service volume statements. States will notify the Administrator within 14 calendar days of any agreed variations.

A123. States may agree to increase the frequency of reconciliation and adjustments through correspondence between health ministers.

Annual reconciliation and adjustment

A124. The Parties will 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 A5.

A125. The Administrator will undertake annual reconciliation for each State following receipt of Required Data from that State.

A126. To ensure the Commonwealth meets its agreed funding contribution, the annual adjustment will be conducted in arrears once actual volumes have been validated by the service volume reconciliations.

A127. In order to attract a Commonwealth funding contribution for each in-scope public hospital and health service, States must ensure that all data relevant to funding of that service has been provided in line with requirements for the relevant funding stream.

A128. In undertaking the annual reconciliation, the Administrator will calculate any Sentinel Event, HAC, AHR, or any other safety and quality, value-based pricing adjustment that applies to a State in a relevant financial year in consultation with the ACSQHC.

A129. The Administrator should consider issues that may affect the annual reconciliation including, but not limited to, general transcription errors such as incorrect coding of services provided and duplicate entries, the exclusion of services paid for by the Commonwealth via other funding programs, and the exclusion of services for which data has not been provided or is incomplete (in either the year being reconciled or the prior year) or services that have not been accurately classified as a public hospital service eligible to receive a Commonwealth funding contribution.

A130. The Parties agree the annual adjustment should also include an adjustment for the Block Funding component where the estimated Commonwealth funding provided for eligible Block activities in the National Efficient Cost Determination is reconciled with the actual payments from State Managed Funds for delivering these activities.

A131. Funding adjustments required due to the annual reconciliation process will be applied to the Commonwealth's contribution for funding streams as follows:

a. for SMRF, adjustments will be applied to the SMRF stream

b. all other adjustments, including for any Block Funding component, will be applied to the ABF stream, including:

    i. application of the funding cap

    ii. private patient neutrality arrangements.

A132. To support the reconciliation of Commonwealth contributions occurring through State Managed Funds, States will provide the Administrator an annual State Managed Fund acquittal and a Statement of Assurance from a senior health department official on the completeness and accuracy of the acquittal. These must be in a format specified by the Administrator and be provided within annual reconciliation timeframes. The following will also apply:

a. For the Block Funding steam, States will also provide their acquittal to the IHACPA. The acquittal will include detail on:

    i. block-funded service category

    ii. establishment or agency

    iii. output, program or grant description

    iv. identification of any payments to State Governments for shared services arrangements or statewide services contributing to delivery and overall in-scope funding for block-funded services.

A133. Where a trial is undertaken through the alternative payment model trial pathway or the SMRF stream, and the service has a direct analogue to an existing ABF or Block classification such that it would be possible to claim the service or part of the service provided under multiple funding streams, the State will nominate only one stream to claim from when providing their service delivery estimates in order to comply with clause A12.

a. States will provide the Administrator equivalent data for delivery of trial services as they would have had these services been delivered under ABF or Block.

Annual adjustment timeframes for advice

A134. Within three months of the end of each reconciliation period, States will provide the Administrator gross volume and patient identified data on annual, actual services delivered for public hospital and health service functions funded by the Commonwealth on an activity basis. This will enable reconciliations to be undertaken in accordance with clause A126.

A135. The Administrator will provide all Parties with a preliminary report on funding entitlements and reconciliation adjustments for the completed financial year (reconciliation period) no later than 30 November following the end of that financial year.

A136. If necessary, the Administrator will facilitate a discussion between each of the States and the Commonwealth to resolve any issues or disputes about how the National Funding Model has been applied to calculations of funding entitlements and reconciliation adjustments. Any such discussions must be completed by 28 February of the financial year following the end of the relevant reconciliation period. The Administrator may release revised reconciliation advice following this consultation.

A137. If the Administrator is not able to resolve the issue within the remit of their functions, the issue may be dealt with under the resolution clauses in Schedule I.

A138. The Administrator will provide advice on the Commonwealth funding entitlements and subsequent adjustments to the Commonwealth Treasurer by the end of March, contingent on the data, reports and advice being provided in a timely manner. States will be provided a copy of that advice contemporaneously.

Determination and payment of final Commonwealth funding entitlements

A139. The Commonwealth Treasurer will aim to finalise the Treasurer's Determination within one month, or as soon as practicable after receiving the Administrator's final advice.

A140. Where the Commonwealth Treasurer's Determination differs from the Administrator's final advice on funding entitlements for a reconciliation period, the Treasurer will publish a Statement of Difference at the time of the Determination. This Statement will outline the new final entitlement amounts and the reason for the differences between the Treasurer's Determination and the Administrator's final advice.

a. In addition to the Treasurer's Statement above, the Administrator will provide Parties with detail on the funding, National Weighted Activity Units (NWAUs), and block-funded activities related to the Commonwealth Treasurer's Determination, by detailed classification at the LHN level. The Administrator will also publish this information on a website.

A141. The Treasurer's Determination will be actioned by the Administrator through the annual adjustment to Commonwealth payments into the National Health Funding Pool. This annual adjustment will commence in the next practicable monthly payment run following the Determination.

A142. Any variation to Commonwealth payments arising from the Treasurer's Determination will be spread equally across payments for a subsequent quarter, or other appropriate period where the Administrator deems necessary.

a. In recognition of the likelihood of increased variance caused by introducing the new funding calculation method from 2026-27, the Administrator will, on request from a State, give consideration to spreading the annual adjustment across payments for the remaining months of the 2026-27 financial year.

Certainty of reconciliation

A143. The Parties agree 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, except in the following circumstances:

a. where an Auditor General or other relevant body finds fraud or other illegal or dishonest activity, the Administrator may make these adjustments at any time

b. where the Administrator has identified matched payments through the process described at clause A218, the Administrator may make these adjustments to take effect in a future year's reconciliation.

A144. Adjustments required under clause A143 will be made through the following processes:

a. notification of fraud or other illegal or dishonest activity for the purpose of clause A143(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 likely impact on Commonwealth funding. A Statement of Assurance must accompany any further submission of data by a State to remedy an identified issue

b. if an issue is identified or raised with the Administrator through clause A143(a), the Administrator will notify the Commonwealth and State(s) of the issue and how the Administrator plans to resolve the issue

c. the Administrator will calculate the impact on the Commonwealth funding entitlement of any affected State, following assessment by the Administrator of an issue under clause A143

d. the Administrator will assess and advise whether adjustments to the Commonwealth funding entitlement of the affected State(s) should be made. Following resolution of an A143(a) issue, the Administrator will notify the Commonwealth and States of the outcome.

Process for the Service Model Reform Funding stream

A145. The process to pay the Commonwealth's funding contribution for the SMRF stream varies from the process set out in clause A114 as follows:

a. States submit SMRF proposals annually for review in line with agreed priorities and approval according to SMRF operational procedures outlined in clause D26

   i. States that elect to opt in to the SMRF stream for a financial year will advise the Commonwealth by the end of February in the preceding financial year their election, designated amount and any approved projects

b. the Commonwealth will advise the Administrator a formal forecast of approved project amounts and payment schedules by the end of March in the preceding financial year, to inform the Administrator's formal forecast of each State's preliminary Commonwealth funding entitlement at clause A114(b)

c. in line with subclause A114(c) the Parties make payments into the National Health Funding Pool based on the Administrator's calculation in line with agreed project parameters

   i. payments by the Commonwealth will be made into the Pool in accordance with clause A157(c)

   ii. payments by States will be made into the Pool in accordance with clauses A172 and A182

d. the Administrator will make SMRF payments from the National Health Funding Pool to State Managed Funds based on the advice from the Commonwealth, at the discretion and direction of the relevant State

e. adjustments may be made throughout the year if necessary, for example to reflect amendments to existing projects, or finalised reconciliation processes for prior years

f. following the end of the financial year, the reconciliation process undertaken by the Administrator will be based on advice from the Commonwealth (provided in line with SMRF operational procedures), including where relevant, SMRF amounts to be made available in future years as SMRF rollover

g. the Administrator provides advice to the Commonwealth Treasurer regarding States' post-reconciliation entitlement amounts, including where relevant, SMRF amounts to be made available in future years as SMRF rollover

h. subclauses A114(h) and (i) regarding determination by the Treasurer of each State's final entitlement amount and the Administrator making the relevant adjustments to future payments apply unchanged to the SMRF stream.

A146. In addition to relevant data as part of clause A133 as it relates to SMRF projects, States will provide acquittal data in line with reporting requirements set out in the SMRF operational procedures.

a. Paid Commonwealth entitlement must be accounted for through the reporting process, including unallocated funds where a project may be subject to rescoping or other adjustments.

b. SMRF amounts will be eligible for SMRF rollover as per clause A29.

A147. Commencing in 2027-28 to support the reconciliation of Commonwealth contributions through the SMRF stream, the Commonwealth will provide a reconciliation report annually to the Administrator by 15 September including detail on:

a. the amount of authorised expenditure for the SMRF stream, including both State and Commonwealth funding, used by each State in the relevant financial year

b. any other relevant information on States' implementation of approved projects, including provision of agreed data, and progress against agreed project deliverables set out in operational procedures documents.

Funding pool arrangements

Funding Pool payments

A148. 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 State public hospital and health services funding under this Addendum.

A149. 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.

A150. Pool accounts will be audited annually, have complete transparency in reporting to the responsible Minister and accounting, and will meet all other transparency requirements including those established by National Cabinet and relevant legislation.

A151. There will be complete transparency and line-of-sight of respective contributions into and out of Pool accounts to LHNs, discrete State Managed Funds, or to State health departments in relation to Public Health 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 LHNs.

A152. Additional streams of funding may be incorporated into the National Health Funding Pool, with the aim of optimising transparency and efficiency of all public hospital and health service funding flows under this Addendum.

A153. Commonwealth payments into the Pool will be made monthly, calculated as 1/12th of the estimated annual payment and then adjusted as required to account for reconciliation and other payments. Commonwealth payments will be made into the Pool in accordance with Schedule D of the Intergovernmental Agreement on Federal Financial Relations.

A154. States will determine when State payments are made into the Pool.

Payments from the National Health Funding Pool and State Managed Funds

A155. Payments will be made from the Pool accounts to LHNs and State Managed Funds in accordance with Service Agreements (or signed service volume statements as set out in clause A122).

A156. Payments may be made from the Pool accounts directly to other parties on behalf of LHNs for the provision of shared services, as detailed in a Service Agreement between a LHN and a State. Any reference to payments made to LHNs in this Addendum includes payments made to other parties for providing shared services.

A157. The payment arrangements for Commonwealth funding are as follows:

a. ABF will flow directly to LHNs through Pool accounts

b. Block Funding will flow through Pool accounts to State Managed Funds and from there to LHNs

c. Service Model Reform Funding will flow through Pool accounts to State Managed Funds and from there to LHNs or relevant entities depending upon the specific funding arrangements for each project

d. funding for teaching, training and research will flow through Pool accounts to State Managed Funds and from there to LHNs 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

e. Public Health Funding will flow through Pool accounts to State health departments.

Reporting by the Administrator

A158. The Administrator will provide a monthly report to the Commonwealth and States detailing the following at the LHN level:

a. the amount and the basis for the amount of Commonwealth funding flowing into Pool accounts

b. the amount and the basis for the amount of State funding flowing into Pool accounts

c. number of public hospital and health services funded, in accordance with the national system of ABF

d. the delivery of other public hospital and health service functions funded through the National Health Funding Pool and State Managed Funds as a running yearly total including Block Funding and Service Model Reform Funding.

A159. 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

b. provision of public hospital and health services by LHNs.

A160. All reports produced by the Administrator will be publicly available and will be structured to avoid duplication and overlap with the reporting undertaken by other bodies detailed in this Addendum.

A161. The Auditor General will conduct a financial audit of the National Health Funding Pools at least annually, at the completion of each financial year. The Auditor General may conduct performance audits of the operation of the National Health Funding Pools and the payment arrangements at any time.

A162. Further to clause I84, 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 A134, A179 and A180

b. dates on which resubmissions of data were provided, if approved and required

c. dates on which reconciliation was completed.

A163. The Administrator will ensure that determinations, and final activity and entitlements at the LHN level, are publicly available for all years the Addendum is in operation.

Part 5 – State and Territory arrangements

A164. This Part sets out the pricing, funding, and reporting responsibilities of States under this Addendum in managing their public hospitals and health services.

Determining the State funding contribution

A165. States will determine the mix of public hospital and health services and functions in their jurisdiction and the amount they pay for those services and functions. States will meet the balance of the cost over and above the Commonwealth funding entitlement.

A166. States will contribute to in-scope public hospital and health services and functions on an ABF, Block, or other basis, as per the IHACPA-defined method for that type of service.

A167. Variations in the State funding contribution in respect of individual Local Hospital Networks (LHNs) 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 share of public hospital and health service funding under this Addendum, or Commonwealth Block Funding paid to States (other than funding for teaching, training or research), to retain some funding from LHNs to adjust service levels across the State, and to respond to unforeseen events and other contingencies as set out at clause A173.

A168. State funding paid on an ABF, Block, or other basis to LHNs will be based for each service category on:

a. the price or cost set by that State (which will be reported in Service Agreements)

b. where relevant to the funding stream, the volume of weighted services as set out in Service Agreements

A169. States will provide the Administrator with a copy of the Service Agreement for each LHN once agreed between the State and the LHN.

a. States must provide Service Agreements as set out in clause E7 within 14 calendar days of finalisation and no later than 15 December of the current financial year).

b. In accordance with clauses A114 and A122, States and LHNs can vary Service Agreements during the financial year as required.

A170. It is expected that the operation of this Addendum will create incentives for LHN efficiency. If a LHN can operate more efficiently than the level of funding set by the State under the LHN Service Agreement, the LHN will be able to retain and reinvest the benefits accruing from efficiency in service delivery and in accordance with State policy and practice, as guided by the Service Agreement.

A171. There will be no requirement for LHNs to be paid the full National Efficient Price or National Efficient Cost if the State considers that a lower payment is appropriate, having regard to the actual cost of service delivery and the LHN's capacity to generate revenue from other sources.

State payments

A172. States will direct the disbursement of State funding from Pool accounts to State Managed Funds and LHNs according to the payment arrangements set out in clause A157.

a. The frequency of State payments to LHNs will be in accordance with Service Agreements, agreed between the State and LHN.

A173. States can make exceptional payments through a Pool account or a State Managed Fund to LHNs at any time.

A174. States will decide timing of Commonwealth payments from Pool accounts to State Managed Funds and LHNs. However, States will not redirect Commonwealth payments:

a. between LHNs

b. between funding streams (for example from ABF to Block Funding)

c. to adjust the payment calculations underpinning the Commonwealth's funding contribution.

A175. 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 A169. These changes to Commonwealth funding will take effect in the next payment period.

A176. To ensure 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 payments and instructed the Administrator to make payments on the State's behalf.

Reporting the State funding contribution and service level data

A177. As part of the annual reconciliation process, to improve transparency and national comparability, States will provide to the Administrator and the IHACPA:

a. the price per weighted service as determined by the State

b. the volume of weighted services as set out by the national ABF classification scheme

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

A178. As part of the annual reconciliation process, States will also provide to the Administrator all State-reported in-scope expenditure at the LHN level, including distribution of Block Funding and other funds from State Managed Funds.

a. Reporting of distributions from State Managed Funds at the LHN level will separately detail the distribution of all Commonwealth Block Funding and Service Model Reform Funding received by the State.

A179. 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.

A180. States will provide the Administrator with *confirmed* aggregate weighted service volumes for a financial year, and estimated service volumes for each LHN, by the end of May in the preceding financial year. The estimated weighted service volumes will incorporate the level of disaggregation required by the Administrator to calculate the Commonwealth funding entitlement.

A181. 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 LHNs.

Service Model Reform Funding

A182. Each State that opts in to the SMRF stream for a given financial year will make an annual contribution for approved projects to the SMRF stream via their Pool accounts. The amount of this contribution must be at least equal to the Commonwealth funding contribution made to all approved projects for that State.

Safety, quality and value – state arrangements

A183. Each State agrees to implement a pricing and funding approach for Sentinel Events, HACs, AHRs, value-based events and pathways and any other safety and quality adjustments, to give effect to the model developed by the IHACPA.

a. These will be included in each State's funding and purchasing arrangements (including in Service Agreements and Purchasing Agreements) for public hospital and health services at the episode of care level.

A184. Each State will provide an annual report to HCEF, within nine months of the end of each financial year, on the outcomes of implementing their pricing approach for safety, quality, and value. These reports will include information on:

a. the financial impacts at the LHN level

b. any relevant safety, quality, and value-based programs.

Maintenance of effort

A185. For the period 2026-27 to 2030-31, Parties agree to, at a minimum, maintain 2025-26 levels of funding for public hospital and health services through the National Health Funding Pool and State Managed Funds, while having regard to new, appropriate models of care that may change the setting in which care is delivered.

A186. The Administrator and AIHW will work with all Parties to continue improving consistency and transparency of reporting for the Administrator to provide an annual report on maintenance of effort.

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

A187. 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 LHN. This arrangement will apply to existing contracts, and contracts entered into after the Addendum commences.

A188. Hospitals owned by charitable organisations that 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 LHN.

A189. Other public hospital and health services provided by the private or not-for-profit sector can be contracted in the following ways:

a. the State may contract centrally and establish a notional 'contracted services LHN' which is not required to meet usual LHN governance arrangements

b. LHNs may enter into individual contracts with the private or not-for-profit sectors, which can include ACCHOs, Aboriginal Medical Services and Primary Health Networks.

A190. For any services provided by the private or not for profit sector on behalf of the LHN, the State will provide information on forecast and actual contracted activity to the Administrator as part of the annual reconciliation process. This will include:

a. the same type, level, and specificity of data as otherwise required of LHNs under this Addendum

b. the volume, weight and type of organisation(s) for services provided.

A191. The Commonwealth will provide funding for the contracted activity through the National Health Funding Pool to the State. IHACPA-determined loadings will apply in respect of patient characteristics, and service location.

A192. Public hospital and health services provided under contract between a State or LHN and a private or not-for-profit service provider will be treated as being provided by public hospitals or health services, consistent with the approach outlined in clauses A100 to A110 to determine eligibility for a Commonwealth funding contribution.

Cross-border arrangements

A193. Arrangements in this section of the Addendum seek to provide an efficient and nationally consistent approach to cross-border arrangements between Parties.

A194. All cross-border arrangements established under the relevant section of the 2020-2025 Addendum expire on 30 June 2026, unless all Parties to such an arrangement have agreed otherwise in writing.

A195. The following applies to cross-border hospital and health services:

a. the resident State (the State where a patient normally resides) will pay for services (excluding the Commonwealth contribution arrangements discussed below) where its resident receives treatment in another jurisdiction (a provider State)

b. for cross-border purposes, services are those provided under activity based and block funded streams funded through this Addendum at clause A8. Public Health funding and Service Model Reform Funding streams are excluded

c. where a resident of a Territory or Island administered by the Australian Government receives treatment in a provider State, the following apply:

i. all cross-border arrangements established under the 2020-2025 Addendum or otherwise agreed between Parties expire on 30 June 2026

ii. any activities delivered up to 30 June 2026 will be subject to the previous bilateral arrangements referred to at subclause A195(c)(i)

iii. from 1 July 2026 onwards, the Commonwealth will pay 100 per cent of the National Efficient Price (NEP) for that service to the provider State

iv. for services delivered as per subclause A195(c)(iii), Commonwealth payment arrangements will occur as set out in Part 4 of this Schedule and will be exempt from the provider State's funding cap

v. for the purposes of subclauses A195(e) to (g), the Commonwealth will only act as the resident State to meet the cost of medical transfers from and to Norfolk Island and the Indian Ocean Territories, and these costs will be met by the Australian Government Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts in line with existing arrangements and where appropriate

vi. to assist with these functions, these residents will be appropriately classified as being from a Territory or Island administered by the Australian Government and reported separately by the Administrator, with assistance from the Commonwealth and provider State

d. in instances where safety, quality, and value-based adjustments have been applied, funding from the resident State to the provider State will not increase to offset the reduced Commonwealth contribution for those services

e. 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

f. where a patient is transferred at the request of a clinician from a provider State to another hospital within that State, or to another provider State, the resident State is to meet the costs of medical transfers

g. 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

h. where a patient is transferred as outlined in clauses A195 (f) and (g), the medical transfer costs are excluded from cross-border reconciliations and subject to separate reimbursement agreed between jurisdictions. States and territories will designate a point of contact to action these clauses

i. 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

j. Commonwealth and State payment flows associated with cross-border services should be administratively simple, and, where possible, consistent with the broader arrangements of this Addendum

k. cross-border payment arrangements should not result in any unintended GST distribution effects

l. States recognise their commitment under the Medicare Principles at Preliminaries clause 21, which require treatment to be prioritised based on clinical need

m. both States should have the opportunity to engage in setting cross-border activity estimates and variations, where this is not linked to payments and as such, would not involve shifting costs or risks

n. there should be transparency of cross-border patient and funding flows.

Reconciliation and funding flows

A196. The cross-border reconciliation process will be incorporated into the annual reconciliation process with the Administrator responsible for calculating and advising States (and the Commonwealth in relation to Australian Government administered Territories or Islands) of cross-border contributions from the Commonwealth and resident State.

a. The Administrator will provide cross-border reconciliation outcomes to State Health Ministers (and the Commonwealth Minister in relation to Australian Government administered Territories or Islands).

A197. Commonwealth funding contributions will flow to provider States through the National Health Funding Pool.

A198. To avoid financially disadvantaging any State, Commonwealth payments made in accordance with these arrangements will not be subject to equalisation by the Commonwealth Grants Commission.

A199. The Administrator will release actual cross-border activity data and Commonwealth contribution advice to the States within one month of the Treasurer's Determination to support bilateral cross-border reconciliations. Administrator cross-border data made available to States will include:

a. Commonwealth percentage funding rates

b. Commonwealth funding contributions

c. activity flows for ABF and block-funded hospitals.

A200. Gross cross-border funding contributions by the resident State will be made to the provider State through the National Health Funding Pool, either:

a. monthly, as a pro-rata payment agreed between the jurisdictions and informed by the most recent activity plus agreed growth, with the final reconciliation payment to be made within three months of receiving the advice from the Administrator, or

b. within three months of receiving the advice from the Administrator.

Collaboration

A201. States with significant cross-border flows may collaborate and put in place arrangements to facilitate service delivery planning and flow management. These arrangements may relate to specific hospitals or services, or state-wide planning activities.

A202. Any such arrangements (excepting the agreement in relation to the Albury-Wodonga hospital) cannot deviate from the cross-border payment provisions above. Arrangements for one State to deliver health services into another State (such as an agreement to purchase services) are excluded from this.

A203. Based on all States' affirmation of the Medicare Principles at Preliminaries clause 21:

a. cross-border funding and activity must not be capped between States

b. application of the funding cap to Commonwealth funding entitlements will not impact State cross-border contributions.

Commonwealth and State contribution (pricing and volume)

A204. Prices will be set at the NEP, as determined by the IHACPA, including adjustments for any loadings for the provider LHN, unless otherwise agreed by the Parties to the specific cross-border agreement.

A205. For activity in block-funded hospitals, including small rural hospital services, the Commonwealth's contribution will be set at the National Efficient Cost (NEC). Prices used to calculate resident State contributions will be set at the NEP where activity data is available, as determined by the IHACPA, including any pricing adjustments.

a. If activity data is not available, the resident State's contribution will not be payable.

A206. For block-funded services, the resident State will contribute the provider State's National Efficient Cost for each of these services, as determined by the IHACPA, less the Commonwealth contribution.

A207. For services not appropriately covered by Diagnosis Related Groups (DRGs), the following arrangements apply:

a. the provision of services not appropriately covered by DRGs must be advised in advance by the provider State to the resident State

b. services not appropriately covered by DRGs are defined by procedures that do not appropriately fit within a DRG 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

c. Parties recognise that referrals are often made and agreed at the clinician level within and between hospitals at short notice in the interests of patient well-being. Where it is not possible for a provider State to notify the resident State prior to treatment commencing, the provider State will endeavour to communicate and notify as soon as possible thereafter

d. relevant States' representatives on the Administrator's Jurisdictional Advisory Committee will be the point of contact to action this clause, unless otherwise advised in writing.

A208. High Cost, Highly Specialised Therapies (HST) will be excluded from cross-border reconciliations and subject to separate reimbursement by agreement between States based on the actual cost, less any Commonwealth contribution, as outlined in clause A235(a), for in-scope and ancillary services.

a. Unless otherwise stated by IHACPA for a specific HST, the following costs are considered in-scope: HST product costs, all admitted, non-admitted and emergency department services at the providing hospital related to the indication while a patient is registered on the HST program, and accommodation and transport of the patient, and if required carer, where those costs are incurred by the providing hospital.

b. Out-of-scope costs comprise hospital services provided to patients registered in a HST program that are out-of-scope of the program. This activity will be funded through cross-border arrangements for activity based funded or block funded hospitals as appropriate.

c. Noting that HST treatment can span multiple financial years, HSTs are to be reconciled annually based on in-year costs, where possible. In the event that costs cannot be determined until the end of treatment, this will be clearly communicated to the resident State and reconciliation deferred until costs are available.

d. Patient caps are managed outside of the cross-border reconciliation process, within national patient caps for respective HSTs, consistent with the HMM-endorsed 'Framework for the assessment, funding, and implementation of high cost, highly specialised therapies and services'. When a price has changed due to a national patient cap the adjustment will be passed on accordingly.

e. Payments will not be made directly to the providing hospital by the resident State.

A209. Capital will not be priced by the IHACPA, however cross-border dispute resolution can include disputes in relation to the resident State's contribution to capital funding where relevant.

A210. The Commonwealth and States agree they will accept and implement any recommendations made by the IHACPA in relation to cross-border disputes under clause I29(k) and will provide additional funding to the other party in a dispute if this is required.

A211. If a resident State has not complied with any element of an IHACPA recommendation under clause I29(k), requiring it to make payments to a provider State within three months, the provider State may ask IHACPA to advise the Commonwealth Treasurer of any adjustments to Commonwealth payments to the National Health Funding Pool required to give effect to the recommendation. Resident States agree to fund any reduction in Commonwealth payments to provider State LHNs from their own resources.

Part 6 – Other arrangements

A212. This Part sets out additional policies and processes agreed by Parties that affect funding, pricing, and reporting of public hospital and health service activities.

Interactions with other Commonwealth-funded programs

A213. The Parties agree that Australia should maintain a viable mix of privately and publicly funded health services.

A214. The Parties acknowledge that the rules, processes and amounts of different funding sources for public hospitals and health services can interact in unforeseen and undesired ways, and that introducing new funding and pricing models under this Addendum may exacerbate this issue.

A215. As such, any Party may request a review of interactions between two or more Commonwealth health funding mechanisms on specific services or parts of services, such as, but not limited to, the Medicare Benefits Schedule (MBS) and the NHRA. The review should identify the tensions in the rules, processes and amounts that have perverse incentives and negative impacts on service delivery.

a. The nominating Party must provide evidence of the problem, detailing the specific service/s or parts of services, suspected cause and impact on price and/or service delivery.

b. The request for review must receive agreement from the Commonwealth and one or more States to be progressed.

A216. Reviews will be jointly conducted by the IHACPA and the Commonwealth within twelve months of the nomination being approved.

a. All Parties, and the national funding bodies may contribute information as part of the review process.

b. Findings will be provided to all Parties for consideration and feedback before a final report to HCEF.

A217. As part of such a review where it relates to the interaction of MBS and NHRA funding for the identified service/s or parts of services, the IHACPA will consider options to address underlying price incentives.

a. One option is for the IHACPA to make prospective corrective pricing changes in the NHRA.

b. If the IHACPA subsequently receives evidence from the Commonwealth that the price incentives have not had an effect, the IHACPA and the Administrator will advise the Treasurer on recommended actions for remedy.

c. In developing any such options and applying any corrective pricing, the IHACPA will consult extensively with the Parties.

Data requirements

Data matching

A218. The Parties agree to jointly identify instances, not covered by the exceptions outlined at clause A13, where services appear to have been paid under this Addendum and other Commonwealth programs, such as through the MBS and PBS. The Administrator, aided by the National Health Funding Body, will also independently assess whether duplicate payments have occurred through other Commonwealth programs.

a. The Administrator's assessment of duplicate payments will only occur after Business Rules have been established in respect of the relevant Commonwealth program.

b. Using comprehensive MBS, PBS, and NHRA datasets, as detailed in clause A219, all Parties, as well as the Administrator, will determine their own data matching business rules for assessing whether duplicate payments have been made.

c. The relevant Commonwealth officer responsible for compliance will: notify, consult, and validate concerns about potential non-compliance with relevant States; and, have regard to timely advice provided by those States prior to undertaking any compliance activity relating to duplicate payments.

d. The Commonwealth will conduct compliance assessments and activities to correct or remedy causes of non-compliance in collaboration with States and at a system level where possible.

e. The relevant State will receive a copy of any matched data provided by the Administrator for verification purposes.

f. Where a State health department identifies any validation or verification issues, it will raise this with the relevant Commonwealth officer responsible for compliance.

g. Commonwealth compliance activities, where possible, will be undertaken in a timely manner.

h. As part of the annual reconciliation process, the Administrator will have primary responsibility for assessing and correcting miscoding of private patients that lead to duplicate payments.

i. Where the Administrator cannot obtain agreement from a State to correct miscoding and/or cannot correct a potentially miscoded patient event, relevant data will be referred to the Commonwealth for consideration in its compliance activities.

j. To support timely compliance activities, the Administrator will refer any miscoding concerns and any other duplicate payment concerns to the Commonwealth and relevant State(s) within two months, or as soon as practicable, of the annual reconciliation being finalised.

A219. To support compliance activities described in clause A218, the Parties will, as soon as practicable after the end of each financial year, exchange data for full financial years as below:

a. Commonwealth to provide each State and the Administrator a jurisdiction specific MBS Claims dataset

b. Commonwealth to provide each State and the Administrator a jurisdiction specific PBS Claims dataset

c. States to provide a copy of NHRA datasets, as defined in the Administrator's three-year data plan, to the Commonwealth and the Administrator.

A220. Data exchange between Parties will align with the 'single-provision, multiple use' principles in clauses H33(a) and I79(e), which aim to increase funding transparency and support shared efforts to achieve health system sustainability in addition to compliance.

a. Data provision will comply with applicable Commonwealth and State legislation, including privacy legislation and principles.

b. Each party will be responsible for seeking any changes to its own legislation or arranging any authorising instruments so data can be exchanged.

A221. Instances of duplicate payments or payments inconsistent with the requirements of clause A12 that are identified and referred by the Commonwealth or the IHACPA (in fulfilling its cost-shifting functions) to the Administrator will not impact Commonwealth national health reform funding, except when:

a. amounts are identified where the services or any part of the service is funded through any other Commonwealth program, that is not excepted through clause A13, and evidence is provided that reasonably demonstrates the amount is unable to be recovered, or

b. the relevant State is unable to provide documentation identified in clause A14 at the request of the Administrator, or the Commonwealth as part of related compliance activities, or

c. documentation provided by a State as outlined in clause J16 does not meet the requirements in clauses J16, J30(g) or both, or

d. the relevant State has been offered the opportunity outside of this Addendum to address over-payments unable to be recovered through Commonwealth compliance activities. In this case, the Administrator will:

   i. work with the relevant State to identify additional mechanisms to prevent further duplicate payments for services through this Addendum.

   ii. adjust Commonwealth NHR funding by the amount of the over-payment, or

e. the Administrator identifies that a matched payment is a false positive – for instance, a privately-funded service has incorrectly been coded as a publicly-funded service – the Administrator will work with the relevant State to correct the source data coding and re-process the necessary calculations.

Data Conditional Payment

A222. Commonwealth funding for public hospital and health services is dependent on provision of data requested by the national bodies outlined in this Addendum, including in relation to the activity and costs of delivering services to patients, and 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.

A223. The Parties agree to maintain a Data Conditional Payment (DCP) to encourage the timely provision of Required Data to facilitate the accurate classification, pricing and funding of public hospital and health services.

A224. The national funding bodies will determine what constitutes Required Data for the purposes of the DCP and will specify this in their Three-Year Data Plans and in accordance with the *National Health Reform Act 2011* and this Addendum.

A225. The Administrator, in consultation with the IHACPA, will determine when a Party has failed to provide the Required Data. In making this determination, the Administrator will engage cooperatively with the Parties, including investigating alternative and/or temporary measures to the supply of Required Data.

A226. If a State has not provided the Required Data, the Administrator will, in calculating the Commonwealth contribution to the National Health Funding Pool for that State, advise the Commonwealth Treasurer to:

a. defer payment of 10 per cent of the monthly amount to the State until the Required Data is provided, for each month up to 3 months

b. defer a further 15 per cent of the monthly amount – for a total of 25 per cent – if the Required Data is not provided after the initial 3-month period.

A227. If an amount is deferred under clauses A226:

a. the Administrator will advise the affected State

b. any funds deferred will be paid in the next available monthly payment, once the Required Data is provided.

A228. The Administrator will be responsible for applying the DCP and providing advice to States on its operation.

A229. The operation of DCP does not reduce a State's funding entitlement as calculated in Part 1 of this Schedule; instead, it reduces the monthly payments of that entitlement owed to the State until the Required Data is provided.

Nationally cohesive health technology assessment

A230. Australia requires a strategic, systematic, cohesive, efficient and responsive national framework for health technology assessments (HTA). Improved health technology decision-making will deliver safe, effective, efficient care that is financially viable and will improve population health.

A231. The Parties agree to the following principles for HTA:

a. nationally consistent, appropriate and evidence-based investment and disinvestment decisions

b. improved patient access to cost effective health technologies

c. improved transparency and reduced duplication of effort between HTA bodies

d. coordinated and timely responses to rapidly changing technologies

e. effective sharing of information and recommendations between jurisdictions and the Commonwealth, including consistent outputs and standardised advice

f. improved stakeholder engagement, understanding and public trust in HTA process.

A232. The Parties agree to a timely and nationally coordinated response to rapidly changing, emerging and disruptive technologies by:

a. further developing a unified national HTA process, addressing issues of national consistency, access and service delivery

b. jointly establishing a structured horizon scanning process that supports forward planning across all governments that includes the potential implementation of technologies or services identified through the horizon scanning process

c. robust and transparent prioritisation of spending on health technologies to ensure coordinated, equitable and efficient service delivery

d. developing improved data infrastructure in support of shared real-world data and evidence, and ongoing monitoring and evaluation. This may include leveraging work progressed in relation to clause A241, collection of testing results, clinical outcomes and, service and therapy use for HTA and related purposes, as agreed by the Parties.

A233. This work program will be led by the Health Technology and Genomics Collaboration established under HCEF. Data sharing and governance arrangements will be reflected in the National Health Data System and enabling Governance Framework in Schedule H.

High Cost, Highly Specialised Therapies

A234. The Parties agree that a review of the governance process for High Cost, Highly Specialised Therapies (HSTs) will be conducted during the term of this Addendum. Until the review is completed, the arrangements and processes in clauses A235 to A241 will apply for HSTs. The review will:

a. be led by the Health Technology and Genomics Collaboration

b. identify improvements to the existing HST assessment and implementation processes, for incorporation into the next iteration of the HMM-endorsed ‘Framework for the assessment, funding, and implementation of high cost, highly specialised therapies and services’ (HST Framework) by June 2027

c. rely on mutual collaboration between Parties and other key stakeholders involved in the governance process, including relevant data sharing.

A235. The Parties agree that funding arrangements for new HSTs, recommended for delivery in a public hospital setting by the Medical Services Advisory Committee (MSAC), will be determined on the basis of hospital funding contributions specified in this Schedule, with the following exceptions for the term of this Addendum:

a. HSTs (including ancillary services) will be funded at a Commonwealth contribution rate of 50 per cent

b. HSTs will be exempt from the funding cap at clause A41 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 operation of the funding cap exemption for that treatment in that State

d. the above exceptions will only apply if the HST is delivered according to MSAC’s advice.

A236. The MSAC and Pharmaceutical Benefits Advisory Committee (PBAC) chairs, together with a HMM representative, will jointly decide which committee should assess applications for new medicines or biological therapies, where the therapies are likely to be delivered in a public hospital setting.

a. 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.

b. The chair of HMM will nominate one representative on behalf of all States to participate in these meetings. This representative is to have the same level of clinical expertise as the MSAC and PBAC chairs.

A237. For therapies that will be assessed by MSAC and delivered in a public hospital setting, the Commonwealth will write to States advising them that an application has been received and invite them to make a submission to MSAC for consideration. States will need to abide by the same confidentiality requirements as MSAC members.

a. States will be invited to send a representative to observe the meeting when the application is being considered.

b. This will enable States to ensure all submissions are considered and have early visibility of MSAC's recommendations related to a therapy for funding under this Addendum.

c. Under its terms of reference, MSAC is obliged to have due regard to the advice of States where it is relevant to comparative safety, clinical effectiveness and/or cost-effectiveness, and total cost of an HST.

A238. Recommendations of MSAC are made public on the MSAC website, including the rationale for those recommendations.

a. States will be notified before publication, on the same day the company receives the ratified recommendations of MSAC.

A239. Following a supportive MSAC recommendation, a deed of agreement will be executed between the company and the Commonwealth to ensure the MSAC recommended conditions for funding are met. This requires the company to agree to the MSAC's recommendations for funding under this Addendum.

a. States will decide if, when, and where the therapy will be provided.

A240. The publicly available HMM-endorsed 'Framework for the assessment, funding, and implementation of high cost, highly specialised therapies and services' outlines the steps required to implement HSTs under this Addendum.

A241. States agree to provide required HST data to existing registries at least quarterly, as agreed from time to time by HMM.

a. Parties agree registry arrangements and minimum dataset requirements may be reviewed following advice from the Health Technology and Genomics Collaboration on HST monitoring and evaluation.

Specialised, low-volume services

A242. The Parties recognise there are certain public hospital and health services that are complex and cater for small population groups (i.e. limited demand or low volume). In addition, such services can only be delivered in dedicated facilities, as these require high quality, safe introduction and ongoing provision of specialised clinical practices and technologies.

A243. These specialised, low-volume services include, but are not limited to:

a. services delivered under the Nationally Funded Centre Program

b. High-cost, highly specialised therapies (HSTs), as recommended by the Medical Services Advisory Committee (MSAC)

c. services not appropriately covered by DRGs, as agreed by States participating in cross-border arrangements

d. other services using certain high cost, low demand, new and emerging technologies, as agreed and recognised by Parties.

A244. The Parties agree to work collaboratively to ensure these specialised, low-volume services are provided safely, efficiently and effectively.

a. Parties can request the IHACPA to consider developing suitable pricing adjustments, pricing mechanisms or models to account for these services. In doing so, Parties agree to support the IHACPA in identifying and providing the required data elements.

National Pharmaceutical Reform Arrangements

A245. The Parties agree to progress work during the term of this Addendum to develop nationally consistent arrangements for accessing PBS-subsidised medicines in public hospitals. This seeks to build on and likely supersede the existing bilateral Pharmaceutical Reform Agreements (PRAs) to support timely, equitable and affordable access to medicines in line with the National Medicines Policy 2022.

A246. The work will be led by the Commonwealth, in consultation with States, and include development work towards a new multilateral agreement within this Addendum period, with the functions and terms of this agreement intended to be incorporated in the next Addendum.

A247. In developing the multilateral agreement, Parties will have regard to the National Medicines Policy as well as recommendations from the 2024 PRA Review Report, including prioritising:

a. removing barriers to access

b. quality use of medicines

c. building and maintaining quality hospital pharmacy programs

d. transparency and accountability.

A248. In addition, the work towards a multilateral agreement would provide an opportunity to modernise current arrangements and consider reforms that benefit all Parties.

A249. States with existing bilateral PRAs may continue to charge the PBS for pharmaceuticals for specific categories of patients as provided for in their agreements.

a. Interim bilateral PRAs for the ACT and NSW will be considered during this Addendum period, contingent on the provision of state-specific data.

A250. The existing PRAs and proposed agreements under this section are not funded through this Addendum.

Veteran entitlements

A251. 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.

SCHEDULE B – BETTER HEALTH OUTCOMES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

FINAL ENDORSED SCHEDULE ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SECTOR

Part 1 – Preliminaries

Recognition statement

B1. The Parties acknowledge Aboriginal and Torres Strait Islander people as the Traditional Custodians of the lands and waters on which Australians live and learn, and pay respects to their Elders past, present and emerging.

B2. The Parties acknowledge that, for Aboriginal and Torres Strait Islander people, health means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community as a collective in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view, self-determined and includes the cyclical concept of life-passing-life.

B3. The Parties acknowledge that culture is a foundation for Aboriginal and Torres Strait Islander health and wellbeing. It is a protective factor across the life course and has a direct influence on broader social determinants outcomes. Gains across these broader determinants, in turn, reinforce cultural connectedness, maintenance, resurgence, nation building and pride in cultural identity.

B4. The Parties further acknowledge that this Schedule, the National Health Reform Agreement, the Addendum and other Schedules respect the richness, strengths, and resilience of Aboriginal and Torres Strait Islander cultures which have continued to thrive despite the ongoing impacts of colonisation, systemic discrimination, racism, and intergenerational trauma.

B5. The Parties reaffirm their shared vision that Aboriginal and Torres Strait Islander people enjoy long, healthy lives that are centred in culture and community, with access to services that are prevention-focused, learning-oriented, culturally safe and trauma-aware and healing informed, responsive, equitable and free of racism.

B6. The Parties further acknowledge the foundations of long-term sustainable and equitable health reform incorporate cultural and social determinants of health.

B7. The Parties agree that all components of Australia's health system must better acknowledge and respect:

a. Aboriginal and Torres Strait Islander community knowledges and lived experience of cultural ways of being, knowing and doing told through stories are valid forms of knowledge and knowledge sharing, and are the intellectual property of Aboriginal and Torres Strait people

b. the centrality of self-determining communities is paramount for culturally informed innovations to be created with policy makers as facilitators rather than leaders

c. that, where worldviews interact at the cultural interface, Aboriginal and Torres Strait Islander knowledges and cultures of ways of being, knowing and doing are paramount.

B8. The Parties acknowledge that better health and wellbeing are achieved when Aboriginal and Torres Strait Islander people have ownership over the decisions that affect their lives, the resources they need and, to progress their goals and priorities, the opportunity to partner with governments, mainstream institutions and government funded organisations.

B9. The Parties affirm that the NHRA Addendum and all Schedules including this Schedule B operationalise the shared commitment of the Commonwealth, States and Territories to work in partnership with Aboriginal and Torres Strait Islander people as agreed in the National Agreement on Closing the Gap.

Principles

B10. The Parties agree to support Aboriginal and Torres Strait Islander people's self-determined health reform.

B11. To implement Schedule B and the broader Addendum, the Parties agree that principles, terminology and commitments specified in Schedule B take precedence in matters in relation to Aboriginal and Torres Strait Islander health and wellbeing unless legislative rules apply.

B12. The Parties agree to:

a. recognise and actively work to counteract the power imbalances, historical legacies and other challenges that have undermined relationships between governments and Aboriginal and Torres Strait Islander people in the past

b. uphold Aboriginal and Torres Strait Islander people's right to culturally safe, trauma-aware and healing informed and responsive health care, free of racism and inequity

c. elevate and formally embed Aboriginal and Torres Strait Islander people and leadership in health governance structures and decision-making arrangements

d. embed transparency and accountability to ensure that all Parties acknowledge their shared responsibility to work in partnership with Aboriginal and Torres Strait Islander people to improve the health outcomes of Aboriginal and Torres Strait Islander people

e. acknowledge that Aboriginal and Torres Strait Islander people are impacted by all health system policies and practices (not just those programs and policies explicitly aimed at Aboriginal and Torres Strait Islander people), and embed formal mechanisms in processes for program and policy reform and evaluation to consider the impact on Aboriginal and Torres Strait Islander people

f. acknowledge the importance of intersectional issues throughout the life course and the interface between health, disability and aged care for Aboriginal and Torres Strait Islander people.

Objectives and Outcomes

B13. The Parties agree that commitments specified in this Schedule B, and relevant commitments contained in the Addendum, including other Schedules, aspire to achieve the following long-term goals:

a. all Aboriginal and Torres Strait Islander people can have choice and control to access culturally safe, effective and equitable health care that meets their needs, aspirations and preferences, regardless of where they live

b. Aboriginal and Torres Strait Islander people enjoy the highest attainable standard of health and wellbeing

c. all participating organisations and institutions are culturally safe and free from racism

d. meeting or exceeding the trajectories specified for Outcomes 1, 2, and 14 of the National Agreement on Closing the Gap

e. Aboriginal and Torres Strait Islander people have full health data sovereignty.

Commitments under agreed co-designed national Aboriginal and Torres Strait Islander health and wellbeing frameworks

B14. The Parties acknowledge four national co-designed frameworks or policies they have already endorsed and reaffirm their commitments to each as below.

B15. The Parties reaffirm their commitments under the National Agreement on Closing the Gap signed in July 2020 and reaffirm that, through Joint Council and agreed Implementation Plans, the National Agreement on Closing the Gap remains the overarching framework to ensure better outcomes for Aboriginal and Torres Strait Islander people including the four Priority Reforms, namely:

a. Priority Reform One: Formal Partnerships and shared decision-making

b. Priority Reform Two: Building the community-controlled sector

c. Priority Reform Three: Transforming government organisations

d. Priority Reform Four: Shared access to data and information.

B16. The Parties further acknowledge their joint responsibility to progress long-term goals against the **three health-related socio-economic targets** specified in the National Agreement on Closing the Gap, namely:

a. **Target 1:** Close the Gap in life expectancy within a generation, by 2031

b. **Target 2:** By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent

c. **Target 14:** Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero.

B17. The Parties reaffirm their commitments to the **National Aboriginal and Torres Strait Islander Health Plan 2021-2031** (the Health Plan 2021-2031) endorsed by all Health Ministers in December 2021 including:

a. the Australian Government's accountability for implementation of the Health Plan 2021-2031 at a national level

b. the State and Territory Governments' accountability for implementation of the Health Plan 2021-2031 within their own jurisdiction

c. all Parties' responsibilities to mainstream service providers, organisations and regulators to drive the systemic and structural change needed to realise the Health Plan's vision

d. the Australian Government's responsibility to develop five-year Commonwealth Implementation Plans for the Health Plan

e. the Australian Government's responsibility to work with the Aboriginal and Torres Strait Islander Health Sector to develop and use a monitoring and accountability framework for the Health Plan 2021-2031

f. all Parties' responsibilities to work with the Aboriginal and Torres Strait Islander Health Sector to undertake a mid-cycle review in 2026, and an end-of-cycle review in 2031.

B18. The Parties reaffirm their commitment to working in partnership with Aboriginal and Torres Strait Islander organisations to implement the **National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031** (the Workforce Plan 2021-2031) endorsed by all Health Ministers in December 2021 including strategies for the following six strategic directions.

a. **Strategic Direction 1:** Aboriginal and Torres Strait Islander people are represented and supported across all health disciplines, roles and functions.

b. **Strategic Division 2:** The Aboriginal and Torres Strait Islander health workforce has the necessary skills, capacity and leadership across all health disciplines, roles and functions.

c. **Strategic Direction 3:** Aboriginal and Torres Strait Islander people are employed in culturally safe and responsive workplace environments that are free from racism across health and all related sectors.

d. **Strategic Direction 4:** There are sufficient numbers of Aboriginal and Torres Strait Islander students studying and completing health qualifications to meet the future health care needs and aspirations of Aboriginal and Torres Strait Islander people.

e. **Strategic Direction 5:** Aboriginal and Torres Strait Islander health students have successful transitions into the workforce and access clear career pathway options.

f. **Strategic Direction 6:** Information and data are provided and shared across systems to assist health workforce planning, policy development, monitoring and evaluation, and continuous quality improvement.

B19. The Parties reaffirm their commitment to the **Health Sector Strengthening Plan** endorsed by the Joint Council for the National Agreement on Closing the Gap in December 2021 by:

a. Refreshing priorities and actions in Formal Partnership with the Aboriginal and Torres Strait Islander Health Sector within two years of execution of this Agreement with tabling of recommendations at Joint Council within three years of execution of this Agreement.

Part 2 – Partnership and governance

NHRA governance

B20. The Parties agree that Aboriginal and Torres Strait Islander governance brings unique and respected values, principles and practical mechanisms to health reform, further ensuring that the shared vision of Aboriginal and Torres Strait Islander people for self-determining their health and wellbeing is translated into structural reform and sustained, organised action.

B21. The Parties acknowledge historical denial of Aboriginal and Torres Strait Islander cultural governance in health reform and health care delivery.

B22. The Parties agree that Aboriginal and Torres Strait Islander people and communities must have the resources to determine their own priorities, aspirations and needs to attain good health and wellbeing outcomes, including but not restricted to:

a. access to resources to establish governing bodies and participate as equal partners with governments in shared decision-making and co-design

b. the right to negotiate, implement and evaluate co-ordinated decisions effectively, efficiently and to the benefit of the community in partnership

c. privileged data access consistent with the principles of governance of Aboriginal and Torres Strait Islander ('Indigenous') data in clause B40 and progress towards the global principles for Aboriginal and Torres Strait Islander ('Indigenous') Data Sovereignty defined in Part 5.

B23. The Parties agree to establish a **new independent Aboriginal and Torres Strait Islander Monitoring and Accountability Group** (Monitoring and Accountability Group) to commence operations alongside this NHRA for the purpose of monitoring implementation and impact of this NHRA on Aboriginal and Torres Strait Islander people's health and wellbeing.

B24. The Monitoring and Accountability Group will be comprised of members nominated by the Aboriginal and Torres Strait Islander Health Sector as follows: Chair (NACCHO); one member each from Queensland, New South Wales, Victoria, Tasmania, South Australia, Western Australia, the Northern Territory and the Australian Capital Territory, and one member from NIHLA. The Commonwealth and representatives from State and Territory Governments will be *ex officio*.

B25. The Parties agree that the remit, membership, nomenclature and responsibilities of the Monitoring and Accountability Group as co-designed with the Aboriginal and Torres Strait Islander Health Sector and other stakeholders through the Health Collaboration will enable stewardship, technical and independent accountability functions such as:

a. ***Stewardship***:

i. working with the Parties to this NHRA, the Aboriginal and Torres Strait Islander Health Sector and the Parties to the National Agreement on Closing the Gap to monitor performance under the NHRA and publicly report on performance monitoring

ii. identifying priorities of the Aboriginal and Torres Strait Islander Health Sector and supporting self-determined health reform to enrich and amplify the NHRA commitments

iii. reviewing and endorsing initiatives codesigned through Formal Partnerships to strengthen healthcare safety, quality, cultural safety and value as experienced by Aboriginal and Torres Strait Islander people during the term of this Addendum

iv. supporting Affiliates as Aboriginal and Torres Strait Islander community-controlled health peak bodies in States and Territories to monitor jurisdictional matters in relation to Aboriginal and Torres Strait Islander health outcomes

b. ***Technical capacity***:

i. appointments of Aboriginal and Torres Strait Islander members nominated by the Aboriginal and Torres Strait Islander Health Sector and other stakeholders through the Health Collaboration

ii. appointments of additional skills-based members in consultation with the Aboriginal and Torres Strait Islander Health Sector in a range of specialist and technical skills and capabilities as required to support its work

iii. resourcing to undertake reviews, contracts and consultations as required to support its work

c. ***Accountability role:***

i. holding the Parties accountable for commitments in relation to Aboriginal and Torres Strait Islander health outcomes in this Schedule, the National Health Reform Agreement, the Addendum and other Schedules

ii. providing oversight of measures and reporting on health system responsiveness to the specific needs and aspirations of Aboriginal and Torres Strait Islander people as outlined in this Addendum

iii. monitoring implementation and impact of national healthcare accreditation standards through the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme to improve outcomes and cultural safety as experienced by Aboriginal and Torres Strait Islander people during the term of this Addendum

B26. The Parties recognise that the independent Monitoring and Accountability Group has the right to liaise directly with the Coalition of Peaks and escalate matters in relation to Aboriginal and Torres Strait Islander health outcomes to Joint Council for the National Agreement on Closing the Gap.

B27. The Parties recognise that the independent Monitoring and Accountability Group may submit agenda items to the HMM via Health Chief Executives Forum (see Part 2).

Working in Partnerships with Aboriginal and Torres Strait Islander People

B28. The Parties commit to working in partnership with Aboriginal and Torres Strait Islander people and organisations to enact the commitments under this Schedule, the National Health Reform Agreement, the Addendum and other Schedules.

B29. The Parties acknowledge that 'partnership' is a general and overarching term, referring to many different and well-intended approaches for specific purposes with Aboriginal and Torres Strait Islander people. For matters in the NHRA in relation to Aboriginal and Torres Strait Islander health outcomes, the Parties will apply the definitions in Part 5 of Schedule B.

B30. The Commonwealth commits to strengthening its Formal Partnership with Aboriginal and Torres Strait Islander people and the Aboriginal and Torres Strait Islander Health Sector to implement the four co-designed national agreements, health plans and health strategies (see Part 1).

B31. States and Territories commit to strengthening or, if not yet in place, initiating and supporting Formal Partnerships with the Aboriginal and Torres Strait Islander community-controlled Affiliate peak health body in their respective jurisdiction to oversee implementation of the four co-designed national agreements, plans and strategies (see Part 1), codesign Implementation Plans for the National Agreement on Closing the Gap in relation to Aboriginal and Torres Strait Islander health outcomes, and receive and review key performance indicator reports as specified in this Agreement.

B32. The Parties recognise these Formal Partnerships with Aboriginal and Torres Strait Islander people and the Aboriginal and Torres Strait Islander community-controlled Affiliate peak health bodies must be adequately funded to enable effective contributions from Aboriginal and Torres Strait Islander partners, as specified in clause 35 of the National Agreement on Closing the Gap, and effective liaison with the independent national Monitoring and Accountability Group.

National Aboriginal and Torres Strait Islander Health Collaboration (the Collaboration)

B33. The Parties acknowledge the value of the National Aboriginal and Torres Strait Islander Health Collaboration (the Collaboration) originally established under National Cabinet architecture to include Commonwealth, State and Territory Government Aboriginal and Torres Strait Islander Health Officers and representatives from the Aboriginal and Torres Strait Islander Health Sector.

B34. The Parties agree that the Health Collaboration and Monitoring and Accountability Group may convene a National Aboriginal and Torres Strait Islander Health Roundtable with Health Ministers biennially to discuss the impact of the NHRA on health outcomes for Aboriginal and Torres Strait Islander people and explore areas for improvement.

B35. The Parties agree that an Aboriginal and Torres Strait Islander representative nominated by NACCHO will be formally appointed as an ongoing member of any comparable health executive forum established during the term of this NHRA, as appropriate.

Aboriginal and Torres Strait Islander ('Indigenous') Data Sovereignty

B36. The Parties acknowledge that health and social data are a cultural, strategic and economic asset for Aboriginal and Torres Strait Islander people.

B37. The Parties endorse the following definitions as globally agreed and adopted by Aboriginal and Torres Strait Islander people, namely:

a. 'Indigenous Data' refers to information or knowledge, in any format, that is about and that may affect Indigenous people both collectively and individually

b. 'Indigenous Data Sovereignty' refers to the right of Indigenous people to exercise ownership over Indigenous data. Ownership of data can be expressed through the creation, collection, access, analysis, interpretation, management, dissemination and reuse of Indigenous data

c. 'Indigenous Data Governance' refers to the right of Indigenous people to decide what, how and why Indigenous data are collected. It ensures that data on or about Indigenous people reflects our priorities, values, cultures, worldviews and diversity.

B38. The Parties acknowledge that Aboriginal and Torres Strait Islander people have been systematically excluded from control over their own health data and that governments are complicit in aiding non-Indigenous parties to extract, analyse, interpret and control health data without reciprocal benefit for Aboriginal and Torres Strait Islander people.

B39. The Parties agree that Aboriginal and Torres Strait Islander people have the right as specified in the *Maiam nayri Wingara* Indigenous Data Sovereignty Collective and the Australian Indigenous Governance Institute communique released in 2018 to decide which datasets require active governance and retain the right to abstain from participating in data processes inconsistent with the global principles of Aboriginal and Torres Strait Islander ('Indigenous') Data Sovereignty (see Part 5).

B40. The Parties commit to strengthen their adherence to principles of governance of Aboriginal and Torres Strait Islander data including:

a. integration of all data lifecycle stages, utilising mechanisms aligned with Aboriginal and Torres Strait Islander-determined needs and aspirations

b. Aboriginal and Torres Strait Islander leadership and control over processes to strengthen governance of data and data for governance consistent with Aboriginal and Torres Strait Islander (Indigenous) Data Sovereignty

c. increasing data literacy and capability by allocating resources for Aboriginal and Torres Strait Islander workforce expansion and investing in digital infrastructure and systems aligned with Aboriginal and Torres Strait Islander people's priorities

d. reviewing and ensuring accountability of entities that hold Aboriginal and Torres Strait Islander data to ensure that data are available to and accessible by the Aboriginal and Torres Strait Islander people and lands to which they relate

e. creation of new Aboriginal and Torres Strait Islander Data Governance mechanisms, guaranteeing that data production is ethical, representative, and beneficial.

B41. The Parties also commit to progress towards full realisation of the five principles for Aboriginal and Torres Strait Islander ('Indigenous') Data Sovereignty including:

a. Aboriginal and Torres Strait Islander people should exercise control of the data ecosystem, including creation, development, stewardship, analysis, dissemination and infrastructure

b. data should be contextual and disaggregated (available and accessible at individual, community, regional and jurisdictional levels)

c. data should be relevant and useable to nourish and sustain self-determination and effective self-governance

d. data structures should be accountable to Aboriginal and Torres Strait Islander people and their community-controlled entities

e. data should be protective and respect Aboriginal and Torres Strait Islander people's individual and collective interests.

B42. The Parties agree to report annually to the Monitoring and Accountability Group on their efforts to strengthen their adherence to the principles for Aboriginal and Torres Strait Islander ('Indigenous') Data Sovereignty in the health system (see Part 5).

B43. The Parties agree that it is the responsibility of all National Bodies to work in Formal Partnership as defined in Part 5 with the Aboriginal and Torres Strait Islander Health Sector to strengthen their adherence to principles of governance of Aboriginal and Torres Strait Islander data including:

a. integration of all data lifecycle stages, utilising mechanisms aligned with Aboriginal and Torres Strait Islander-determined needs and aspirations

b. Aboriginal and Torres Strait Islander leadership and control over processes to achieve Data Governance consistent with Aboriginal and Torres Strait Islander (Indigenous) Data Sovereignty

c. increasing data literacy and capability by allocating resources for Aboriginal and Torres Strait Islander workforce expansion and investing in digital infrastructure and systems aligned with Aboriginal and Torres Strait Islander people's priorities

d. reviewing and ensuring accountability of entities that hold Aboriginal and Torres Strait Islander data to ensure that data are available to and accessible by the Aboriginal and Torres Strait Islander people and lands to which they relate

e. creation of new Aboriginal and Torres Strait Islander Data Governance mechanisms, guaranteeing that data production is ethical, representative, and beneficial.

Aboriginal and Torres Strait Islander ('Indigenous') Cultural and Intellectual Property

B44. The Parties acknowledge definitions of Aboriginal and Torres Strait Islander ('Indigenous') Cultural and Intellectual Property (ICIP) as outlined in Appendix A and their application in the context of this agreement and respect Aboriginal and Torres Strait Islander people's rights to their heritage, cultural knowledge and cultural expression that originates from a family or community group and is passed on from generation to generation. For the purposes of this agreement, ICIP rights may exist in:

a. literary, performing and artistic works

b. languages

c. types of knowledge, including spiritual knowledge

d. tangible and intangible cultural property

e. cultural environmental resources; and

f. documentation of Indigenous heritage

created, performed, expressed or contributed to by Aboriginal and Torres Strait Islander people.

Accountability and Reporting

B45. The Parties acknowledge that accountability and reporting are foundations for successful national health reform.

B46. The Parties acknowledge their obligations to better respect Aboriginal and Torres Strait Islander people's self-determining health agenda and the benefits of shared decision-making in health reform under this Agreement.

B47. The Parties agree that accountability, structures and policies in relation to Aboriginal and Torres Strait Islander health outcomes should be transparent, with clearly defined responsibilities specified for all levels of government, sectors and services.

B48. The Parties agree to strengthen actions to standardise and enhance data collection across all states and territories to ensure consistency and comprehensiveness. This includes addressing data gaps, particularly in rural and remote areas, through equity-informed methodologies and greater investment in data infrastructure at national through to local levels.

B49. The Parties acknowledge that performance indicators about Aboriginal and Torres Strait Islander people's health should be co-designed and take into account factors including connection to land, cultural practices, and the social and cultural wellbeing of communities as collectives, and cultural safety of health services.

B50. The Parties agree that it is the responsibility of AIHW to work in Formal Partnership as defined in Part 5 with the Aboriginal and Torres Strait Islander Health Sector to ensure that indicators in the health system performance assessment Framework measuring health system performance in relation to Aboriginal and Torres Strait Islander people's health are co-designed, relevant, accurate, meaningful and reflective of Aboriginal and Torres Strait Islander people's health priorities.

B51. The-Parties agree that the health system performance assessment framework as it relates to Aboriginal and Torres Strait Islander people's health outcomes will be developed to the satisfaction of the independent national Monitoring and Accountability Group.

National Bodies

B52. The Parties agree that it is the responsibility of all National Bodies to enact and embed the National Agreement on Closing the Gap and its four Priority Reforms by transforming their structures, systems, processes and cultures. These National Bodies are:

a. The Independent Health and Aged Care Pricing Authority

b. The Administrator of the National Health Funding Pool (the Administrator) and the National Health Funding Body

c. The Australian Commission on Safety and Quality in Health Care

d. The Australian Institute of Health and Welfare.

B53. The Parties agree that the National Bodies must ensure:

a. their decision-making and governance arrangements include Aboriginal and Torres Strait Islander representation through actions including but not limited to:

i. appointing Aboriginal and Torres Strait Islander representatives on agency boards and committees (if required, the Parties will review amendments to legislation and other barriers to enable this)

ii. establishing Formal Partnership arrangements with Aboriginal and Torres Strait Islander people and the Aboriginal and Torres Strait Islander Health Sector

iii. establishing dedicated Aboriginal and Torres Strait Islander teams in their organisations

iv. embedding strategies for the recruitment, retention and career advancement of Aboriginal and Torres Strait Islander staff

b. public reporting on efforts they have undertaken to implement the National Agreement on Closing the Gap and its four Priority Reforms including:

i. presenting in their corporate plans and annual reports their efforts to operationalise the National Agreement on Closing the Gap and its four Priority Reforms as above

ii. contributing to their respective departmental formal reporting on the National Agreement on Closing the Gap, including through the Partnership Stocktake, Implementation Plan and Annual Report

iii. strengthening Aboriginal and Torres Strait Islander ('Indigenous') data governance including Aboriginal and Torres Strait Islander ('Indigenous') Data Sovereignty.

Part 3 – Health equity

Health Equity

B54. The Parties acknowledge that racism and associated discriminatory practices create inequities within Australia's health care system and harm good health outcomes for all Australians.

B55. The Parties recognise the importance of primary health care as a foundation for an effective, sustainable and equitable health care system.

B56. The Parties agree that Aboriginal and Torres Strait Islander Australians have a right to culturally safe, trauma-aware and healing informed, responsive health care, free of racism and inequity.

B57. The Parties recognise the leadership of Aboriginal and Torres Strait Islander people in driving health equity.

B58. The Parties acknowledge that the attainment by Aboriginal and Torres Strait Islander people of equitable health outcomes requires shared decision-making, power-sharing, accountability and monitoring.

Part 4 – Culturally safe health care

Cultural Safety and Racism

B59. The Parties accept their responsibilities as system managers to ensure that health care is provided in facilities free of racism and that specific efforts are required to ensure hospitals, public health services and all health facilities are free of systemic and institutional racism.

B60. The Parties acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health for Aboriginal and Torres Strait Islander people.

B61. The Parties will show the leadership necessary to ensure that members of the HMM, Health Chief Executives Forum and System Reform Deputies Group commit to improve their stewardship of partnership, co-design, shared decision-making and power sharing with Aboriginal and Torres Strait Islander people, their communities and the Aboriginal and Torres Strait Islander Health Sector.

B62. The Parties agree to foster safe working environments through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

B63. The Parties accept the two-part definition of cultural safety developed by the Australian Health Practitioner Regulation Authority (AHPRA) for the National Registration and Accreditation Scheme, as follows:

a. Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities

b. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism

and also acknowledge that

c. cultural safety requires organisational change through critically analysing and addressing racism, biases, assumptions, stereotypes and prejudices expressed through the organisations structures, values, policies and procedures that create barriers to provide good health care and good health outcomes.

B64. The Parties agree that it is the responsibility of the Australian Commission on Safety and Quality in Health Care to work in Formal Partnership as defined in Part 5 with the Aboriginal and Torres Strait Islander Health Sector to ensure that cultural safety as defined in Part 5 is embedded in the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme.

B65. The Parties agree that States and Territories will ensure that their health system governance arrangements including at Local Hospital Network (LHN) level, include and resource Aboriginal and Torres Strait Islander people with local community health and cultural expertise to sit on key health system governance groups e.g. governing councils or as per clause E10.

B66. The Parties require all LHNs to commence the collection and reporting of the following measures to their jurisdiction's Aboriginal and Torres Strait peak health body complying with the terms for data sharing as agreed in Formal Partnerships (clause B31):

a. Number and rates of admissions disaggregated by Aboriginal and Torres Strait Islander status where hospitals have not ensured completion of treatment (known elsewhere as Discharge Against Medical Advice (DAMA) rates)

b. Number of sentinel events by Severity Assessment Code (SAC) category disaggregated by Aboriginal and Torres Strait Islander status

c. Number and rates of 'Missed Opportunities to Treat' (MOT) disaggregated by Aboriginal and Torres Strait Islander status in presentations to Emergency Departments (known elsewhere as 'Did Not Wait' (DNW) rates)

d. Number and percentage of Aboriginal and Torres Strait Islander staff to measure attraction and recruitment, retention and leadership roles

e. Amounts received in the previous financial year through the Indigenous adjustment and the amounts expended on Aboriginal and Torres Strait Islander services

and report these as a minimum annually.

B67. The Parties require all LHNs to measure and report to the Aboriginal and Torres Strait Islander community-controlled peak body in their respective jurisdiction using, at a minimum, indicators specified in-the health system performance assessment framework and national accreditation standards in the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme that pertain to Aboriginal and Torres Strait Islander people's experiences of and outcomes from health care.

B68. The Parties agree to support LHNs to comply with clause B65 including giving due consideration to capacity building in LHNs, resources and investment in phased implementation and change management.

B69. The Parties agree to require all LHNs to co-design, implement and evaluate strategies to eliminate racial discrimination and institutional racism from its services and institutions, working in partnership with the Aboriginal and Torres Strait Islander Health Sector to share best practice and adopt effective strategies.

B70. The Parties acknowledge implementation of clauses B67 to B69 could be impacted by on the digital capacity and maturity, workforce capability and data infrastructure of each LHN, with varying levels of readiness across the country.

B71. All Parties agree to require all LHNs to have formal racism complaints processes in place and operational within the timeframe of this Addendum. These must be co-designed and data reported to Formal Partnerships with the Aboriginal and Torres Strait Islander Health Sector including those ACCHOs located in the respective LHN footprint to ensure that complaints processes are appropriate for and meet the needs and aspirations of the local Aboriginal and Torres Strait Islander community.

Prioritising the ACCHO Sector

B72. The Parties recognise the role of the Aboriginal and Torres Strait Islander community-controlled Health Sector as defined in Part 5 including Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs) and respect that Aboriginal and Torres Strait Islander community-controlled health care is an act of self-determination.

B73. The Parties acknowledge that ACCHOs, when resourced, provide holistic multi-disciplinary primary health care as described in the community-controlled health sector's Core Services and Outcomes Framework.

B74. The Parties acknowledge that ACCHOs, when resourced, also support system level, regional and local planning and coordination of healthcare delivery for Aboriginal and Torres Strait Islander people.

B75. The Parties acknowledge that ACCHOs, when resourced, also support a broad range of other services of relevance to the NHRA including secondary healthcare services such as sub-acute medical and allied health care, disability services, and aged care that respond to an Aboriginal and Torres Strait Islander definition of health and wellbeing.

B76. The Parties recognise the challenges of service delivery in remote and very remote areas and agree to support the critical role that ACCHOs play in self-determined health and wellbeing in remote and very remote communities.

B77. The Parties recognise that complex care pathways can be difficult to navigate for patients requiring access to specialist review/more complex investigations that cannot be accessed in remote communities and /or hospital care.

B78. The Parties agree that any monitoring processes for primary care, aged care, and the NDIS as per Schedule C will be developed in partnership with the Aboriginal and Torres Strait Islander Health Sector.

B79. The Parties agree that strategic initiatives including but not limited to policy and service redesign, innovation, trials or service-based research in relation to Aboriginal and Torres Strait Islander health and wellbeing are co-designed, as defined in Part 5.

B80. The Parties acknowledge the need to improve the interface between primary health care and the secondary, tertiary and quaternary components of the Australian health system. The Parties commit to co-design, measure and improve the Australian health system in partnership with the Aboriginal and Torres Strait Islander Health Sector, focusing on but not limited to, the quality and outcomes of discharge planning and handover procedures for Aboriginal and Torres Strait Islander people admitted to hospitals and returning to primary health care.

Funding Reform

B81. The Parties agree the identification of priorities and funding rules for any dedicated funding under this Addendum and outside the National Funding Model such as an Aboriginal and Torres Strait Islander (First Nations) Health Reform Fund to drive better health outcomes for Aboriginal and Torres Strait Islander people will be led by Aboriginal and Torres Strait Islander people as set out in Part 1 of Schedule B.

B82. The Parties agree to continue integrating safety, quality and value into the pricing and funding of public hospitals and health services, with particular focus on the measurement and reporting of racism and cultural safety; and incentives to address health system inequities for Aboriginal and Torres Strait Islander people.

B83. The Parties including the National Bodies agree to work in Formal Partnership with the Aboriginal and Torres Strait Islander Health Sector and the Health Collaboration and other Aboriginal and Torres Strait Islander stakeholders to determine and action priority areas for funding reform, including (but not limited to):

a. reviewing the methodology for determining the pricing adjustments for 'Indigenous' status and 'regional and remote' status (Schedule A)

b. considering, as part of the review of safety and quality measures (Schedule D), the feasibility of funding or pricing adjustments for safety, cultural safety and quality to address racism

c. reviewing the funding model to ensure that funding to ACCHOs for the provision of in-scope hospital services is incentivised.

Workforce

B84. The Parties agree to implement the strategies in the **National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031** with priority given to:

a. ensure compliance with occupational health and safety legislation regarding culturally safe workplaces

b. work in partnership with the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP) to address barriers to support and enable implementation of the national minimum scopes of practice for Aboriginal and Torres Strait Islander Workers and Health Practitioners

c. work in partnership with the Aboriginal and Torres Strait Islander Health Professional Organisations to develop and deliver jurisdictional and LHN Aboriginal and Torres Strait Islander health workforce plans and initiatives to ensure:

    i. Culturally safe recruitment processes

    ii. Active recruitment processes

    iii. Initiatives to ensure vertical/horizontal distribution of workforce

    iv. Retention programs and initiatives

d. report progress on implementation of the Workforce Plan 2021-2031 to Affiliates and other stakeholders including data for indicators by occupational category, attraction, recruitment, retention and seniority, and progress in community obligations to attain or exceed proportional employment

e. work with local Aboriginal and Torres Strait Islander communities to undertake cultural safety reviews and implement remedial actions to address institutional racism within health, education and training sectors

f. develop and promote career pipelines and pathways with priority given to a resource that maps career journey within LHNs and the creation of VET in school programs

g. work with the Aboriginal and Torres Strait Islander Health Sector to reform the national and jurisdictional collection and use of Aboriginal and Torres Strait Islander health workforce data

h. undertake a national review of Aboriginal and Torres Strait Islander workforce data for all health disciplines in terms of national, jurisdictional and regional distribution and health needs.

Part 5 – Terminology

B85. The Parties agree to operationalise, under this NHRA, a range of partnership and consultations processes with the Aboriginal and Torres Strait Islander Health Sector including but not limited to those defined below and agree to adopt the term only when activities fully comply with the definitions as below.

a. **Health and wellbeing** means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-passing-life.

b. **Formal Partnership** as defined in the National Agreement on Closing the Gap clauses 28 to 33 enshrine agreed joint decision-making by setting out who makes decisions, how decisions are made, and what decisions will be about. Formal Partnerships provide Aboriginal and Torres Strait Islander parties with a level of power that is equal to or higher than other parties. In Formal Partnerships, Aboriginal and Torres Strait Islander people choose their own representatives. Formal Partnerships require formal signed agreements between Aboriginal and Torres Strait Islander people, governments, and/or other parties that sets out how they will each work together to achieve agreed goals and aims. As stated in the

National Agreement on Closing the Gap, adequate funding is needed to support Aboriginal and Torres Strait Islander parties to be partners with governments in Formal Partnerships for activities to:

i. engage independent policy advice

ii. meet independently of governments to determine their own policy positions

iii. support strengthened governance between and across Aboriginal and Torres Strait Islander organisations and parties

iv. engage with and seek advice from Aboriginal and Torres Strait Islander people from all relevant groups within affected communities, including but not limited to Elders, Traditional Owners and Native Title Holders.

c. **Shared decision-making** which refers to processes mutually described as shared between government and Aboriginal and Torres Strait Islander people. Activities characterised as shared decision-making must adhere to the definition of shared decision-making in the National Agreement on Closing the Gap, namely:

i. by consensus, where the voices of Aboriginal and Torres Strait Islander parties hold as much weight as the governments

ii. transparent, where matters for decision are in terms that are easily understood by all parties and where there is enough information and time to understand the implications of the decision

iii. where Aboriginal and Torres Strait Islander representatives can speak without fear of reprisals or repercussions

iv. where a wide variety of groups of Aboriginal and Torres Strait Islander people, including women, young people, Elders, and Aboriginal and Torres Strait Islander people with a disability can have their voice heard

v. where self-determination is supported, and Aboriginal and Torres Strait Islander lived experience is understood and respected

vi. where relevant funding for programs and services align with jointly agreed community priorities, noting governments retain responsibility for funding decisions

vii. where all parties have access to the same data and information, in an easily accessible format, on which any decisions are made.

d. **Co-design** which refers to an equitably resourced partnership process that is Aboriginal and Torres Strait Islander-led and built on authentic relationships, communicating through agreed mechanisms, two-way understanding, cumulative evaluation and reflection in order to generate and sustain shared development pathways to outcome delivery and reform. To be described as co-design, the Parties agree that respective activities, arrangements and claims must:

i. Ensure early and consistent involvement of Aboriginal and Torres Strait Islander people and/or communities throughout the design process for transparency and accountability;

ii. Prioritise and respect the voices of Aboriginal and Torres Strait Islander people to determine and drive the agenda and design solutions for health reform; and address the interface between the health, disability and aged care sectors, and

iii. Facilitate knowledge-sharing, power-sharing, shifts in control consistent with the National Agreement on Closing the Gap and capability building between the healthcare system, Aboriginal and Torres Strait Islander experts and patients.

iv. Examples of co-designed process were the development of the National Agreement on Closing the Gap, National Aboriginal and Torres Strait Islander Health Plans, and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031; and Health Sector Strengthening Plan.

e. **Aboriginal and Torres Strait Islander ('Indigenous') Cultural and Intellectual Property (ICIP)** means Aboriginal and Torres Strait Islander people's rights to their heritage, cultural knowledge and cultural expression that originates from a family or community group and is passed on from generation to generation. These rights may exist in literary, performing and artistic works; languages; types of knowledge, including spiritual knowledge; tangible and intangible cultural property; cultural environmental resources; and documentation of Indigenous heritage created, performed, expressed or contributed to by Aboriginal and Torres Strait Islander people.

f. **Nation building** refers to the efforts enhancing Aboriginal and Torres Strait Islander people’s capacities for self-governance and self-determined economic development and, according to the Social Justice Report (2014), is achieved when local Aboriginal and Torres Strait Islander people, Nations, communities, authorities and organisations have power and control over decision making and resources.

g. **Cultural safety** for Aboriginal and Torres Strait Islander people acknowledges the two-part definition of cultural safety developed by the Australian Health Practitioner Regulation Authority (AHPRA) for the National Registration and Accreditation Scheme namely:

i. Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.

ii. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

and also acknowledges that

iii. Cultural safety requires organisational change through critically analysing and addressing racism, biases, assumptions, stereotypes and prejudices expressed through the organisations structures, values, policies and procedures that create barriers to provide good health care and good health outcomes.

h. **Trauma-aware, healing-informed practice/**approach has been developed to address the high prevalence of trauma amongst Aboriginal and Torres Strait Islander people and support journeys of individual, family, and community healing. It recognises the

co-existence of trauma with intergenerational trauma, built within individual and collective experiences of colonialism and racism. It is strengths based and grounded in Aboriginal and Torres Strait Islander people's ways of knowing, being, and doing. The approach is non-linear and cyclical, reflective of the story and journey of each individual, family, community and Country. In practice, it emphasises cultural, spiritual, physical, psychological, and emotional safety, when engaging with issues of high importance that are likely to be sensitive and triggering of trauma responses. It requires a reflective practice and an awareness of cultural and unconscious bias, privilege, and the ongoing impacts of colonialism. Its principles are:

i. Stolen Generations survivors have complex needs related to their experiences of trauma

ii. Aboriginal and Torres Strait Islander people's ways of knowing, being, and doing encompass belonging, (re)connection, collectivity, intergenerational learning, knowledges, and relationships

iii. an understanding of and engagement with collective and interconnected trauma and intergenerational trauma experienced by First Nations people

iv. culture and cultural expression are central to healing

v. strengths based interconnected approaches

vi. healing informed is a nonlinear, holistic journey that addresses physical, emotional, and spiritual needs.

i. **The Aboriginal and Torres Strait Islander Health Sector** (short-hand where appropriate to the 'Health Sector' or 'the Sector') refers to the National Indigenous Health Leaders Alliance (NIHLA) and the National Aboriginal Community-Controlled Health Organisation (NACCHO), the State and Territory Affiliate peak health bodies and ACCHOs.

j. **The Aboriginal and Torres Strait Islander community-controlled health sector** (short-hand where appropriate to 'the community-controlled health Sector') refers to NACCHO, Affiliates and all ACCHOs which meet the criteria for delivering comprehensive community-controlled primary health care as stated in the Core Services and Outcomes Framework

k. The **Coalition of Peaks** is a national network of more than 80 Aboriginal and Torres Strait Islander community-controlled peak bodies and members across Australia, who represent some 800 organisations. The Coalition of Peaks bring forward the views of their members and communities to all their discussions with governments.

l. The **National Indigenous Health Leadership Alliance** (NIHLA) is a partnership of Aboriginal and Torres Strait Islander health and wellbeing organisations, whose purpose is to drive systemic and structural transformation of mainstream government systems, including addressing institutional racism and advancing the human rights of Indigenous people in alignment with the National Agreement on Closing the Gap, the National Aboriginal and Torres Strait Islander Health Plan, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan. Each member of the NIHLA has their own membership who work across the public and private hospital systems through to primary health through ACCHOs and general practice, and private practice. The breadth of locational

practice, scopes of professional practice and lived experience provides NIHLA with a broad understanding of the strengths, weaknesses and failing of our health systems. Thus, NIHLA plays an important role in advocating for and supporting improved outcomes for Aboriginal and Torres Strait Islander people:

i. sharing their knowledge, expertise and insights to strengthen the capability of governments and mainstream organisations to deliver more effective policies and programs

ii. providing advice on matters relating to Aboriginal and Torres Strait Islander health from the perspective of the mainstream service system, education and training systems.

m. **ACCHOs** or Aboriginal Community Controlled Health Organisations must be non-government and not-for-profit incorporated Aboriginal or Torres Strait Islander organisations that are initiated by a local Aboriginal or Torres Strait Islander community; based in a local Aboriginal or Torres Strait Islander community; governed by an Aboriginal or Torres Strait Islander body which is elected by the local Aboriginal or Torres Strait Islander community; and deliver a holistic and culturally appropriate health service to the community which controls it. Through their unique corporate structure, ACCHOs are an expression of self-determination that aim to improve health and wellbeing and mitigate the processes of ongoing colonisation by offering comprehensive community-controlled primary health care described in the Core Services Framework published by NACCHO in 2021. The terms ACCHO, Aboriginal Community Controlled Health Service (ACCHS) and Aboriginal Medical Service (AMS) and Aboriginal and Torres Strait Islander Health Organisations (A&TSIHOs) are used interchangeably. In some jurisdictions like Victoria, these services are also known more broadly as Aboriginal Community Controlled Organisations (ACCO). While this NHRA refers to ACCHOs, this is intended to be inclusive of services across the community-controlled health services sector.

n. **Affiliates** comprise eight community-controlled peak health bodies each based in a state or territory within Australia ('jurisdiction') supporting and amplifying NACCHO in its leadership of the Aboriginal and Torres Strait Islander community-controlled health sector. Each Affiliate supports the Aboriginal Community-Controlled Health Organisations (ACCHOs) in their jurisdiction through the provision of support and practical advice in the areas of organisational governance and services, continuous quality improvement (CQI) accreditation, program implementation, workforce development and building capacity. Affiliates facilitate partnerships between the ACCHOs, the respective government departments and other service providers in the development and application of co-designed health policies, plans and evaluations.

o. **The National Aboriginal Community Controlled Health Organisation (NACCHO)** is a community-controlled peak body for Aboriginal and Torres Strait Islander people's health and wellbeing operating at national level to co-design and provide guidance to the Australian Government on policy and budget matters while advocating for community-developed health solutions that contribute to the quality of life and improved health outcomes for Aboriginal and Torres Strait Islander people. Almost all ACCHOs in Australia are NACCHO Members. NACCHO contributes significantly to closing the gap in health outcomes between Aboriginal and Torres Strait Islander people and other Australians.

p. **Indigenous Data Sovereignty** is the right of Aboriginal and Torres Strait Islander people, communities and organisations to maintain, control, protect, develop, and use data affecting self-determination. Five principles convey these rights to:

   i. Exercise control of the data ecosystem including creation, development, stewardship, analysis, dissemination and infrastructure.

   ii. Data that are contextual and disaggregated

   iii. Data that are relevant and empowers sustainable self-determination and effective self-governance.

   iv. Data structures that are accountable to Aboriginal and Torres Strait Islander people.

   v. Data that are protective and respects our individual and collective interests.

   Indigenous Data Sovereignty guarantees that the rights of Indigenous people, their experiences, values and understanding are developed and reflected in any data and information gathered about Aboriginal and Torres Strait Islander people, communities and their knowledges. Indigenous Data Sovereignty is practiced through Indigenous data governance.

q. **Joint Council** supports national leadership, coordination and cooperation for the National Agreement on Closing the Gap. It has two Co-Chairs, namely a Government Minister with responsibility allocated on a rotational basis and an Aboriginal and Torres Strait Islander representative nominated by the Coalition of Peaks. The Joint Council is responsible for monitoring implementation of the National Agreement on Closing the Gap, including progress by the Parties against their Implementation Plans. Its membership comprises one Minister with responsibility for Closing the Gap nominated by each jurisdiction, one representative from the Australian Local Government Association and 12 representatives nominated by the Coalition of Peaks, with broad geographic and subject matter coverage.

r. **Ex Officio** means a non-voting member with the authority to attend meetings, receive the meeting agenda and relevant documents in advance, participate and contribute views and insights.

SCHEDULE C – SYSTEM INTERFACE REFORM

C1. For people to receive quality health care, we need seamless interfaces between many different types of services, delivered by public, private and non-government providers.

C2. This schedule aims to improve care at the interface of public, private and not-for-profit systems, including: hospitals, non-GP specialist services, GP services and broader primary and community care, the Aboriginal Community Controlled Health Organisation (ACCHO) sector, ambulance and patient transport services, aged care in both home and residential settings, and disability services. It focuses on reforms addressing barriers between Local Hospital Networks (LHNs) and the primary care, aged care, and disability care systems.

C3. This Schedule commits Parties to:

a. taking a routine and systematic approach to addressing interface issues between services and sectors

b. new governance mechanisms designed to address problems at the interface between services and sectors

c. embedding cooperative working arrangements between LHNs, Primary Health Networks (PHNs), Commonwealth Department of Health, Disability and Ageing's Local Network, National Disability Insurance Agency (NDIA), Rural Workforce Agencies, ACCHOs, and local service providers involved in the provision of health, disability or aged care services

d. coordinating planning for service delivery in the future by working together through agreed governance mechanisms to review and analyse service interactions, service gaps, and relevant data, for example demographic, population health and workforce data.

C4. The Parties recognise that:

a. quality health care means committing to person-centred care and seamless coordination of services throughout the patient journey, especially when patients need to transition between service providers and service types

b. the disability, aged care, primary care, hospital, non-GP specialist care and community health systems (such as nursing and allied health), and the ACCHO sector, form part of a whole care and support system and are a collective responsibility underpinned by long-term system-wide planning in each system by the responsible party

c. there are complex interrelationships between the health, primary care, aged care and disability systems, and that policy changes in one system can have an impact on other systems, particularly as these are resource constrained environments

d. there is a need to ensure changes in one system do not create unintended consequences in other systems

e. all governments have a shared responsibility to improve people's health outcomes, by supporting system users, carers and their families to navigate the health, primary care, aged care, and disability support systems, with the aim of optimising care and support, maintaining health and reducing avoidable admissions and delayed discharge from hospital

f. digital enablement, through greater uptake of national digital health capabilities, is required for near real-time sharing of health information between relevant providers, healthcare organisations, consumers, patients and their carers, to support quality decision making, transitions between interfacing care systems, and effective care coordination

g. timely and relevant data is needed to build a shared understanding of the pressure points across sector interfaces, develop local solutions that address them, and identify issues that need to be escalated up from the local level

h. major initiatives are being implemented in the primary care, aged care, and disability sectors that will impact on the interface between systems over the life of this Addendum. They will require all Parties to be flexible and adapt their responses over time. These initiatives include:

   i. government responses to the Royal Commission into Aged Care Quality and Safety

   ii. government responses to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission)

   iii. the *Aged Care Act 2024*

   iv. government responses to the Royal Commission into Defence and Veteran Suicide

   v. government responses to the Independent Review into the National Disability Insurance Scheme (NDIS)

   vi. reforms to the *National Disability Insurance Scheme Act 2013*, including associated legislative instruments and rules

   vii. Strengthening Medicare primary care reforms

   viii. government responses to the Strengthening Medicare reviews which include Unleashing the Potential of our Health Workforce (Scope of Practice) Review

C5. Parties acknowledge the issues older people and people with disability encounter navigating the interface between public hospitals, primary care, disability support and aged care services. This can be further impacted by intersectional factors such as being from a culturally and linguistically diverse background.

C6. All Parties acknowledge the importance of supporting older people and people with disability to safely transition back to home, community, or residential care after a hospital admission. Addressing discharge barriers remains a priority for all governments in particular for older people who are medically fit for discharge to their preferred (and clinically feasible) longer-term care setting but remain in the hospital for a range of non-clinical reasons (delayed discharge of older patients).

C7. Parties agree to convene to discuss ways of continuing to fund effective Strengthening Medicare initiatives that support older people.

a. New proposals should be considered by Health Chief Executives Forum (HCEF) and Health Ministers (HMM).

b. Service Model Reform Funding could also be used to trial new initiatives or scale up and embed successful ones (refer to Schedule D).

c. IHACPA will review outcomes of relevant state projects where they include in-scope NHRA services under the Federation Funding Agreements for opportunities to update classification and pricing models by 30 October 2029.

C8. Parties commit to further understanding the discharge barriers for older people experiencing delayed discharge from hospital and supporting implementation of evidence-based approaches, including by:

a. improving data sharing (see data clauses C43 to C47)

b. identifying effective models of care including through the Service Model and Funding Reform Collaboration to be established under Schedule D.

Roles and responsibilities

C9. The roles and responsibilities of the Parties within the broader health system are outlined in the Preliminaries of this Addendum. Roles and responsibilities for local level governance arrangements are outlined in Schedule E.

C10. The roles and responsibilities of the Parties where they relate to the interface between hospitals, primary care, aged care, and disability support systems, including community and residential aged care, and the NDIS, should be considered in the context of relevant agreements, legislation, and supporting documents including but not limited to:

a. Bilateral Agreements between the Commonwealth of Australia and each jurisdiction on the National Disability Insurance Scheme

b. National Mental Health and Suicide Prevention Agreement

c. the *Aged Care Act 2024*

d. *the Aged Care Safety and Quality Commission Act 2018* (noting updates will be made to reflect the *Aged Care Act 2024)*

e. Australia’s Disability Strategy 2021-2031

f. the *National Disability Insurance Scheme Act 2013* (NDIS Act) and associated legislative instruments and rules

g. the NDIS Rules and legislative instruments.

h. the 'Principles to Determine the Responsibilities of the NDIS and other Service Systems - Applied Principles and Tables of Support (APTOS)' agreed by COAG, and subsequent decisions by Ministerial Councils on responsibilities of service systems

i. the National Agreement on Closing the Gap

j. the National Aboriginal and Torres Strait Islander Health Plan 2021-2031

k. the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031

l. the National Medical Workforce Strategy (2021-2031)

m. the National Palliative Care Strategy 2018

n. the 'Joint Statement to clarify the roles and responsibilities for the delivery of health care for people accessing aged care services', developed following the Royal Commission into Aged Care Quality and Safety. The Joint Statement will be updated as needed in the term of the Addendum to reflect changes to roles and responsibilities resulting from any other program review or amendments

o. National Preventive Health Strategy 2021-2030.

C11. The Commonwealth, supported by the Parties, has a stewardship role for primary care, aged care and the NDIS, and will apply a systematic approach to collaborative planning to meet service demands and address market sustainability in a timely way. This will consider the short, medium and long-term impacts on the broader healthcare system.

C12. In addition to health care responsibilities specified in the Preliminaries, the Commonwealth is responsible for:

a. funding, policy and regulation of community, home and residential aged care delivered under the *Aged Care Act 2024*

b. overarching guidance on policy for people with disability, through Australia's Disability Strategy, as part of Commonwealth obligations related to the *Convention on the Rights of Persons with Disability*. This includes planning, policy, management, and delivery of the NDIS

c. providing continuity of support, where required, for individuals accessing Commonwealth programs for support and who are aged under 65 years with disability but are not NDIS participants, while they continue to require that service

d. regulating the provision of services under the NDIS via the NDIA and the NDIS Quality and Safeguards Commission.

C13. In addition to health care responsibilities specified in the Preliminaries, States are responsible for:

a. policy, funding, and regulation of relevant disability supports and services for people with disability aged under 65 years, and Aboriginal and Torres Strait Islander people aged under 50 years as per clause C15, where the participant is not eligible to receive the support under the NDIS. This includes supports for NDIS participants where the support addresses needs that do not arise from an impairment for which the participant meets the NDIS access criteria

b. continuing to fund and provide access to mainstream public hospital and State owned and run community health services for all Medicare eligible people, including older people and people with disability

c. providing continuity of support, where required, for clients of State disability programs who are not NDIS participants, to assist them to achieve similar outcomes.

C14. The Parties will share responsibility for:

a. providing continuity of care across interfacing care systems to ensure smooth client transitions and reduce avoidable hospital admissions and readmissions, and avoidable disability and aged care admissions and readmissions, and enable timely hospital discharge to appropriate care or home setting, including the two-way sharing of relevant client information between systems to support these outcomes

i. Some programs such as the Transition Care and Multi-Purpose Services programs will continue to be jointly funded by the Commonwealth and the States

b. working collaboratively to identify the need for legislative and policy reform required to enable NDIS markets

c. providing strategic governance through the Disability Reform Ministerial Council on the NDIS and Australia's Disability Strategy, which represents all governments' shared commitment to improve the health and wellbeing of all people with disability

d. implementing data and digital reforms to achieve an interconnected and efficient health system that supports continuity of patient care across all health and care settings (as set out in this Schedule and in Schedule H).

C15. Where applicable, the Parties will share program responsibility for their respective community care and residential care services for Aboriginal and Torres Strait Islander people 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.

C16. All parties recognise the need for further work to agree on roles and responsibilities and mechanisms to improve how systems and agencies work together to plan and coordinate streamlined care for people with significant and permanent disability resulting from chronic or complex health conditions, including life-limiting conditions, and that:

a. the National Palliative Care Strategy (2018) notes that palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-limiting illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual

b. the health system has ongoing responsibility for providing health services, including palliative care, for people with life-limiting conditions

c. aged care services can provide care and support services, and disability services can provide functional supports (funded via the NDIS where the person meets eligibility requirements under the NDIS Act or by States as per clause C13(a)), including disability-related health supports, for eligible people with life-limiting conditions at the same time as palliative care services are delivered by the health system.

C17. In addition to the roles and functions of the NHRA national bodies as described in Schedule I, the roles and functions of other relevant bodies including the Aged Care Quality and Safety Commission, the Office of the Inspector General of Aged Care, and the NDIS Quality and Safeguards Commission will be considered in delivering the intent of this Schedule.

Monitoring supply of services to identify interface issues early

C18. Consistent with the principles for market stewardship at Preliminaries clause 20, the Parties are committed to monitoring primary care, aged care, and NDIS services at a regional and local level to identify accessibility issues and/or service gaps. Monitoring processes will align with emerging reforms and be flexible to allow for adaptations over time as per clause C4(h), to support a sustainable and responsive service market.

C19. Consistent with the principles for market stewardship, the Commonwealth will monitor performance of primary care, aged care, and NDIS services through the following arrangements:

a. in primary care, the Department of Health, Disability and Ageing, together with PHNs, Rural Workforce Agencies and other stakeholders will monitor the sustainability of primary care services typically delivered within a general practice or equivalent setting and identify communities, where possible, with services at risk of closure resulting in limited or no access to primary care. Parties commit to improved sharing of market intelligence, including through HCEF and HMM processes as required, as soon as practical after December 2026

b. in aged care, the Department of Health, Disability and Ageing (including through the Department's Local Network) and the Aged Care Quality and Safety Commission will actively monitor aged care services and conduct routine analysis of market performance of these services. This includes an ongoing commitment to monitoring supply and demand for services; and monitoring sector-level financial performance, publishing sector-level financial information, and provider-level financial and operations information

c. in disability, the Department of Health, Disability and Ageing will work with the NDIA and NDIS Quality and Safeguards Commission to actively monitor NDIS services and conduct routine analysis of market performance of these services.

C20. States will monitor performance of the public hospital and health care system.

Governance and escalation pathways

C21. Consistent with Schedule E, relevant governance arrangements at the local, regional, state, and national level will support monitoring, escalation, and responses to market performance and interface issues.

C22. In accordance with Parties' roles and responsibilities, market monitoring will take a top-down and bottom-up approach, which involves system leadership by the Commonwealth and States and using market intelligence shared by local stakeholders, including PHNs, LHNs, ACCHOs and other primary care, aged care and NDIS providers.

C23. Local governance approaches will need to recognise existing roles and responsibilities across the system, and the levers available to each Party to address interface issues identified.

C24. Consistent with the principles for market stewardship, any Party can raise issues regarding market performance of interfacing systems.

a. PHNs will be the main point of contact for primary care. PHNs will work in collaboration with LHNs, ACCHOs and other primary care stakeholders where relevant, particularly in rural and remote regions.

b. The Department of Health, Disability and Ageing's Local Network will be the main point of contact for aged care.

c. The NDIA will be the main point of contact regarding NDIS participants and prospective participants.

d. State and territory governments will be the main point of contact regarding disability services outside the NDIS, as per clause C13(a) of this agreement.

e. State and territory health departments and/or LHNs will be the point of contact for public hospital and health system delivery issues.

C25. The Commonwealth, through PHNs, the Department of Health, Disability and Ageing's Local Network and the NDIA will assess identified issues, and lead local stakeholder collaboration with the following parties, as relevant:

a. Local Hospital Networks

b. State and territory health departments

c. Primary Health Networks

d. Rural Workforce Agencies

e. The ACCHO sector

f. Other Aboriginal Community Controlled Organisations

g. NDIA

h. Local service providers involved in delivering health, disability or aged care services

i. Peak bodies.

C26. Where markets are identified as at risk, the following escalation pathway will be deployed to support action:

a. in the first instance, local stakeholders (as identified at clause C25) will work together to address the problem, minimise impacts on adjacent services, stabilise the service system(s) and re-establish sustainable services as soon as possible. Local stakeholders will be supported by State and Commonwealth level leadership in line with the roles and responsibilities of the Parties and local level governance outlined in Schedule E. Before escalating further, all Parties commit to documenting all mechanisms trialled to address market issues at the local level, including assessing their effectiveness

b. where the local market response is ineffective, this will be escalated to the relevant system manager or system steward, for example, the relevant health, aged care or disability services officials. This process will be the mechanism used for determining whether any further existing or proposed policy, program or funding options could be deployed to assist the local area

c. where system manager or system steward intervention remains unsuccessful, Parties will provide reports to HCEF or delegated group for further consideration and action. If there is an impact on the NDIS or broader disability service system, Parties will concurrently report to senior officials responsible for disability policy. If there are similar market issues across multiple service areas or multiple jurisdictions, the Commonwealth will facilitate meetings with officials from all relevant portfolios and jurisdictions to consider the issues and potential solutions.

C27. HCEF will report to HMM on systemic issues and resolution strategies and seek endorsement for any action that requires Ministerial approval. Further:

a. the Intergovernmental Health and Aged Care Senior Officials Group, with escalation pathways to Aged Care Ministers will be included in any decisions relating to aged care systems

b. HCEF and the Disability Deputy Department Heads (DDH) will monitor interface issues that may arise between the health system and disability service systems

c. HCEF and the Intergovernmental Health and Aged Care Senior Officials Group (or similar aged care delegate group) can raise an issue to be resolved with outcomes or recommendations to be provided to the HMM, and Disability Deputy Department Heads (DDH) may escalate issues to Disability Reform Ministerial Council (DRMC) for resolution

d. Ministerial Councils may refer matters and make representations to each other on interface issues. Where an issue relates to the provision of social or community housing, these parties may also provide recommendations to Housing Ministers via the appropriate forum.

C28. Any new Commonwealth funding to support actions below will remain subject to Australian Government decisions.

Mechanisms to support continuity of primary care services

C29. The Commonwealth, in consultation and collaboration with states and other key stakeholders, will ensure appropriate enablers and incentives are in place for the primary care system to work effectively. The Commonwealth will remain committed to Strengthening Medicare measures, and other commitments, to support all Australians to access services when and where they need them. The principles guiding primary care investments will include supporting continuity of healthcare in the community, prioritising early intervention and the prevention of avoidable hospitalisations.

a. The Commonwealth will consider opportunities to reform primary care funding arrangements, as recommended in the Strengthening Medicare reviews, to support continuity of primary care services. This includes exploring new blended funding arrangements and arrangements to more effectively support primary care in rural and remote Australia.

C30. In areas where continuity of primary care services is at risk, as per clauses C26(a) and (b), the Commonwealth will lead actions, through PHNs, in partnership with relevant local stakeholders (outlined in clause C25) which may encompass:

a. monitoring the local situation and, where necessary, capacity building for local organisations, coordinating action of all relevant entities, and escalation according to agreed escalation pathways

b. utilising/exploring capacity building for local organisations

c. addressing service delivery gaps within available resources

d. collaborating on alternate primary care service delivery models, appropriate to the local community circumstances, informed by primary care access measures

e. coordinating actions of all relevant entities

f. escalating action to governments, where necessary.

C31. The Commonwealth may also enter into an agreement with a State (or non-government organisation or ACCHO), where the State may be an alternative provider or provider of last resort for primary care services typically delivered within a general practice or equivalent setting. This would include consideration of whether current exemptions apply under Section 19(2) of the *Health Insurance Act 1973*.

C32. Before any agreement with a State (or non-government organisation or ACCHO) can be made for providing primary care services typically delivered within a general practice or equivalent, the Commonwealth will need to assess all available policy levers to ensure the agreement is comprehensive. The agreement may outline:

a. Short and medium-term actions

b. Timeframes

c. Performance/accountability mechanisms

d. Compensation arrangements

e. Longer-term market remediation strategies to be trialled and evaluated

f. Addressing primary care needs of the community, including those living with a disability and older people

g. Engagement with PHNs and local stakeholders.

C33. Parties recognise that key considerations for stakeholders to determine the preferred provider will include community preferences for the appropriate mode of care, the appropriate provider (e.g., an ACCHO), and the availability, capacity and capability of providers to deliver some or all services.

C34. Parties recognise policy and funding frameworks that further the capability of ACCHOs are an important enabler to transition primary healthcare services to ACCHOs over time.

Mechanisms to support continuity of aged care services

C35. The Commonwealth will ensure appropriate enablers and incentives are in place for the aged care system to work effectively. The Commonwealth will remain committed to ongoing improvements that allow eligible older people to access services when and where they need them.

C36. In areas where aged care markets are at risk, the Commonwealth will lead actions, in collaboration with LHNs/state and territory health departments where necessary, to prevent service closure or restore care services, as appropriate. These actions may encompass:

a. reviewing access to, and suitability of, transition care places, respite care and related models of care that aim to optimise care and reduce avoidable hospital stays and admissions

b. investing in state-led, integrated, multidisciplinary outreach care models for older patients using funding streams outside the NHRA

c. active management of older people placements, including establishing a system for tracking placement into aged care settings, and timely provision of hospital discharge summary and care requirements information to support safe transitions that avoid readmission

d. addressing discharge delays, especially for people with complex needs who also need aged care services, such as people with bariatric support needs or behavioural and psychological symptoms of dementia

e. building staff capacity in aged care settings, other step down/supported accommodation and support services.

f. local coordination of Commonwealth and state/territory services to address specific need and increase availability of service through collective action, including engaging with local stakeholders

g. the Commonwealth entering into an arrangement with a State, where the State may be an alternative provider or provider of last resort, acknowledging that the Commonwealth has existing separate arrangements to fund States for the delivery of aged care

Mechanisms to support continuity of disability services

C37. In areas where NDIS service markets are at risk, actions may encompass:

a. identifying and addressing delays in accessing disability supports, including for specialist disability accommodation, supported independent living, and state and territory funded social and community housing, and timely provision of hospital discharge summary information to support safe transitions

b. the Commonwealth committing to work with States and Territories through DDH and DRMC in response to market risk and market failure, engaging with ACCHOs and other stakeholders on a needs-based and place-based basis

c. the Commonwealth continuing to work with States and Territories on existing trials on commissioning measures to support or complement the operation of NDIS markets

d. the Commonwealth or States entering into arrangements, from time to time, to establish an alternative provider or provider of last resort for people with disability, acknowledging and funding this service in specified local areas.

Digital enablement of interface transitions

C38. Digitally enabled care supports timely access to patients' health information and history so clinicians, patients, and their care teams can make more informed decisions at the point of care.

C39. The Parties commit to adopting key digital reforms to enable safe and timely information exchange across interfaces, including:

a. nationally consistent Healthcare Identifiers, which are necessary for near real-time information exchange about patients across care settings, such as between hospitals and aged or disability care (see clause H66). This underpins high quality connected care for all Australians

b. enhanced digital infrastructure, including national interoperability standards and capabilities, so that information transfer is less reliant on manual handling. Additionally, investment in digitisation of information or automation of information capture will reduce the burden on staff.

C40. The delivery of digital priorities that support high quality connected care and transitions of care will be undertaken in line with principles and commitments in Schedule H.

Mechanisms to support smooth client transitions

C41. The Parties recognise that information sharing to support people's transitions between hospitals and other care settings can have significant benefits for clinical safety, equity, and quality health outcomes. This is especially important for priority groups, such as those requiring aged care services or people with disability.

C42. The Parties agree to progress timely sharing of high-quality hospital discharge summaries from public hospitals to community care (including primary care, particularly GPs, residential aged care homes and disability support teams and accommodation) and vice versa. This includes adopting minimum standards for information exchange and timeliness of discharge summaries (refer clauses D47 and D48). Digital implementation will be undertaken in line with commitments in Schedule H (see clauses H71 to H73).

Interface data and performance monitoring

C43. Parties recognise data is critical for providing evidence about issues at the interface of sectors. All Parties commit to developing ongoing data sharing capability at the local level to ensure timely access to care and services when and where needed. This includes a commitment to facilitating data access and sharing for Aboriginal and Torres Strait Islander-led data outcomes as agreed in Schedule B, in line with Reform Priorities under the National Agreement on Closing the Gap.

C44. The Parties agree that the AIHW, in consultation with the Parties, will prioritise development of public hospital, primary care, aged care and disability interface performance indicators as part of the health system performance assessment framework outlined in Schedule H, including for performance reporting to HMM. This work will take advantage of enhanced data capability as it becomes available, including linked data, and will consider the impact on patient outcomes, with a focus on priority population groups.

C45. All Parties will further leverage opportunities in the National Health Data System (see Schedule H) to gain insights from existing or emerging data integration infrastructure and data assets, such as the National Disability Data Asset (NDDA).

C46. In recognising the role of States in providing services across the different sectors, particularly in thin and failing markets, the Commonwealth will support work to harmonise regulation across the health, aged care and disability sectors, with the aim of reducing duplication of regulation requirements. This work should consider:

a. providers delivering services across care and support sectors in small communities, including rural and remote communities, where undue regulatory burden restricts the supply of services

b. continuity of appropriate care for people with complex cognitive and behavioural care needs, including where medication management is delivered in partnership with specialised health care providers.

C47. All Parties will progress streamlined data sharing across governments, including to integrated data assets to enable critical data collection across interfaces.

Strengthening consistent and regular delayed discharge of older patient data

C48. To support timely reporting to HMM and HCEF and problem solving at the local level, the Parties acknowledge that a shared national and local understanding of delayed discharge of older patient from hospital, including on discharge barriers, is critical to providing evidence on the areas in need of government support.

C49. Parties therefore commit to developing a nationally consistent definition for delayed discharge of older patients by December 2026. Additionally, all Parties will collaborate to develop nationally consistent data collection, as required for the Performance Framework (see Schedule H) and transparency across governments by December 2026. Key metrics under a national data collection may include but are not limited to those outlined in clause C52.

C50. As part of the Commonwealth's $1.2 billion Strengthening Medicare package, $598.8 million has been allocated (over four years from 2024-25 to 2027-28) to State-led initiatives that support older people to avoid hospital admission, be discharged from hospital earlier, and improve their transition from hospital to other appropriate care.

C51. All funding agreements with the Australian Government under this package include a commitment by States to provide data that supports evaluation of these initiatives by 30 October 2028 unless otherwise agreed.

C52. Evaluation will measure the number of older people experiencing delayed discharge from hospital within each State and efficacy and effectiveness of interventions. Other indicators may be collected at quarterly intervals over the four years, including:

a. number of patients ready for discharge to their preferred (and feasible) longer-term care setting. This means that the patient has stabilised and is receiving care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition, and they are awaiting discharge to their preferred care setting in their Local Hospital Network or region

b. bed days occupied while meeting the above criteria

c. main barriers to discharge, where primary reasons include:

i. Administrative – personal reasons such as financial affairs, making family arrangements, preparing the home environment

ii. Administrative – related to guardianship proceedings

iii. Aged care assessment in progress or waitlisted

iv. Awaiting a transition care bed

v. Awaiting a bed in a residential aged care home – no availability at selected home(s)

vi. Awaiting a bed in a residential aged care home – cannot identify a suitable home due to complex care needs

vii. Awaiting aged care services in the home – Commonwealth Home Support

viii. Awaiting aged care services in the home – Support at Home

ix. Patient/family prefers not to move

d. demonstrated impact of the initiatives including hospital bed days for the relevant patient cohort and admission rates for participating patients.

C53. Development of the national data collection will align with work under the health system performance assessment framework to develop meaningful system measures (see clause H15). Parties will also have regard to reporting against any relevant quality and safety principles and standards for transitions of care in development.

C54. The Parties commit to monthly reporting of relevant data and to address barriers to data sharing, including legislative barriers, to support these reforms. This will be done in alignment with the national Governance Framework outlined in Schedule H, National Health Data System section.

C55. The Intergovernmental Health and Aged Care Senior Officials Group or relevant HCEF nominated forum will be accountable for progress under this Addendum, with parallel reporting to HCEF and other sub-committees as needed.

Further work to commence during the Addendum

C56. The Parties, in collaboration with the NDIA, will develop nationally consistent definitions, data collection and performance reporting on public hospital patients who are NDIS participants or prospective NDIS participants to support safe and timely discharge and seek endorsement from HMM and Disability Reform Ministerial Council by December 2026.

a. The Parties will provide quarterly reporting to HMM and Disability Reform Ministerial Council at the state and territory, Local Health Network and individual hospital level. The Parties also agree to make quarterly performance reporting publicly available at this level from 1 July 2027.

C57. As part of broader disability reforms, during the life of this Addendum, the Commonwealth will collaborate with states in developing options for a nationally consistent approach to health system navigation for people with disability.

SCHEDULE D – TRANSFORMING SERVICE DELIVERY

D1. Structural health reform is needed to ensure people receive the right care, in the right place, at the right time, from the right provider. Through this Schedule, the Parties agree to work together to progress national system reforms by trialling and scaling optimal models of care, supporting improvements in service delivery, and providing more flexible pricing and funding arrangements.

D2. The Parties agree that more health care can be provided safely outside of hospitals, including through the Addendum. In many instances, this means: timelier access to care, and better health and mental health outcomes and experiences for people and health practitioners; a greater focus on preventive care, which will support all Australians to live healthier lives; a reduction in avoidable hospital admissions; and delivery of care that is less resource intensive, which improves sustainability of health expenditure for all governments, and helps reduce climate impacts.

D3. To ensure the health system can respond to the changing needs of the Australian population while ensuring ongoing sustainability, the Parties agree that reforms to NHRA financing arrangements are needed to make the system more productive, value-based and focused on individual and community needs.

D4. The Parties acknowledge progress was limited on the long-term reform commitments from the 2020-25 Addendum, due to a range of factors identified in the 2023 NHRA Mid-Term Review. A new approach is needed to improve implementation of reforms required to shift the system to more effectively and efficiently meet the current and future needs of patients, populations and the health system. This includes, but is not limited to:

a. implementing expanded scope of services and service models that help reduce avoidable hospital admissions

b. trialling and introducing alternative funding and payment models for optimal models of care, supported by new governance arrangements

c. establishing the Service Model Reform Funding (SMRF) stream.

D5. The Parties agree to work collaboratively and proactively in accordance with the national principles as set out in the Preliminaries to:

a. address the financial, governance, reporting and accountability barriers to reform, and facilitate effective models and modalities of care being embedded into the National Funding Model

b. better support identifying, trialling and scaling contemporary, safe, high-value and quality care models, including gathering and sharing evidence of critical success factors across jurisdictions and care sectors to demonstrate proof of concept at a system level

c. better support trialling and evaluating new payment and funding arrangements that enable the delivery of optimal care models that support better outcomes.

D6. To deliver the reform objectives of this Schedule and the National Health Reform Strategy at Preliminaries clause 17, the Parties will:

a. support a nationally coordinated approach to prioritising optimal models of care and new payment and funding arrangements that will drive system reform through the Service Model and Funding Reform Framework (clauses D12 to D23)

b. implement a SMRF stream as a mechanism to foster system-wide innovation and improved productivity through the Addendum (clauses D24 to D30)

c. introduce value-based pricing approaches, including for high-value care, low-value care, normative pricing, priority care loadings and other payment models (clauses D31 to D39)

d. strengthen safety and quality pricing mechanisms, including introducing national hospital discharge reporting (clauses D40 to D55).

Governance

D7. To support and drive implementation of activities outlined in this Schedule, the Parties agree a new participatory governance group, the Service Model and Funding Reform Collaboration (the Reform Collaboration), will be established under the broader NHRA governance arrangements (Preliminaries clause 42) and supported by the Commonwealth.

a. Establishment arrangements and Terms of Reference for the Reform Collaboration will be agreed through HCEF by 30 September 2026. The Terms of Reference should ensure that co-design and shared decision-making with Aboriginal and Torres Strait Islander people and organisations are embedded.

b. The Reform Collaboration will provide advice and technical support as needed to jurisdictions to deliver optimal models of care, including through the SMRF stream, and for developing and refining funding and payment models. The Reform Collaboration will also support shared learning, best-practice exchange and capacity building across jurisdictions.

i. All Parties agree to participate in the Reform Collaboration, including to share lessons from existing reform activities as well as new activities under this Addendum such as those funded through the SMRF stream.

ii. Membership should include Commonwealth and State and Territory representatives with relevant expertise, National Bodies, and the Aboriginal Community Controlled Health sector and other Aboriginal and Torres Strait Islander health organisations, as well as other identified experts.

iii. The Reform Collaboration will have capacity to access specialised independent expertise as needed, including from State and Territory health innovation units, to support jurisdictions to inform optimal models of care, help develop enabling payment approaches, and assist with spreading and scaling reforms and innovations that demonstrate value across jurisdictions.

D8. The Reform Collaboration will develop a limited number of national priorities for structural health system reform for HMM to consider and agree by December 2026. The national priorities will guide decision-making and reform activities set out in this Schedule and give consideration to the following:

a. evidence-based optimal models of care that are nationally implementable and have the potential to reduce the prevalence or slow the progress of avoidable health conditions, reduce avoidable hospitalisations and significantly improve patient outcomes for specific cohorts

b. addressing the barriers preventing providers from delivering optimal integrated care models and balancing the need for local flexibility and solutions with national priorities

c. system enablers needed to implement improved care models on a national scale (e.g. health data systems; health workforce regulation, policy or practice; funding and payment arrangements; and clinician engagement and support)

d. addressing and leveraging other reform commitments and priorities in this Addendum and other national agreements (e.g. improving service delivery across interfaces, integration with mental health and suicide prevention systems)

e. supporting activities that have potential benefit for all jurisdictions, including the potential to reduce demand for health care services

f. the impact on health outcomes for Aboriginal and Torres Strait Islander people, with a focus on Closing the Gap

g. the feasibility of implementation and evaluation within the period of the Addendum.

D9. The Reform Collaboration will develop the first version of a Service Model and Funding Reform Framework (the Reform Framework) for HCEF consideration by December 2026 to support prioritising, planning, implementing and evaluating reform activities within this Schedule (clauses D12 to D23).

a. The Reform Framework will align with the objectives and outcomes identified in the Preliminaries (clauses 11 and 12) and the National Health Reform Strategy (clause 17), including to support action on the Parties' shared commitment to implement the National Agreement on Closing the Gap.

b. The Reform Collaboration will provide advice and technical support as needed in developing and applying the Reform Framework, and broader reform implementation activities.

c. The Reform Framework will be appended to the Addendum once agreed. Any subsequent updates to the Framework must be agreed by HCEF.

D10. The Reform Collaboration will also support the design and development of operational arrangements for the SMRF stream, for consideration by HCEF by December 2026 (clause D26).

D11. These governance arrangements and the Reform Framework will be reviewed annually to confirm their suitability and effectiveness, with any change subject to HCEF approval.

Developing a Service Model and Funding Reform Framework

D12. The Parties agree that a Service Model and Funding Reform Framework (the Reform Framework) is needed to provide a more structured approach for identifying and implementing optimal models of care and new payment and funding arrangements that will drive system reform in line with agreed HMM priorities.

D13. The Reform Framework will include criteria to assess whether proposed patient cohorts, clinical pathways or service/care models are suitable for payment and/or funding reforms, including bundled and capitation payment models, value-based pricing approaches and alternative payment models. These criteria may include:

a. defined model or process of care – a clinically accepted and evidence-based practice and/or guidelines that define ‘appropriate’ care for the cohort/pathway exists, and/or compelling clinical evidence exists

b. appropriate for care type – the payment or funding type is appropriate for the proposed care model, patient cohort and/or pathway

c. culturally safe and appropriate – all models of care are culturally appropriate, safe and where relevant, co-designed with local Aboriginal and Torres Strait Islander communities and organisations, including the ACCHO sector and peak workforce organisations, and where appropriate commissioned or delivered by ACCHOs

d. rationale for reform – the current funding model poses a barrier to implementing an optimal model of care, or the proposed cohort/pathway experiences significant variation or has opportunity for improvement in either one or more of: clinical outcomes, access, equity, safety and quality, health care utilisation, or costs

e. evidence – local or international evidence is available to suggest that improvements could be made by using a different funding, payment or pricing model

f. traceability – access to relevant data sets makes it possible to accurately monitor patient activity, safety and quality across this pathway/cohort to design, implement and evaluate the model

g. outcome measures – standardised and validated patient-centred and/or reported outcome measures, and population outcome measures including Closing the Gap, are available that can be monitored, evaluated, and benchmarked

h. volume – the proposed cohort/pathway has sufficient volume of services delivered on a national or state level to justify implementation costs, achieve economies of scale, and produce replicable evaluation results during an initial implementation phase

i. ease of implementation – consideration will be given to the relative ease of implementing the reform for a cohort or pathway from the perspective of the Parties, IHACPA and ACSQHC.

D14. The Reform Framework will support the Reform Collaboration to develop recommendations via the System Reform Deputies Group (SRDG) to HCEF regarding the most appropriate reform pathway to progress service delivery, funding stream and/or payment and pricing model changes that will contribute to better health outcomes and experiences for people. This would include:

a. identifying best practice and evidence-informed models of care that should be incentivised or delivered at scale through more appropriate pricing and funding arrangements

b. identifying and agreeing nationally important models of care and services suitable for inclusion in the national funding model as per Part 3 of Schedule A

c. determining the most appropriate funding, payment and/or pricing mechanism to support the reform, in conjunction with the IHACPA Funding Models Framework (clause A9), including options for:

i. fast-tracking changes to existing ABF classifications, costings and pricing where appropriate

ii. progressing high/low value care, priority care loadings, normative pricing, new ABF and non-ABF classifications and/or payment models for specific cohorts

iii. trialling and/or scaling specific bundled payment arrangements, capitation funding models and novel models of care via the SMRF stream

iv. trialling alternative payment models via block funding arrangements where other funding arrangements above are not considered suitable.

D15. The Reform Framework will set out the specific roles and functions of National Bodies, leveraging their expertise, to support implementation of reforms under this Schedule.

a. As part of the Reform Collaboration the ACSQHC will advise on a systematic process to assess current service delivery models and identifying national priority cohorts and conditions according to contemporary best-practice, optimal models of care.

D16. Where the Reform Collaboration considers a change in the pricing or funding model would better support optimal models of care, the Funding Models Framework developed by IHACPA will provide guidance for Parties on how to request pricing, classification, or funding stream changes (clause A9).

D17. The Reform Framework (developed by the Reform Collaboration) and the Funding Models Framework (developed by the IHACPA per clause A9) are complementary documents that together will guide reform implementation.

a. The Reform Framework addresses:

i. reform priorities and pathways

ii. SMRF operational procedures

iii. evaluation and reporting requirements

iv. cross-jurisdictional learning

b. The Funding Models Framework addresses:

   i. technical pricing and classification matters

   ii. funding stream criteria and transitions

   iii. IHACPA processes and decision-making

c. The Reform Collaboration and the IHACPA will consult to ensure alignment between the frameworks consistent with clauses I5 to I16.

   i. The Reform Framework will be updated annually to maintain alignment with Funding Models Framework developments.

d. Both frameworks will be published together once developed and cross-referenced to support user navigation.

Data and reporting requirements

D18. The Parties agree all reform activities will comply with specified reporting requirements. This includes financial reporting, data provision and implementation monitoring on progress and outcomes, and specific reporting requirements for SMRF funding reconciliation and acquittal as outlined in clauses A145 to A147. These requirements will be developed by the Reform Collaboration and outlined in the Reform Framework.

a. Reporting and accountability requirements should be balanced and commensurate with the size and complexity of the reform or projects, giving decision-makers enough data and evidence to assess outcomes without overburdening service delivery organisations.

b. The Funding Models Framework will outline data and reporting requirements as well as processes for scaling and embedding successful reforms into the national funding model.

D19. The Reform Framework will also outline reporting arrangements to support cross jurisdictional learning by sharing materials and experience in designing, implementing, scaling, and embedding reforms, as well as arrangements for publicly reporting reform outcomes.

Evaluation

D20. The Parties recognise that a common and robust approach to evaluation is required to assess the impact of new care pathways, optimal models of care and funding and payment reforms, in line with the principle at clause D18(a).

D21. The Reform Framework will outline evaluation requirements and processes that will be used to inform recommendations on whether to refine, scale up, expand, or discontinue specific reforms.

Intellectual property

D22. The Parties recognise that acquiring and disseminating knowledge, lessons and skills in health system reform are a public benefit. Further, the Parties agree all intellectual property, including materials or models developed through any of the reforms under this Schedule, will be freely available.

D23. The Reform Collaboration will develop an intellectual property policy to be included in the Reform Framework that will:

a. provide guidelines for the use, generation, acquisition and management of intellectual property

b. ensure that intellectual property generated through projects is used to generate public value, knowledge transfer and innovation to the fullest extent possible

c. manage intellectual property with a potential commercial value in a manner which benefits the entire Australian health system.

Implementing the Service Model Reform Funding stream

D24. The Parties recognise that dedicated funding, incentives, expertise, and national collaboration are required to design, trial, scale up and embed successful service models and deliver system-wide, structural reform. While clinicians and service providers often innovate to improve service delivery and patient outcomes at a local level, there are no mechanisms in place to fully evaluate and scale up proven care models and embed them into the health system at a national level. This is especially challenging when it requires both levels of government to make changes to their respective programs and funding arrangements.

D25. A culture of continually demonstrating return on investment, cost-effectiveness, system improvement, and outcomes and value for patients within a data driven environment will underpin the new Service Model Reform Funding (SMRF) stream.

a. Decision-making will be guided by a clear process and criteria to be developed and outlined in the Reform Framework to either progress along the SMRF pathway or exit (including into mainstream funding arrangements where agreed).

b. Parties receiving funding through the SMRF stream will need to comply with reporting and evaluation requirements as outlined in clauses D18 to D23.

D26. Administrative arrangements and operational procedures for the SMRF stream (in line with clauses A145 to A147 and A182) and supporting activities will be developed by the Commonwealth in consultation with the Reform Collaboration, for HCEF consideration and approval by December 2026 and inclusion in the Reform Framework. These will include but not be limited to:

a. process and timing for States to advise the Reform Collaboration of their intent to opt in for the SMRF stream in each year

b. application guidance

c. clear and transparent criteria to assess States' proposals under the SMRF stream guidance, requirements and tools to support States in designing, implementing and evaluating projects; and mechanisms to share progress, learnings and outcomes about projects across jurisdictions, as well as public reporting.

Scope

D27. The Parties agree that SMRF will be used to support the design, trial or evaluation of projects that align with clauses D8 and D9 and are in one of the following categories:

a. progressing changes to service delivery arrangements that support safety and quality improvements, scaling up and spread of best-practice and high-value models of care already funded under the Addendum

b. trialling new, evidence-informed models of care, including bundled and capitation service models, that require funding-related reform within the Addendum, potentially through:

i. expansion of in-scope services

ii. inclusion of care models and other funding sources that cross adjacent care sectors (e.g. public hospitals, aged care, mental health and suicide prevention, primary care), in line with existing roles and responsibilities

c. trialling novel models of care that do not yet have any identified funding source, including for components of care that are not currently funded under the Addendum but might be considered in future

d. supporting implementation of new models of care through enabling activities, such as local level clinical and stakeholder engagement, and nationally agreed workforce, digital and data reforms.

D28. The SMRF stream will not be used to fund any projects or existing services that are already funded through another Commonwealth program as per clause A12, or are wholly funded through another NHRA payment mechanism or funding stream (e.g. ABF, Block Funding).

a. For the avoidance of doubt, a pathway of care (e.g. bundled payment trial) may be funded by a combination of SMRF (e.g. non-service delivery components, services not already in-scope) and another funding stream within the NHRA (e.g. ABF, Block Funding), provided no part of the pathway of care receives funding from multiple streams as per clause A12.

b. SMRF is not intended to fund novel technologies, highly specialised therapies, or major capital or infrastructure costs.

D29. Guidance documents will be developed for HCEF consideration and inclusion into the appropriate Framework once sufficient trials of bundled payment and capitation models have been proposed to inform their development. Where relevant, development will occur in consultation with Aboriginal and Torres Strait Islander stakeholders (as set out in Schedule B).

Procedures and operations

D30. Funding under the SMRF stream will be available to States from 1 July 2027, with payments made through the Administrator. Funding will be determined through the following process:

a. the Reform Collaboration will undertake initial assessment of proposals in line with the Reform Framework and HMM-agreed priorities, as required when States bring forward proposals

b. if agreed suitable for SMRF, proposals will be provided to the SRDG for assessment against agreed criteria and approval

i. Disputes will be resolved through escalation to HCEF and HMM as needed

c. once approved by SRDG the Commonwealth will confirm the amount of funding for each State's approved projects to be paid and provide advice to the Administrator

d. the Commonwealth will also:

i. provide a report annually to the Administrator by 15 September on compliance with SMRF reporting and evaluation requirements, as per clause A147

ii. provide advice to the Administrator as part of annual reconciliation processes outlined in Part 4 of Schedule A.

Value-based and alternative pricing and funding models

D31. A range of additional pricing and funding reform models are also essential to help drive structural reform to support improved patient experiences and outcomes, and deliver more productive, efficient and effective care.

Trialling value-based pricing approaches

D32. The Parties agree that safer, higher quality care should be incentivised to deliver value for patients and the system. Value-based pricing approaches included in this Addendum will contribute to improved patient outcomes, by ensuring that resources are allocated to the most clinically beneficial care.

a. For avoidance of doubt, value-based pricing approaches in this Addendum include:

i. Low-value care disincentives

ii. High-value care incentives

iii. Normative pricing

iv. Priority care loadings.

D33. The Parties agree that new approaches to value-based pricing of in-scope services are not limited to those described in this Addendum and that new approaches may be identified by the Parties and/or National Bodies.

Normative pricing

D34. The Parties agree that a normative pricing approach should be investigated and developed by the IHACPA in consultation with the Reform Collaboration and the ACSQHC during this Addendum as a new mechanism to price some procedures, episodes of care, and price loadings, where the weighted national average cost is not the most appropriate (such as when it is too low or too high to incentivise best-practice care, or where there is insufficient data to define an average cost). The Parties agree that the intent of changes is to promote delivering care efficiently and in accordance with current evidence-based clinical guidelines and/or agreed best practice.

D35. The Parties agree normative pricing may be recommended for consideration when using the Reform Framework and aligned with the Funding Models Framework.

Priority care loadings

D36. The Parties agree that additional pricing adjustments to incentivise identified priority services or types of care for specific populations and/or delivery in specific settings should be investigated and developed by the IHACPA in consultation with the Reform Collaboration and the ACSQHC during this Addendum. This includes for example, non-admitted care that can prevent or delay hospital readmissions, incentivising day surgery over in-patient admissions, health professionals working to the top of their scope of practice and promoting increased access and better-quality care for Aboriginal and Torres Strait Islander people and communities.

D37. The Parties agree priority care loadings may be recommended for consideration using the Reform Framework.

Alternative payment model trials

D38. The Parties agree there may be a need to trial alternative payment models outside the specified funding streams and reform mechanisms outlined at clause A8 and otherwise described in this Schedule.

   a. Alternative payment model trials will only be considered where existing national funding model payment streams (ABF, existing block funding arrangements and SMRF) are not suitable.

D39. The Commonwealth and a State(s) may agree to trial an alternative payment model through a bilateral agreement, as outlined at clauses A76 to A79.

Strengthening patient safety and improving quality of care

D40. Australia's public hospitals and health services deliver safe, high-quality care but there are opportunities to improve. Developing standards for national hospital discharge information, continuing to reduce Sentinel Events, Hospital Acquired Complications (HACs), Avoidable Hospital Readmissions (AHRs), and reducing low-value care, while also increasing the amount of high-value care delivered, will improve patient safety, health outcomes and efficiency in the health system.

D41. The ACSQHC and the IHACPA are primarily responsible for maintaining and curating safety, quality and value measures implemented under this Addendum (see Schedule I).

   a. Criteria for ongoing measures addressing Sentinel Events, HACs and AHRs established in the 2017-20 and 2020-25 Addenda are specified in Appendix B.

b. The Parties agree to promptly provide any relevant input and advice, including relevant data if requested by the ACSQHC, to support any safety, quality and value related work under this Addendum.

D42. HMM will oversee the continued development, implementation, and ongoing refinement of reforms to integrate safety, quality and value into the pricing and funding of public hospitals and health services (clauses A84 to A97 and Appendix B), including:

a. receiving advice from National Bodies on pricing and funding approaches, including shadow approaches, for value-based pricing adjustments.

b. final approval of the Sentinel Events, HACs, AHRs, low-value care and high-value care lists for funding and pricing purposes.

D43. The Parties agree to work with the ACSQHC, the Reform Collaboration, other National Bodies and other stakeholders to progress broader safety and quality reforms. This includes the review of safety and quality measures (clauses D51 to D55) and using discharge summaries to improve quality (clauses D44 to D48).

Using discharge summaries to improve quality

D44. Nationally consistent hospital discharge information is critical to patient safety and continuity of care.

D45. All Parties agree to enable the sharing of high-quality hospital discharge information at clinical transfer of care to enhance safety and quality outcomes, reduce medication errors, and reduce preventable hospitals admissions in line with Schedule C and Schedule H.

D46. The ACSQHC has identified concerns regarding content, quality, outdated paper-based modes of transmission and the timeliness of sharing discharge information[2]. These concerns include gaps for carers in community settings and other care sectors, which contribute to quality and safety risks for patients.

D47. The ACSQHC will work with the Parties, National Bodies and related stakeholders, including ACCHOs, to build on existing guidelines and develop standards for hospital discharge information for approval by HCEF by 30 June 2027. These standards should:

a. expand on relevant National Safety and Quality Health Service Standards

b. consider, but not be limited to, relevant recommendations from the Royal Commission into Aged Care Quality and Safety, and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

D48. Following HCEF approval, Parties will agree a coordinated implementation approach and priorities for all patients by 30 June 2028, for adoption by the end of this Addendum.

a. Hospital discharge information should be accessible to GPs, patients, carers and families, residential aged care homes, ACCHOs and relevant health and care providers through digital channels, including via a patient's My Health Record.

[2] https://www.safetyandquality.gov.au/our-work/e-health-safety/safety-issues-transitions-care-pain-points-relating-clinical-systems

Reporting for safety, quality and value

D49. States will provide the following data to the ACSQHC and IHACPA, within nine months of the end of each financial year, on the outcomes of implementing safety, quality, and value-based initiatives. ACSQHC will develop a reporting template in consultation with the Parties by 30 June 2027 to collate this information and provide reports to HMM annually, including:

a. rates of Sentinel Events, HACs and AHRs

b. once lists are developed, rates of low-value care and high-value care to support further safety and quality improvements

c. information on the financial impacts of any safety, quality and value-based pricing adjustments (both those contained in the national funding model, and any implemented by States) at the State level and LHN level

d. any other relevant safety, quality, and value-based programs undertaken at state/LHN/hospital level, including any local pricing mechanisms

e. disaggregated data for Aboriginal and Torres Strait Islander people to enable examination of potential inequities in adverse event rates

   i. Aboriginal and Torres Strait Islander data will be reported to the Aboriginal and Torres Strait Islander governance groups as detailed in Schedule B

f. state compliance with data provision, if necessary.

D50. For the purposes of improving transparency of safety and quality in public hospitals and health services, the IHACPA will continue to publish rates of Sentinel Events, HACs, AHRs, and low-value and high-value care on the public National Benchmarking Portal on an annual basis. The ACSQHC will also publish rates by hospital of Sentinel Events, HACs, AHRs and other indicators as developed, in its Safety in Health Care web tool.

Review of safety and quality measures

D51. The Parties recognise that reviewing and refining existing safety and quality pricing mechanisms are essential to ensuring patients receive safe, high-quality care, in the right place, at the right time.

D52. The ACSQHC will work with the Parties, other National Bodies and related stakeholders, including Aboriginal and Torres Strait Islander experts (as set out in Schedule B), to review existing safety and quality measures according to the detailed parameters in Appendix B. This review will assess and propose recommendations on:

a. the effectiveness of existing safety and quality indicators and pricing adjustments (Sentinel Events, HACs and AHRs) in driving improvements

b. how to revise and strengthen existing measures

c. how to introduce safety and quality pricing adjustments for new payment reforms and funding streams

d. driving improved safety and quality for patients through appropriate mechanisms that could support the reinvestment of pricing adjustments towards safety and quality improvement activities, if found to be effective

e. whether safety, quality and/or value-based pricing mechanisms are appropriate to encourage sharing of hospital discharge summaries

f. whether reforms are driving improvement in access and outcomes for Aboriginal and Torres Strait Islander people.

D53. The terms of reference for the review will be agreed by HCEF. The ACSQHC will provide an interim progress report to HCEF by December 2026, and a final report by 30 June 2027.

D54. National Bodies will consider the HCEF-agreed recommendations from the review. Subsequent actions by National Bodies may include:

a. The IHACPA considering any recommended changes to safety, quality and/or value-based pricing adjustment models and advising HCEF on the effects of these changes to the broader funding model.

b. The IHACPA developing and maintaining agreed safety and quality pricing adjustment models for new reforms such as bundled or capitation payments, or any other agreed actions within their scope, and advising HCEF on the effects of these changes to the broader funding model.

c. The ACSQHC considering any recommended changes in Sentinel Events, AHR or HAC lists, or any other agreed actions within their scope.

d. The Administrator adjusting funding reconciliation formulas as appropriate.

D55. If implemented, review recommendations for changes to one or more of the Sentinel Events, HAC and/or AHR lists, or their pricing adjustment models should ideally start no later than one year after recommendations from the final report are considered by HCEF.

SCHEDULE E – LOCAL GOVERNANCE

E1. This Schedule sets out the responsibilities of local-level health service planning organisations with key roles in delivering core services and implementing reform under this Addendum, being:

a. Local Hospital Networks (LHNs, including Local Health Districts, Health and Hospital Services)

b. Primary Health Networks (PHNs)

c. Aboriginal Community Controlled Health Organisations (ACCHOs).

E2. The Parties recognise:

a. that acute care, primary care and community health systems, including the ACCHO sector, are part of a whole care and support system and all governments play a collective stewardship role

b. all governments have a shared responsibility to improve people's health outcomes by supporting individuals, carers and their families to better navigate the health care system, with the aim of optimising equity, wellbeing and health outcomes, and reducing avoidable hospitalisations

c. the need to better plan and co-ordinate health services at the local level and agree to work together to strengthen regional planning and commissioning to provide culturally safe, person-centred, and place-based care.

Local Hospital Networks

E3. The role of Local Hospital Networks (LHNs) is to decentralise public hospital management and increase local accountability to drive improvements in performance. LHNs 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.

E4. LHNs 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.

E5. LHNs 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. LHNs are required to work with PHNs and ACCHOs to integrate services and improve the health of local communities.

E6. LHNs 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 in collaboration with PHNs and other providers where relevant, 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

h. collaborating with PHNs, ACCHOs, and private and non-government providers to meet the health and mental health needs of the community and minimise service duplication and fragmentation

i. Sharing information with PHNs on LHN-delivered primary care services (including associated workforce) to support Commonwealth monitoring of primary care services as per clause C19(a)

j. contracting ACCHOs to deliver secondary care services, where appropriate.

E7. The LHN Service Agreements are required to include at a minimum:

a. the number and broad mix of services to be provided by the LHN, to inform the community of expected outputs from the LHN and allow the Administrator to calculate the Commonwealth's funding contribution

b. the quality and service standards that apply to services delivered by the LHN, including the Performance and Accountability Framework (2011 NHRA) and health system performance assessment framework outlined in Schedule H

c. the level of funding to be provided to the LHNs under the Service Agreement, through ABF, reported based on the national efficient price, block funding and any other agreed funding arrangements, including Service Model Reform Funding

d. the teaching, training and research functions to be undertaken at the LHN level.

E8. Service Agreements are required to be publicly released by States and provided to the Administrator and relevant national bodies within fourteen calendar days of finalisation or amendment. States may agree additional matters with LHNs (such as the delivery of additional programs).

E9. LHNs 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.

E10. LHNs 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 LHN Service Agreement

b. ensuring accountable and efficient provision of services and producing annual reports, subject to State financial accountability and audit frameworks

c. monitoring LHN performance against the agreed performance monitoring measures in the LHN Service Agreement, as per clause E7

d. improving local patient outcomes and responding to system-wide issues

e. maintaining effective communication with the State and relevant local stakeholders, including clinicians and the community

f. developing partnerships with PHNs, ACCHOs, and other providers, to progress work such as joint regional needs assessments and planning.

E11. LHN 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 LHN wherever practicable

c. Aboriginal and Torres Strait Islander people with health and cultural expertise

d. cross-membership with Primary Health Networks wherever possible

e. where appropriate, people from universities, clinical schools and research centres

f. where appropriate or required, people with other skills and experience.

E12. LHN Governing Council members are required to be appointed under State legislation by State Health Ministers. Each LHN 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.

Local Hospital Network Structure

E13. LHNs are required to comprise single or small groups of public hospitals and health services with a geographic or functional connection, large enough to operate efficiently and to provide a reasonable range of hospital services, and small enough to enable the LHNs to be effectively managed to deliver high quality services.

E14. Types of LHNs include:

a. metropolitan LHNs, 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 LHNs, 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

c. other LHNs, bringing together an individual or groups of hospitals operated by third parties as public hospitals, including those operated by religious orders.

E15. In regional Australia, a flexible approach is required to determine the regional, rural and remote LHN structure that best meets the needs of these communities, including co-governance with Aboriginal and Torres Strait Islander communities where appropriate, and best take into account the challenges of managing multiple small hospitals.

E16. If over time States identify that significant changes are needed to roles and structures for LHNs, they are required to work with LHNs to deliver the adjustments necessary to respond to these changes, including the number and location of staff.

E17. LHNs are required to co-design through funded partnerships with NACCHO Affiliates and ACCHOs in their regions to comply with their requirements as government entities under the National Agreement on Closing the Gap. This includes to work in partnership with Aboriginal and Torres Strait Islander people to deliver culturally safe and appropriate care to communities. Where there are no ACCHOs, LHNs will co-design with other local Aboriginal and/or Torres Strait Islander led organisations.

Primary Health Networks

E18. Primary Health Networks (PHNs) are a national network of primary health care organisations that take a system-level approach to improving coordination, integration and capacity building across the primary care system within their designated geographic areas.

E19. PHNs are responsible for:

a. supporting system level planning of primary healthcare delivery

b. monitoring and reporting, jointly with Rural Workforce Agencies, on the status of the general practice workforce in their designated local area and general practices at risk of closure resulting in no access to primary care. The Commonwealth will consider opportunities to further scale-up and embed this function, where possible, including engaging with other local stakeholders, such as LHNs, as appropriate. identifying the health needs of their local areas, in partnership with LHNs and the ACCHO sector, to monitor and inform the development of relevant and responsive services

c. identifying the health needs of their local areas, in partnership with LHNs and the ACCHO sector, to monitor and inform the development of relevant and responsive services

d. working in partnership with LHNs, Rural Workforce Agencies, ACCHOs and other stakeholders to identify service gaps in GP and primary health care services at the local level and working with service providers and funders to put in place timely strategies to address these gaps

e. ensuring funded formal partnerships with the ACCHO sector

f. commissioning services to meet primary health needs in their region, including co-commissioning with LHNs, ACCHOs and other partners wherever relevant, including for mental health services and ensuring culturally appropriate services

g. improving the patient journey by integrating and coordinating primary care services with services across the care continuum from community to hospital-based care

h. providing support to clinicians and service providers to improve patient care

i. implementing primary health care initiatives and programs, including any relevant preventive health and population health activities

j. being efficient and accountable with strong governance and effective management

k. in rural and remote areas, partnering with Rural Workforce Agencies to ensure collaboration and coordination of recruitment and retention activities for the primary care workforce

l. partnering with LHNs, ACCHOs and other stakeholders to implement agile responses to support continuity of primary care services in line with the escalation pathway in Schedule C.

E20. To achieve this, the Parties acknowledge that PHNs engage with stakeholders across their local community, including LHNs, other health and care providers and government entities to support health system integration. This includes but is not limited to:

a. undertaking population health needs assessments (e.g. to understand prevalence of chronic disease, access issues for at risk populations) and service mapping

b. gathering and analysing data on service provider activity and emerging health needs to inform planning for new services, providers and workforce requirements

c. building connections across general practice, allied health, nursing and midwifery, mental health, drug and alcohol treatment, specialist, pharmacy, ACCHOs and other Aboriginal and Torres Strait Islander providers to facilitate multidisciplinary team care

d. building connections across public and private sectors, with LHNs, public health and community health services (including ACCHOs), national digital health and triage services (e.g. Healthdirect) to support efficient health system functioning

e. strengthening care pathways (including referral and discharge processes) in line with local, regional, State and national needs and priorities.

E21. The Parties acknowledge that changes to improve the PHN Program will be made over the life of this Addendum. Improvements to the PHN Program will aim to strengthen PHNs' capability and capacity, including to deliver on priorities identified in this Agreement. The Commonwealth will implement actions to strengthen PHN governance and accountability arrangements, uplift PHN performance, promote transparency and improve data intelligence capability. These improvements will support PHNs to work collaboratively with local stakeholders, including LHNs, to identify and flexibly address local needs and deliver national programs. Parties agree to be flexible and adaptive in response.

E22. The Commonwealth commits to supplying the annual PHN program performance report to HMM. This report will be publicly available to promote transparency and accountability of PHNs, including against indicators for stakeholder engagement.

Aboriginal Community Controlled Health Organisations

E23. The Aboriginal Community Controlled Health Organisation (ACCHO) sector is made up of individual organisations, state and territory level Affiliates and the National Aboriginal Community Controlled Health Organisation (NACCHO) at the national level. See Schedule B for more information about the ACCHO sector. Each of these organisations play critical roles across different levels of the health system:

a. An ACCHO is a primary health care service initiated and operated by the local Aboriginal and/or Torres Strait Islander community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a Board of Management elected by the local community

b. State and territory Affiliates represent ACCHOs and support sector development in their jurisdictions. Affiliates play a pivotal role in health system leadership and partnership across each State and Territory

c. At the national level, NACCHO plays a critical role as the leadership body for its member ACCHOs. NACCHO influences policymaking through strategic partnerships with government and the mainstream health sector.

E24. ACCHOs play an important role in supporting improved outcomes for Aboriginal and Torres Strait Islander people by:

a. providing a range of complex multi-disciplinary services, including but not limited to, delivering health, mental health, social and emotional wellbeing, early childhood, disability, family, youth and aged care support to Aboriginal and/or Torres Strait Islander people in their communities. The full scope of these services is detailed in the NACCHO Core Services Outcomes Framework

b. supporting system level planning of healthcare delivery for Aboriginal and Torres Strait Islander people

c. identifying the health needs of their local community to inform the development of relevant and responsive services

d. engaging in formal partnerships with PHNs and LHNs, where appropriate

e. engaging in opportunities for co-commissioning with LHNs, PHNs and other partners to meet the needs of the local Aboriginal and/or Torres Strait Islander community.

E25. ACCHOs are also key stakeholders that engage across their local community, including health and other care providers and government entities, to support better outcomes for their communities. This includes but is not limited to:

a. improving the patient journey by playing a care coordination role for Aboriginal and Torres Strait Islander people between community and hospital-based care

b. providing support to mainstream health providers to ensure they are accountable for delivering culturally safe and appropriate care to Aboriginal and Torres Strait Islander people

c. advocating for their communities' right to health and providing a leadership role in holding mainstream services (including hospitals) accountable for providing culturally safe and responsive care to Aboriginal and Torres Strait Islander people

d. approving and informing health related policy, initiatives and consultations which involve their communities.

E26. Parties formally acknowledge ACCHOs as an integral part of the health system and recognise the critical role they play in improving health and wellbeing outcomes for Aboriginal and Torres Strait Islander people.

E27. Parties agree to authorise ACCHOs as legitimate partners in the governance and planning of integrated health services at a regional level.

E28. Parties agree to provide funding to ACCHOs to support joint planning and co-commissioning of integrated health services.

Supporting more integrated local care delivery

E29. The Parties agree that optimal service delivery within any community relies on a commitment to collaboratively identify and prioritise health needs, implement plans and monitor and report outcomes to meet these needs.

E30. Strong local governance across care systems is integral to creating linkages between local services and addressing identified service gaps. Local governance is essential for supporting shared decision making, which is needed to address service gaps.

E31. To ensure effective local governance, the Parties agree to work together to support local, regional and State-level planning, decision-making and commissioning of health care services.

E32. The Parties acknowledge the diversity of service delivery in local communities and regions, and that a range of stakeholders will be included in regional planning and collaboration to commission services. This includes consumer representatives, non-government organisations, ACCHOs, and organisations delivering services that support the social and cultural determinants of health.

Joint governance, planning, and commissioning

E33. Models for commissioning health services should support providers to engage in shared planning, coordination, and integration of care across a treatment journey or whole life-course.

E34. The Parties agree to work together to strengthen regional planning and commissioning with the aim of improving system integration and coordination and achieving better outcomes for communities. Parties will consider ways of identifying, prioritising and addressing fragmentation, gaps, and duplication in service delivery.

E35. Parties acknowledge that local service commissioning and planning operates within a state-wide and national environment. The parties agree to embed national approaches with local responses, for example cross-jurisdictional investment in Healthdirect. These approaches reduce cost, duplication and fragmentation. It helps ensure health consumers have continuity of care when moving outside local boundaries, or receiving care from care providers beyond their local areas.

E36. The Parties recognise that service integration can only be achieved if:

a. there is greater collaboration across care settings, including shared decision-making, where appropriate

b. clinicians are engaged and supported to adopt new practices

c. patients and carers are empowered, particularly through co-design of services, collaboration with providers and expanded use of new and existing technologies

d. solutions are co-designed with ACCHOs and other Aboriginal and Torres Strait Islander organisations and experts. Partnering with ACCHOs should be consistent with the principles set out in the National Agreement on Closing the Gap to ensure relevant needs are appropriately and respectfully assessed and key decisions are shared

e. accountabilities are clear

f. there is a joint commitment across all organisations and governments that span the continuum of care, and efforts support the sustainability of participating organisations.

E37. As part of this shared commitment, the Commonwealth and each State will work together on joint state-wide planning by establishing and/or formalising governance and decision-making structures by December 2026 to:

a. facilitate collaboration between local health organisations, such as PHNs, LHNs, ACCHOs, as well as aged care, disability and primary health care organisations, and health consumer representatives to undertake joint needs assessments, plan and prioritise services and make investment decisions

b. develop commissioning arrangements that provide stronger support for local health organisations to co-ordinate care, test pooled funding with appropriate flexibility to respond to local needs (when agreed by all parties), and integrate health, disability, and aged care services

c. work towards equitable access to high quality health care, with a focus on embedding preventive care, and reducing disadvantage for all Australians, including for Aboriginal and Torres Strait Islander people and those living in rural and remote areas

d. establish shared reporting and accountability arrangements to effectively measure, monitor and evaluate the impact on population health outcomes, quality of health services and value at the local level, aligned with the health system performance assessment framework in Schedule H

e. identify and work to remove barriers to joint governance, joint needs assessment, service integration, evaluation, and funding, and streamlined reporting and data sharing at national and state levels

f. support health service access continuity through early identification and action to address workforce matters, including skills and capability gaps for the effective operation of health services, explore innovative workforce models, and support better care integration and coordination by enabling the workforce to operate to their full scope of practice.

E38. The Parties will develop a national framework to guide statewide regional planning and commissioning outlined in E37 by December 2026. This advice will need to provide clear direction on national standards, while recognising the unique requirements and needs in each jurisdiction and region including:

a. Conducting joint needs assessments

b. Developing agreed Joint Regional Health Plans

c. Sharing data and monitor outcomes

d. Commissioning services collaboratively to address local needs.

E39. The Commonwealth and each State’s shared and agreed governance structure should:

a. include, at a minimum, representatives from Commonwealth, State and Territory agencies, LHNs, PHNs, the ACCHO sector and peak consumer bodies

b. include senior executive and other relevant staff/members to ensure an authorising, enabling and dynamic environment. Larger jurisdictions should have a tiered governance structure and part of the governance structure should have a decision-making responsibility particularly for collaborative commissioning priorities and investments

c. identify and develop foundational elements to support shared responsibility and priorities for the local health care system. These include funding options, linked data arrangements and sets, an environment for sharing and discussing insights, strategic planning and the commissioning of services and projects

d. work together to determine the needs of local communities, through joint needs assessments to identify gaps, duplication and inefficiency, within their region based on evidence and data and consultation within their communities, including system users and carers with lived experience who are representatives of their local communities

e. plan, design and evaluate health care to respond to the needs of local communities

f. coordinate and integrate care across the health care system and support transition between health and non-health services

g. bring perspectives from national and statewide policy leaders, and provide a platform for local insights to inform national and statewide policy.

E40. The Parties agree to support PHNs, LHNs, ACCHOs, peak consumer bodies and other state-based commissioning bodies to engage in regional planning and commissioning activities by improving the transparency of health services spending and outcomes delivered by:

a. establishing shared reporting through development of Joint Regional Health Plans and reported on through regional commissioning arrangements

b. establishing shared accountability across levels of Government under the governance structures of this Addendum

c. working towards streamlining reporting and accountability requirements for service delivery organisations.

E41. PHNs and LHNs will be expected to share some common membership of their governance bodies and work closely to establish formal engagement protocols. This includes a commitment to multi-way data sharing in alignment with the national governance framework to be developed under Schedule H (National Health Data System), including for hospital services, community and primary care, NDIS and aged care services and workforce.

E42. The Parties will work cooperatively to ensure, wherever possible, there are common geographic boundaries between PHNs and LHNs including where States maintain or introduce arrangements for cross-border LHNs.

SCHEDULE F – BETTER HEALTH EQUITY FOR RURAL AND REMOTE COMMUNITIES

F1. This schedule outlines reforms that will help achieve equitable health outcomes and access to health services for people living in rural and remote Australia. Rural and remote communities can face unique challenges accessing health care. Service systems can be fragile as they rely on a small number of providers, with well-recognised workforce recruitment and retention issues, and there can be geographic barriers to accessing tertiary and specialist care.

F2. Roles and responsibilities under this Schedule are in accordance with those set out in the Preliminaries and in Schedules C and E, which also pertain to health services in rural and remote areas.

F3. All Parties recognise:

a. ACCHOs and other Aboriginal and Torres Strait Islander community-controlled organisations as legitimate and critical partners in the rural and remote service system

b. the importance of culturally appropriate, sustainable healthcare services and the need to deliver on commitments in Schedule B to improve health outcomes for Aboriginal and Torres Strait Islander people

c. the need for an equitable response to address the more complex needs in rural and remote communities

d. the need to provide all patients with access to essential health services as close to their home as is feasible.

F4. The Parties acknowledge that cross-agency partnerships and targeted work on the social and environmental determinants of health, such as housing, education, employment, and childcare, are also fundamental to improving outcomes for current and future generations living in rural and remote areas.

F5. This Schedule will prioritise rural towns and remote communities, according to relevant geographical classifications, that have inequities in health outcomes and health service access compared to metropolitan areas. This approach acknowledges that existing geographical classifications are used for different purposes, and that reviews and updates to data may change classifications from time to time.

F6. To implement this Schedule, Parties commit to a focus on rural and remote communities and services under the following key reforms outlined in other Schedules:

a. Schedule A – funding reforms, including reviews of pricing adjustments for Indigenous status and rural and remote status, and a review of block-funded services and their categorisation/classification

b. Schedule B – operationalising the National Agreement on Closing the Gap

c. Schedule C – governance and escalation pathways for primary care market performance and interface issues

d. Schedule D – delivering optimal models of care that support improvement in service delivery and provide more flexible pricing and funding arrangements

e. Schedule E – local governance arrangements, including joint commissioning

f. Schedule G – health workforce reforms, including a commitment to the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031

g. Schedule H – performance reporting including indicators, benchmarks and disaggregated data by geographical area and for priority population groups where appropriate.

Access to services

F7. The Parties recognise the strengths of rural and remote communities and acknowledge areas of excellence in health service delivery.

F8. The Parties also recognise that it is not always practicable or efficient to deliver the same range of health services in the same way across rural and remote areas due to factors such as geographic distance, smaller populations, cultural context, and workforce availability.

F9. The Parties commit to providing access to quality and affordable health care to all Medicare-eligible persons, regardless of where they live.

F10. For people living in rural and remote communities, where possible, service delivery models should focus on the needs and preferences of the person receiving care. Rural and remote service delivery may include a combination of in-person services, virtual care, and remote monitoring, with the mode determined by clinical indications, patient safety, quality of care, and where practicable, patient preference.

F11. The Parties acknowledge that in rural and remote areas, services are not always commercially viable or sustainable so alternative models of care may be needed to support access to general practitioner services and multidisciplinary care.

F12. In line with the principles of market stewardship at Preliminaries clause 20, the Commonwealth is committed to regular market monitoring of primary care, aged care and NDIS services, in collaboration with LHNs and ACCHOs, and addressing the spectrum of market sustainability that can impact delivery of services in rural and remote regions. The States are committed to regular monitoring of public hospitals.

F13. Where it is not feasible for services to be delivered locally, Parties will work collaboratively, in line with their roles and responsibilities, to take appropriate actions that may include:

a. transporting patients to and from locations (including accommodation) where services are available, giving regard to patient circumstances and the principles of person-centred care

b. organising regular visits from health practitioners into rural and remote areas, including specialists, allied health and primary care providers

c. using digital and other technologies so services can be delivered remotely (where reasonable, noting the constraints of telehealth and variance in access to digital infrastructure)

d. supporting local practitioners (such as paramedics, nurse practitioners, registered nurses, general practitioners, allied health professionals, Aboriginal and Torres Strait Islander health workers, Aboriginal Health Practitioners) to work to their full scope of practice by removing impediments and supporting them to upskill

e. funding alternative services or models of care that respond to the health and wellbeing needs of each community, including culturally safe services for Aboriginal and Torres Strait Islander people.

Flexible models to support better health equity for rural and remote communities

F14. The Parties agree to work cooperatively over the course of this Addendum on reforms to better meet community needs and preferences across rural and remote areas.

F15. To develop, trial and evaluate reforms that support rural and remote areas, all Parties:

a. recognise and support the need for joint governance, planning and commissioning of health services, as set out in Schedules C and E

b. agree to use the processes set out in Schedule D, which outline how the following types of initiatives can be progressed:

i. implementing expanded scope of services and service models that help reduce avoidable hospital admissions

ii. payment reforms to support optimal models of care

iii. embedding prevention and preventive health action

iv. service model and funding reform through the Service Model Reform Funding stream.

F16. The Parties commit to key health workforce reforms outlined and further developed in Schedule G and any subsequent actions to build and retain a sustainable health workforce in rural and remote areas.

Initiatives to support better health equity for rural and remote communities

F17. The Parties agree that:

a. block funding will continue for relevant services in rural and remote communities, as per Schedule A, with a commitment to greater transparency, which is needed to progress payment reforms and innovative models of care

b. the IHACPA will review the methodology for determining pricing adjustments as per clause A64 in relation to:

i. Indigenous and rural and remote status

ii. baseline financial viability of smaller jurisdictions.

F18. Parties agree that the Commonwealth, in consultation with states, will lead development of a paper for HMM consideration by December 2026 that examines options to support better health equity in rural and remote areas. The paper to HMM may include options such as:

a. pooling funds for care services, particularly in Modified Monash Model areas MM 6 and MM 7, aimed at improving sustainability of services

b. trialling new payment approaches and innovative service models, potentially as a mechanism to address higher rates of potentially preventable hospitalisations in rural and remote areas, as per Schedule D

c. mechanisms to support joint commissioning and integrated services across health, aged care and disability in rural and remote areas, as per Schedule E

d. flexible provider and employment models for primary care services, including enabling multidisciplinary teams to deliver primary healthcare with appropriate safeguards in place, predominantly in MM 4 to MM 7 areas

e. funding primary care services typically delivered within a general practice or equivalent setting, as per Schedule C

f. mechanisms aimed at improving access to primary care and specialist services.

F19. The report should include detail on how proposals could be progressed through reforms outlined at F6, or if new reform mechanisms would be needed to implement the proposals.

F20. The Parties commit to working together to consider the findings of the evaluation of the COAG Section 19(2) Exemptions Initiative as per the *Memorandum of Understanding in relation to the cooperative implementation of the Council of Australian Governments improving access to primary care in rural and remote areas initiative*. The findings will be used to inform development and delivery of appropriate locally driven, place-based solutions to support improved primary care access in rural and remote areas.

F21. If indicated by the evaluation findings, the Parties agree to seek opportunities to simplify and streamline the COAG Section 19(2) Exemption Initiative, to ensure it supports policy, legislative and regulatory requirements.

SCHEDULE G – HEALTH WORKFORCE

G1. To achieve the goals of this Addendum, it is vital that Australia's health system has a sufficient and skilled health workforce. The health workforce should be resilient, sustainable, and capable of delivering quality health services that meet the increasingly complex needs of the population. This schedule commits Parties to:

a. working together to deliver high quality, multidisciplinary, connected, culturally safe, and responsive care across all health settings

b. achieving optimal patient outcomes and experiences by ensuring the right care is provided in the right place, at the right time, regardless of where people live.

G2. The Parties acknowledge:

a. the importance of national strategic workforce planning, informed by robust data and evidence, to understand and prepare for future health workforce needs and challenges and the importance of translating national strategic planning into local place-based solutions

b. the need to maintain a focus on the drivers for workforce demand and workforce maldistribution to understand how and whether these drivers should be addressed through policy and program responses. Key drivers include (but are not limited to):

i. population growth and ageing

ii. geographical distribution and access

iii. rates of chronic conditions

iv. changes in health service utilisation trends, including due to emerging technologies

c. an accessible and sustainable health workforce, that is responsive to change and working to its optimal scope of practice, will lead to better health outcomes for all people appropriate to context and setting

d. the need to augment generalist workforce models in support of effective and sustainable rural and remote healthcare

e. the need to ensure regulation, including through legislation, guidelines, standards and the National Law, enable the effective and efficient utilisation of the health workforce to better align with community expectations

f. to ensure the health workforce can respond to external shocks and pressures, including pandemics and climate change, there is a need to collaborate and commit to build robust governance and workforce monitoring

g. the need to grow and sustain a strong domestic health workforce, enabled through a robust system of training, support and employment opportunities across vocational education and training (VET), tertiary, prevocational, vocational, and workplace education in public, private and community settings aligned to service need, place and context

h. facilitating migration for internationally trained health professionals as an important part of sustaining Australia's health workforce, and Australia's existing commitment to comply with the WHO Global Code of Practice on the International Recruitment of Health Personnel

i. the unique challenges of the rural and remote health workforce such as geographic distance, smaller populations, cultural context, and workforce availability and poorer health outcomes

j. existing initiatives underway must be considered when developing new reforms, including initiatives focusing on different workforce professions (e.g. medical, nursing, midwifery, allied health, Aboriginal and Torres Strait Islander), workforce sectors (e.g. mental health, primary care, aged care and maternity care) and workforce development components (e.g. training, supply, accreditation)

k. Aboriginal and Torres Strait Islander people working in the health workforce, including clinical and non-clinical staff, can experience harm from racism and discrimination. Parties will work together to improve cultural safety in the workplace for Aboriginal and Torres Strait Islander people in the health workforce and address racism at the institutional level

l. the importance of a culturally safe workforce in supporting improved access to culturally safe health services and better health outcomes for Aboriginal and Torres Strait Islander people

m. culturally and linguistically diverse (CALD) health professionals can experience harm from discrimination and racism. Parties will work together to support CALD health professionals to feel valued and culturally safe in their workplace through initiatives that improve cultural safety and address racism where it arises in workplaces.

Shared responsibilities, stewardship and governance

G3. The Commonwealth is responsible for oversight of national health workforce planning and is a central driver of governance to advance workforce priorities. This role is underpinned by a shared responsibility and commitment from all jurisdictions to meaningfully engage in collaborative reform efforts, as outlined in the Preliminaries, clause 26(c). The responsibilities of Parties are further outlined in the Preliminaries.

G4. All Parties commit to national health workforce planning by collaborating at the regional and local levels with key sector stakeholders, including Local Health Networks, Aboriginal and Torres Strait Islander organisations, universities, the vocational education and training sector, unions, peak bodies and professional colleges and/or associations, regulators, health economists and the private sector.

G5. The Health Workforce Taskforce (HWT) will provide stewardship and governance of planning objectives, actions and implementation of this schedule, reporting to HCEF and HMM as outlined in Preliminaries clause 42.

G6. In line with its Terms of Reference, HWT will develop an annual workplan which:

a. sets out the strategic priorities and areas for cross-jurisdictional collaboration, including stewarding implementation of this schedule

b. supports national modelling of future workforce supply and demand using quantitative projections as well as qualitative methods to support transformation of health services

c. provides workforce insights to inform national and jurisdictional investment decisions on workforce

d. develops accountability measures for the delivery of initiatives in response to national strategic workforce planning.

G7. The workplan will be agreed by HCEF and HMM. HWT will report on the HWT annual workplan to HCEF every May, starting with May 2027.

G8. Recognising the breadth of work outlined in the schedule, HWT will draw on appropriate expertise in line with its Terms of Reference as needed to implement actions of the schedule. This may include:

a. sub-groups to manage different streams of work

b. working groups or reference groups for coordination and implementation of priority projects

c. consulting with other organisations as required in carrying out its functions.

National Strategic Workforce Planning

G9. The Parties acknowledge the need for meaningful access to data to inform jurisdictional, local and regional workforce and service planning. The Parties acknowledge that forecasting workforce demand based on current patterns of utilisation is an insufficient basis for determining future health workforce needs and that national strategic workforce planning must also embrace purposeful collaborative design of future healthcare systems based on population need.

G10. The Parties commit to developing a shared evidence base, including exchange of relevant data and the use of nationally consistent data sets that enhances workforce planning. This shared evidence base will underpin collaborative national strategic workforce planning and guide the HWT annual workplan. It will also support the achievement of the following outcomes:

a. a more integrated approach to addressing workforce maldistribution, especially in rural and remote areas, including how best to deploy workforce across the continuum, to improve access to services for all Australians

b. increased and better collaboration between governments, education and training providers, post-graduate councils, professional colleges and/or associations and other relevant bodies to inform the coordination, setting and distribution of prevocational and vocational training numbers and capacity building efforts.

G11. By February 2027 HWT will agree the following parameters that will inform the evidence base and guide work described at clause G6 over the term of this Addendum. These parameters will be documented in an update to the HWT annual workplan.

a. The objectives of national strategic workforce planning.

b. The workforce planning methodology, based on population need, including key indicators that will be used.

c. How this enables cross collaborative workforce planning and reform at a state/territory and Commonwealth level.

d. A plan for data provisions and data sharing requirements.

e. Regular review points to maintain currency with the evolving needs of national strategic workforce planning, with urgent matters reviewed by exception.

Strengthening health workforce data to enable national strategic workforce planning

G12. The Parties recognise and commit to best endeavours to support data standardisation and sharing as a key enabler of building the evidence base for national strategic workforce planning and development, noting that some data sets are held by the Commonwealth only. This includes:

a. agreeing the data needed for workforce supply and demand modelling and workforce planning, including working towards and implementing nationally consistent data standards and definitions for the data on health workforce practitioners

b. collaboration on and commitment to ongoing data sharing, including required legislative reforms to remove barriers to data collection and sharing

c. commitment to an improved, nationally consistent data collection system that supports better data modelling, analysis and sharing

d. recognising the principles of Indigenous Data Sovereignty as outlined in Schedule B and prioritising shared access to data in line with Priority Reform Four of the National Agreement on Closing the Gap

e. agreeing to undertake data modelling that differentiates clearly between sectors in recognition that the demands, models of care, and service delivery characteristics influence modelling outputs. This includes between health (acute and primary care), aged care and disability sectors, rural and regional, as well as between health professions such as doctors, nurses, midwives and allied health professionals. It is noted that states and territories do not have access to aged care and disability data

f. ongoing refinement and tuning the methodology to ensure modelling processes and outputs remain useful for developing timely solutions

g. support for public transparency through regular publication of workforce trends and forecasts

h. workforce data being considered during the development of the health system performance assessment framework in Schedule H.

G13. This work will be led by HWT, in consultation with the Parties, Aboriginal and Torres Strait Islander health workforce peak organisations, the Aboriginal and Torres Strait Islander Health Collaboration and other subject matter experts. The work will progress in parallel with performance reporting and system-wide data reforms as outlined in Schedule H.

G14. The Parties will further agree elements of workforce data to be included in the performance assessment framework (Schedule H) by June 2028.

National workforce strategies and reviews

G15. Implementing health workforce priorities requires a coordinated approach across Commonwealth, State and Territory governments. All Parties commit to working collaboratively, including recognising skills and capabilities across health professions, implementing training and education reforms, and harmonising regulation outcomes including legislation and guidelines.

G16. In progressing shared national priorities agreed under this Schedule, the Parties will have the flexibility to prioritise health workforce reforms according to local needs and priorities.

G17. The Parties agree to work together and with key stakeholders, including Aboriginal and Torres Strait Islander organisations, to develop a program of reform in the HWT annual workplan described in clause G6. The program of reform will be informed by the national strategic workforce planning described in clause G11 and from emerging and existing workforce priorities, national workforce strategies and targets including (but not limited to):

a. National Agreement on Closing the Gap

b. National Aboriginal and Torres Strait Islander Health Plan 2021–2031

c. National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031

d. National Nursing Workforce Strategy (once finalised)

e. Independent review of Australia's regulatory settings relating to overseas health practitioners Final Report (Ms Robyn Kruk AO)

f. Nurse Practitioner Workforce Plan

g. National Maternity Workforce Strategy (once finalised)

h. National Medical Workforce Strategy 2021-2031

i. National Allied Health Workforce Strategy (once finalised)

j. Unleashing the Potential of our Health Workforce (Scope of Practice) Review

k. Working Better for Medicare Review

l. Stronger Rural Health Strategy

m. National Registration and Accreditation Scheme Complexity Review and relevant reviews and reports from the National Health Practitioner Ombudsman's

n. National Health and Climate Strategy

o. National Mental Health and Suicide Prevention Agreement

p. National Mental Health Workforce Strategy 2022-32.

G18. Parties acknowledge that there are common themes that have emerged across national workforce strategies outlined at clause G17 that impact the entire health workforce. There is need for collaborative actions to address these issues. The following themes are a focus for health workforce reform over the term of this Addendum:

a. better aligning health workforce distribution to areas of need, particularly in rural and remote areas

b. growing and supporting the Aboriginal and Torres Strait Islander health workforce

c. ensuring cultural safety of Aboriginal and Torres Strait Islander health professionals and consumers

d. improving the wellbeing and culture of the health workforce

e. supporting and resourcing health professionals to supervise and train future health professionals

f. supporting health professionals to work to optimal scope of practice

g. adapting and supporting new models of care.

G19. By July 2026 Parties will develop a program of reform to address priority joint actions of the Scope of Practice Review that have been agreed by HMM. This will be incorporated in the HWT annual workplan, as described in clause G6.

G20. Parties agree an initial focus will be to undertake harmonisation of scope of practice outcomes through changes to regulation including legislation and guidelines to enable a wider range of health professionals to undertake restricted activities consistent with their scope of practice. Parties will:

a. Commence with an initial tranche targeting harmonisation outcomes focussed on prescribing and the Drugs and Poisons Acts by December 2026

b. Consider further tranches of harmonisation to follow, such as work aligned to the Radiation Safety Acts and Mental Health Acts.

Reducing complexity in the National Registration and Accreditation Scheme

G21. Parties acknowledge the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions (IGA NRAS), signed on 26 March 2008, as the foundational agreement establishing a nationally consistent approach to the registration and accreditation of health professionals in Australia. Parties reaffirm their commitment to arrangements established under the IGA NRAS and ongoing oversight of the NRAS.

G22. The Review of Regulatory Complexity in the NRAS (Complexity Review) aimed to improve regulatory outcomes and keep Australians safe by removing complex or unnecessary processes of the NRAS. Parties acknowledge that the recommendations in the final report, “Transforming health professions regulation in Australia”, are founded on the principles of regulatory stewardship, evidence-based decision-making, and collaboration across sectors.

G23. The HWT will oversee the implementation of actions endorsed by Health Ministers and will develop a Complexity Review Implementation Plan by March 2026. This will be incorporated in the HWT annual workplan, as described in clause G6.

G24. Parties agree to undertake regular evaluation of the NRAS as stewards through the IGA NRAS. This will be a time limited evaluation every 5 years, resourced through the HCEF cost-shared budget and aligned with the timeframes of the NHRA mid-term review described in Preliminaries clause 47.

Growing and supporting the Aboriginal and Torres Strait Islander health workforce

G25. All Parties recognise that systemic and interpersonal discrimination and racism in the health system leads to negative health outcomes that widen the gap in health inequities experienced by Aboriginal and Torres Strait Islander people.

G26. All Parties further recognise that Aboriginal and Torres Strait Islander people working in the health workforce, including clinical and non-clinical staff, can experience the same discrimination in health systems as Aboriginal and Torres Strait Islander patients.

G27. Aboriginal and Torres Strait Islander people in the health workforce have unique skills that deliver culturally safe and responsive care that improves outcomes for Aboriginal and Torres Strait Islander people and communities.

G28. All Parties recognise their shared responsibility to ensure a culturally safe, responsive workforce to improve Aboriginal and Torres Strait Islander experiences and outcomes in the health system. This includes:

a. growing the Aboriginal and Torres Strait Islander health workforce across all settings, including clinical, non-clinical and leadership roles

b. strengthening the cultural capability of non-Indigenous health workforces

c. increasing cultural safety and addressing racism at the institutional level.

G29. All Parties agree to work in partnership with Aboriginal and Torres Strait Islander organisations through the HWT Subcommittee (National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan Working Group) to grow and support Aboriginal and Torres Strait Islander health workforces by:

a. implementing commitments under the National Agreement on Closing the Gap and the National Aboriginal and Torres Strait Islander Health Plan 2021-2031

b. implementing the strategic directions and priority strategies of the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 (see clauses B18 and B84)

c. Taking action to embed cultural safety and address racism in healthcare workforce environments in line with clauses B59 to B71

d. Co-designing nationally consistent workforce cultural safety measures for inclusion in the performance assessment framework as outlined in clause H13.

G30. All Parties will work in partnership with Aboriginal and Torres Strait Islander organisations in developing actions to grow, monitor and sustain the Aboriginal and Torres Strait Islander Health Workforce, recognising the role of this specialised workforce in improving outcomes for Aboriginal and Torres Strait Islander people.

Sustainability and training of the health workforce

G31. All Parties recognise the health workforce needs to be suitably trained, innovative, digitally enabled, adequately resourced and distributed, supported to work to its optimal scope of practice, and responsive to change aligned to service need, place, and context.

G32. Parties will support the health workforce to increase capability and deliver early intervention and prevention activities, including innovative and integrated care models, and evaluate their impacts.

G33. Parties will also seek to:

a. increase the capacity and capability of the health workforce, including ensuring they are prepared for future health system developments such as increased use of artificial intelligence and genomics

b. strengthen the nation’s preparedness and responsiveness to health emergencies, including through partnerships with Aboriginal Community Controlled Health Organisations (e.g. pandemics, climate-related disasters and extreme weather events)

c. consistent with work health and safety legislative duties, work together to improve and protect the physical and mental health and wellbeing of the health workforce, in particular during health emergencies by developing a workforce wellbeing consensus statement for endorsement by HMM by December 2027

d. support a focus on the intersection between hospital-based and primary care training and identifying training opportunities for junior doctors to develop key skills in general practice primary care, such as the rural generalist pathway.

G34. Where initiatives of this schedule relate to the work of the Australian Centre for Disease Control (ACDC), Health Workforce Taskforce will engage with the ACDC.

G35. Parties acknowledge the sustainability of the health workforce relies on teaching and training activities. Parties agree better transparency of teaching, training and research funding would support the objectives of this schedule. Improvements in transparency of teaching, training and research funding will occur through commitments described at clauses A72(e), A132, A172 and A178.

SCHEDULE H – PERFORMANCE, DATA AND DIGITAL REFORMS

H1. This Schedule sets out key enabling activities needed to embed stronger, shared system stewardship of national health reforms and deliver the outcomes Parties have committed to, as articulated in the Preliminaries. It contains three elements: Transparency and performance; National Health Data System; and Digitally enabled healthcare.

H2. The Schedule set outs out an aspirational and long-term reform vision that will extend beyond the life of this Addendum. In outlining the key areas for focussed and cooperative efforts, the Parties recognise that the timing and implementation of reforms may be subject to decisions of governments and jurisdictional budget processes.

H3. The Parties recognise that funding, and workforce capability and capacity are critical dependencies in delivering the reforms contained within this Schedule.

Transparency and performance

H4. The Parties recognise that regular and ongoing performance assessment is necessary for achieving this Addendum's vision of a person-centred, equitable, responsive, and financially and environmentally sustainable health system. A new health system performance assessment framework will underpin a shared understanding of how the health and adjacent care systems work together to integrate care and improve outcomes for all Australians.

H5. The Parties define a health system performance assessment framework as a structured and organised way to collect, analyse and present information and provide insight on the performance of the health system. The framework will identify areas needing improvement and support decision-making and resource allocation across the health care and adjacent systems. It will also be used to assess progress of the Addendum in achieving its objectives, in accordance with clause 12 (Preliminaries).

H6. The Australian Institute of Health and Welfare (AIHW) will work with the Parties and other key stakeholders to develop a new health system performance assessment framework which contemporises and replaces the Australian Health Performance Framework and is informed by international best practice relevant to Australian priorities. The new framework will be the foundation for ongoing NHRA performance reporting and broader health performance reporting in Australia.

H7. The Parties agree that the performance assessment framework will be delivered in stages and will evolve over time as data access and sharing improves and digital systems mature.

H8. Regular monitoring against a contemporary health system performance assessment framework will increase transparency with clear lines of governance, accountability, and reporting. It will provide timely measurement and actionable information to Health Ministers and other key stakeholders with responsibility for enacting change within and across systems. It will enable governments to take a more active approach to improving services and system management in collaboration with sector leaders. Implementation of the framework will also support broader improvements in access and consistency of health systems performance data.

H9. Measures of governments' progress towards improving access, health outcomes and equity for Aboriginal and Torres Strait Islander people will be co-designed in partnership with Aboriginal and Torres Strait Islander stakeholders outlined in Schedule B.

H10. The health system performance assessment framework will:

a. monitor the whole health system by providing a common set of domains and a structured process to support systematic assessment of overall performance. This includes prevention, primary, secondary, and tertiary services, programs, strategies and agreements across public, private and community settings

b. measure how effectively all elements of the health and adjacent care systems work together and inform policy to improve patient outcomes

c. support mutual understanding of emerging pressures and the capacity of the system to respond to these pressures, including to progress towards a net-zero, climate-resilient health system

d. specifically monitor progress against the objectives of this Addendum including its outcomes, focussed on appropriate care, quality care, equitable access and health outcomes, value and governance (refer Preliminaries clause 12), and have a stronger focus on enabling domains, such as workforce

e. disaggregate performance reporting and insights by geographical area and for priority population groups where appropriate, including but not limited to Aboriginal and Torres Strait Islander people, women and gender diverse people, people living with disability, and culturally and linguistically diverse communities. Analyses will consider contextual factors, including social and environmental determinants of health

f. support navigation to a curated collection of existing health system information, reports, frameworks and indicator data. A quality assurance process as part of the review (clause H15(b)) will support a broad range of users to discover and access these resources more easily and make the information more influential. The review will be informed by the data management and stewardship principles of findability, accessibility, interoperability, reuse of digital assets and governance of Indigenous data

g. support continuous quality improvement through stakeholder input and an ongoing cycle of monitoring, evaluating, and updating arrangements for system performance data development, collection, analysis, interpretation and reporting.

H11. In implementing the performance assessment framework, the Parties will minimise duplication of effort and burden on data providers by:

a. building on Australia's long history of health system performance reporting and wealth of established data and information

b. ensuring the national framework complements effective existing performance reporting arrangements where they are fit for purpose

c. rationalising parallel indicator and performance reporting obligations

d. balancing demands for timely data with the costs of collection for each intended use

e. considering the relative importance of indicators and other ways to gain insights to inform policy action

f. increasing the efficiency, quality, timeliness and accessibility of health system data and performance reporting through the development and use of digital technologies, where appropriate

g. ensuring outcome domains and performance measures are nationally consistent, able to provide valid comparisons, and are fit for purpose.

H12. The Parties agree to develop indicators and reporting for performance priorities identified by Health Ministers. Parties agree initial priorities should include:

a. Aboriginal and Torres Strait Islander people's experiences, including cultural safety and racism

b. preventive health

c. long-stay patients in hospitals

d. system performance at the acute, primary, aged and disability care interfaces

e. patient reported outcomes and experiences

f. levels of unmet need.

H13. The Parties recognise the need for specific measures for cultural safety and quality care for Aboriginal and Torres Strait Islander people and will work to develop nationally consistent measures for inclusion in the performance assessment framework. These may include:

a. cultural safety and appropriateness of healthcare services for Aboriginal and Torres Strait Islander people

b. Aboriginal and Torres Strait Islander workforce and leadership roles within mainstream organisations

c. the impact of racism on Aboriginal and Torres Strait Islander people's health outcomes.

Principles

H14. Australians are entitled to accessible information on the status, quality and performance of the health system.

H15. Health system performance reporting will be:

a. comprehensive, impactful, and timely – it will prioritise actionable information for health leaders, including Health Ministers, and will include a range of reporting products to meet the needs of these audiences

b. regular and responsive – existing stable mature data sets will support long-term trend monitoring and more timely data will provide signals to the system when emerging issues require investigation and intervention. Qualitative information will complement quantitative data to support meaningful insights and inform policy responses

c. tiered and fit for purpose – reporting will be provided at the lowest meaningful level of granularity, in line with best practice and subject to any applicable privacy legislation.

Deliverables

H16. The Parties agree that the following products and activities will deliver improved health system performance reporting to support this Addendum in achieving its objectives:

a. the new health system performance assessment framework provides a contemporary conceptual model to define and shape future performance, assessment and reporting

b. a performance reporting indicator development and review mechanism to harmonise indicator collection and performance reporting obligations and work towards addressing persistent gaps in health system performance monitoring

c. an annual report card for Health Ministers, with high-level, impactful reports containing meaningful measures of progress against their shared aspirations for the health system and priority objectives of this Addendum

d. an annual Aboriginal and Torres Strait Islander health report card for Health Ministers highlighting health system performance against a set of headline Aboriginal and Torres Strait Islander health indicators specific to the NHRA and the National Agreement on Closing the Gap

e. an 'NHRA Tracker' to Health Chief Executives, providing comprehensive reports on progress towards NHRA objectives using a combination of agreed qualitative information and metrics

f. a national health performance portal will provide supported navigation to quality assured government, academic and private sector resources. The portal will include standardised data sets, performance metrics and insight reports that interpret the data

g. an agreed process will be established for engaging with the community to identify priority areas for policy development, regularly test what measures and methods of reporting are meaningful to inform the community about the state of the Australian health system.

Implementation

H17. The AIHW will lead this work in collaboration with all jurisdictions, the Australian Commission on Safety and Quality in Health Care (ACSQHC), the Independent Health and Aged Care Pricing Authority (IHACPA), the National Health Funding Body, other relevant data custodians and health data governance bodies, including Aboriginal and Torres Strait Islander governance arrangements outlined in Schedule B.

H18. The AIHW will work in partnership with Aboriginal and Torres Strait Islander experts and the Aboriginal and Torres Strait Islander governance groups outlined in Schedule B to develop measures and reporting on governments' progress towards improving health system responsiveness to the specific needs of Aboriginal and Torres Strait Islander people.

Milestones

H19. The Parties agree that by 30 September 2026, AIHW will have:

a. reviewed existing frameworks, indicators and reporting commitments.

b. developed a new health system performance assessment framework to replace the Australian Health Performance Framework.

c. commenced work to address core gaps in health system performance monitoring.

H20. By 30 June 2027, the Parties will work with relevant HCEF sub-committees and the AIHW to develop the 'NHRA Tracker' for Health Chief Executives.

H21. The Parties agree that by 30 June 2027, the AIHW will have:

a. designed and produced the annual report cards for Health Ministers and the Aboriginal and Torres Strait Islander governance groups.

b. launched the national health performance portal.

c. commenced sector and community engagement activities.

H22. Over the life of the agreement, the AIHW will:

a. produce annual reports for Health Ministers, Health Chief Executives and the Aboriginal and Torres Strait Islander governance groups in Schedule B.

b. maintain the national health performance portal.

c. review and evaluate the health system performance assessment framework and its conceptual model.

Governance

H23. HCEF and its sub-committees will ensure these performance reporting arrangements meet Health Ministers' expectations by:

a. communicating priorities for the AIHW's work program and reviewing progress at an annual review.

b. considering the policy implications of health performance data and coordinating the insights and recommendation report as part of the annual performance report to Health Ministers.

c. responding to early signals and trends in the performance reporting and directing investigation and response by the accountable parties.

H24. The AIHW will work with jurisdictional, academic and private sector subject matter experts, national bodies, Aboriginal and Torres Strait Islander health organisations and experts in the interfacing care systems to:

a. agree a process for identifying early signals and trends

b. review and advise on the specifications for performance measures

c. agree the provision of data by the Parties to the AIHW for use in performance monitoring and reporting

d. ensure accurate analysis and interpretation of shared data.

H25. The Parties remain responsible for jurisdictional reporting of performance information outside the scope of NHRA reporting. Where possible, jurisdictional reporting should align with the health system performance assessment framework.

National Health Data System

H26. The Parties agree that safe and secure data sharing and governance is necessary to deliver meaningful health system improvement and health reform objectives of this Addendum.

H27. Data is required across health and related care sectors, such as acute, primary, disability, and aged care, for evidence-based planning and decision-making. Information must flow between multiple system managers, contingent on their data needs.

H28. The Parties agree to reduce information silos and work together to maximise the value of data. Harnessing data allows governments, national bodies, healthcare providers and researchers to develop evidence-based policies and services for Australians.

H29. Safe and secure data sharing and governance is needed to deliver other health reform proposals, including service model reform (Schedule D) and nationally cohesive health technology assessment (Schedule A), reform priorities for Aboriginal and Torres Strait Islander people (Schedule B), interface reforms, including for older Australians and people with disability (Schedule C), and workforce planning (Schedule G).

H30. All Parties commit to:

a. normalising multi-way data sharing and access across the health system while maintaining data security and preserving individuals' privacy

b. working together to harness data and analytics to drive meaningful improvements in the health system

c. facilitating timely access to data, including for national bodies, for health systems monitoring, planning, policy- and decision-making

d. closing data gaps in patient pathways across the health and care systems.

e. developing a sustainable national approach to data governance, platforms and data linking that limits duplication of effort and ensures all parties can leverage data opportunities

f. deliver enduring and more timely linkages of high-value health datasets.

H31. All Parties further commit to implementing Indigenous data governance principles, and facilitating data access and sharing for Aboriginal and Torres Strait Islander-led data outcomes as agreed in Schedule B. In line with the Priority Reforms under the National Agreement on Closing the Gap, this includes:

a. partnering with Aboriginal and Torres Strait Islander people

b. building data-related capacity and capabilities within governments and across the health sector

c. maintaining transparency of data holdings

d. building an inclusive data system that reflects Aboriginal and Torres Strait Islander perspectives and facilitates the integration of governance of Indigenous data principles.

H32. All Parties commit to building data-related capacity and capabilities within governments and across the health sector, including the ACCHOs, to facilitate data outcomes as agreed in this Addendum.

H33. The following principles will ensure strategic alignment across governments when developing a national system for improved data sharing and linkage.

a. Single collection-multiple use of data – Maximise efficiency of data provision and linkage, where practical, to on-share or expand the use of data provided in accordance with legislative and privacy requirements.

b. Protect privacy and build trust in data sharing – Develop and embed a culture that supports safe and transparent data sharing and linkage, in line with relevant privacy legislation, data sharing principles, Aboriginal and Torres Strait Islander data governance principles, ethical guidelines and safeguards agreed by all parties.

c. Sharing by default – All parties agree to share data as a default position, where it can be done in line with subclauses (a) and (b).

d. Be collaborative and provide national leadership – Establish a unified approach for all parties to operate within, acknowledging the complexity of a federated health system, and competing priorities.

e. Leverage existing national and jurisdictional infrastructure – Leverage existing infrastructure and integrated data assets for sharing, linkage and analytics; this includes interoperability between assets. Where feasible, limit duplication of effort and ensure all jurisdictions can access data opportunities for public benefit.

f. Enhance data access for stakeholder groups where it is safe to do so and for public benefit, including the research community, and enable health experts to appropriately contextualise findings and support innovative delivery.

g. Keep pace with technology – Continually improve and modernise to keep pace with changing technology, cybersecurity, and digital innovations that expedite data sharing, linkage, and analytics, while maintaining public trust and privacy.

h. Interoperability enables better data - The increased interoperability of our underlying source systems will build better data assets.

i. Invest in transparent and repeatable analytic methods - Analytic approaches to using shared data should be open and repeatable across governments for best-practice interoperability, quality assurance and efficiency.

j. Funding for success – The Parties recognise that funding and workforce capability and capacity are critical dependencies in designing and delivering system-wide data reforms and enabling governance and analytic functions under this Addendum.

H34. The Parties agree to design and develop a National Health Data System (NHDS) by 30 June 2031 to accelerate data sharing and linkage across the health system and care sectors. The NHDS will leverage a federated data linkage model and existing national infrastructure, where possible. The timing and implementation of the NHDS will be subject to future decisions of government and jurisdictional budget processes.

H35. In delivering the NHDS, all Parties agree to collaborate on:

a. designing a networked data ecosystem to streamline and expedite data access and provision across government and health sector assets, with appropriate governance and risk management

b. resolving conflicting information in datasets for national consistency and linkage readiness

c. identifying data gaps and information missing from whole-of-systems view.

H36. To deliver federated linkage of nationally significant datasets, and improve interoperability, Parties will work with the AIHW and the Australian Bureau of Statistics (ABS) to leverage existing or emerging data integration infrastructure and established integrated data assets.

H37. All Parties agree to provide data for the National Minimum Data Sets (NMDS) listed in the National Health Data Dictionary, which may be updated periodically with the agreement of the Parties.

Data sharing

H38. To ensure that States can effectively fulfil their responsibilities in public hospital management and health planning, the Commonwealth will commit to multi-way sharing, for purposes in the public interest, of its own nationally significant health datasets in line with relevant legislation, including the *Data Availability and Transparency Act (DATA) Scheme*. Datasets may include but are not restricted to:

a. Medicare Consumer Directory

b. Medicare Benefits Schedule

c. Pharmaceutical Benefits Scheme

d. Australian Immunisation Register

e. Aged Care (residential and community-based care extracts from the National Aged Care Data Clearinghouse)

f. Primary care information owned by the Commonwealth

g. New or emerging priorities as mutually agreed over the life of this Addendum.

H39. Multi-way data sharing by States will in turn support the Commonwealth to fulfil its stewardship and health system responsibilities. To deliver an end-to-end systems view of diverse patient pathways under the NHDS, all Parties commit to broader sharing and linkage of health-related NMDS and key State data in line with relevant legislation. Datasets may include but are not restricted to:

a. Admitted Patient Care (APC) NMDS

b. National Non-admitted Patient Emergency Department Care National Minimum Data Set (NAPEDC NMDS)

c. Non-admitted patient National Best Endeavours Dataset (NAP NBEDS)

d. Community Mental Health Care National Minimum Dataset (CMHC NMDS)

e. Mental Health Establishments (MHE) NMDS

f. Local Hospital Networks/Public Hospital Establishments (LHN/PHE) NMDS

g. National Outcomes and Casemix (NOCC) NMDS

h. Residential Mental Health Care (RMHC) NMDS

i. Australian Cancer Database (extract)

j. Primary care information owned by States

k. National Notifiable Disease Surveillance System (NNDSS)

l. National Perinatal Collection

m. New or emerging priorities as mutually agreed over the life of this Addendum.

H40. Datasets outside the health portfolios may be required to develop comprehensive policy, models of service delivery and research, such as across care interfaces or for priority populations. The Parties agree to engage with relevant State, Commonwealth or other custodians to facilitate reasonable data access or multi-way sharing where possible, in line with parameters agreed in H31 and H33, such that:

a. the Australian Government Department of Health, Disability and Ageing will engage with relevant Commonwealth custodians on datasets including but not restricted to:

   i. National Disability Insurance Scheme.

   ii. Department of Veterans' Affairs administrative dataset(s).

   iii. Data Over Multiple Individual Occurrences (DOMINO).

b. states will engage within their relevant jurisdictions on datasets including, but not limited to:

   i. Disability Services National Minimum Dataset (DS NMDS).

   ii. Death Registrations.

c. data to support new or emerging priorities as mutually agreed over the term of this Addendum are considered.

H41. In line with relevant legislation, all Parties will work towards streamlined data sharing across governments, including by leveraging existing national data sharing arrangements for key assets and infrastructure such as the Australian National Data Integration Infrastructure (ANDII), National Health Data Hub (NHDH) and the ABS' Person Level Integrated Data Asset (PLIDA).

Data governance

H42. There are differences in legal pathways for data sharing across jurisdictions. To support the principled and trusted use of a NHDS, all Parties agree to develop an authorising National Health Data System Governance Framework for health data by 30 June 2029. The Framework will be accessible to governments, healthcare providers and researchers and will reflect guidance for culturally appropriate governance of Aboriginal and Torres Strait Islander data.

H43. In developing the Framework, the Parties commit to identifying legislative and regulatory barriers to data sharing with the intent of harmonising legislation, where required. In keeping with clause H33(g), the Governance Framework should consider any relevant digital reforms that enable information sharing across the health system.

H44. Development of the national Governance Framework will include a review of the National Health Information Agreement, consistent with the principles outlined in this Addendum.

High-value data linkages

H45. All Parties agree to work towards the sharing and linkage of nationally important health datasets, and those that support the reform outcomes of this Addendum, including:

a. ongoing standardisation and sharing of workforce data for national planning, modelling, and policy development

b. data sharing to close gaps in the patient pathway and improve service planning, such as for Local Hospital Networks (LHNs), Primary Health Networks (PHNs), Aboriginal Community Controlled Health Organisations (ACCHOs), private hospital data and other interface sectors, including aged and disability care

c. ongoing and more timely linkages of hospital and other health data with socio-economic determinants of health.

Analytic insights for system improvements

H46. Making data more available supports more comprehensive analyses of health system performance and outcomes by researchers, local area system managers and governments.

H47. To build shared analytic capability across all jurisdictions, the Parties agree to develop a shared analytic function that can be harnessed to deliver actionable and meaningful insights for NHRA priority areas. The Parties further agree to transparency in delivering this function by embedding open and repeatable analyses within legislative conditions of states.

H48. The Parties commit to working toward an interoperable system where analytic code is shared openly, with appropriate technical documentation, to all data users.

Accountability and governance

H49. The relevant cross-jurisdictional expert committee established under HCEF, will be accountable for the development of proposed work programs for HCEF and HMM consideration that will consider:

a. a prioritisation framework for implementation that considers both short term implementation priorities and longer-term measures alongside the costs and differing capacities of jurisdictions to support implementation

   i. This will inform development of an implementation plan with milestones, funding requirements and timelines for the work program outlined in this Schedule by 30 September 2026. Implementation plans will be reviewed at agreed intervals to ensure they remain accurate and reflect agreed priorities

b. further tasking the design and delivery of the NHDS to one or more expert data organisations or national bodies

c. reporting on measurable progress, barriers and risks against the implementation-plan will be provided to HCEF and relevant sub-committees.

Enabling other reforms in the Addendum

H50. When designing or implementing other health system reforms as part of this Addendum, the relevant program leads will be responsible for identifying any new or emerging requirements for data in consultation with the relevant cross-jurisdictional expert committee and advising HCEF and relevant sub-committees.

H51. Where existing data funding is insufficient to meet the policy objectives, HCEF and other relevant sub-committees, the relevant cross-jurisdictional expert committee and the program leads will collaborate to find a pragmatic solution or escalate appropriately. Where an appropriate solution is unable to be identified, the relevant implementation plans may require adjustment.

Digitally enabled health care

Outcomes

H52. This Addendum builds on the commitments of all governments to prioritise digital health through the *Intergovernmental Agreement on National Digital Health 2023-2027* and the *National Digital Health Strategy.* It follows the principles embedded in those instruments, for example people-centred delivery, leveraging existing infrastructure and capabilities, and ensuring security of systems and information.

H53. Digital capability is critical to a modern and connected health system. It improves the way people engage with their health information and interact with their healthcare providers. Digitally enabled care provides access to flexible health services, such as ePrescribing and virtual care, and enables improved coordination and continuity of care across care settings and jurisdictional borders.

H54. Digital health is also a fundamental enabler for other reforms agreed in this Addendum. This includes improved access to care for Aboriginal and Torres Strait Islander

communities (Schedule B) and rural and remote communities (Schedule F); supporting transitions of care across interfaces (Schedule C); enabling more effective funding and payment models (Schedule A); and optimal models of care and care pathways (Schedule D). The digital reforms therefore support critical clinical outcomes.

H55. Parties will work together to support digital health reforms with Aboriginal and Torres Strait Islander health providers and communities, in alignment with Schedule B and the National Agreement on Closing the Gap.

H56. All Parties commit to developing plans under the Addendum to consider:

a. phased adoption of digital health and information and communication technology (ICT) interoperability standards across the health system:

    i. Adoption of consistent national Healthcare Identifiers to enable care coordination

    ii. Adoption of national interoperability standards as they are developed to underpin the consistent capture and exchange of health information

b. phased adoption of national health information exchange, infrastructure and capabilities as they are developed

c. enabling timely access and reduced manual handing of key health and care information across different care sectors, including discharge information

d. creating an authorising environment for digital health through the development and implementation of national policy and legislative protocols for health and care information sharing at the point of care. Including:

    i. addressing barriers to exchanging health information across care settings and jurisdictional borders

    ii. supporting the development of national approaches to the timely and safe sharing of health information at the point of care while considering individuals' expectations and impacts

H57. Implementation of digital health initiatives will be subject to jurisdictional consideration on local level capacity and resourcing.

Roles and responsibilities

H58. Parties have a joint responsibility to:

a. drive digital reforms and deliver effective and equitable health care for consumers, providers, the sector and governments, taking into consideration service maturity and digital capability

b. make shared decisions, including with ACCHOs and other Aboriginal and Torres Strait Islander health organisations, on national health information sharing priorities and minimum standards, and core infrastructure and capability requirements for the sharing of health information through agreed cross-jurisdictional governance

c. engage proactively within respective jurisdictions and with key stakeholders, including Aboriginal and Torres Strait Islander people, to support the design, implementation and adoption of digital reforms. Ensure impacted stakeholders and consumers are supported through clearly articulated and aligned change management

d. harmonise legislation, where required, to enable sharing of standardised health and care information across care settings and jurisdictional borders, in alignment with data reforms under the National Health Data System (see clause H43).

H59. The Commonwealth is responsible for:

a. progressing national legislative change to support sharing of health information across all care settings, as well as requiring the use of national Healthcare Identifiers to support transitions of care

b. progressing improvements to the Healthcare Identifier Service to increase data quality and matching, and the timely allocation of Healthcare Identifiers in partnership with Services Australia and jurisdictions

c. supporting jurisdictions with their implementation and adoption of Healthcare Identifiers through policy and technical support

d. progressing adoption of Healthcare Identifiers across other care settings, for example primary care and aged care, to underpin whole-of-system interoperability

e. establishing interoperability protocols, data standards and health and care information exchange capabilities for national adoption and use in partnership with jurisdictions and industry.

H60. The States are responsible for:

a. engaging in the development of national level implementation plans and related local level implementation

b. planning and uplift of internal systems to meet digital reform commitments in line with implementation principles

c. reporting on measurable progress towards digital reform commitments through agreed governance processes

d. progressing consultation on and, where applicable, implementing jurisdictional legislative changes alongside national legislative change to enable access to and sharing of health and care information.

Accountability and governance

H61. The existing cross-jurisdictional Digital Health Oversight Committee (DHOC) established under the Intergovernmental Agreement on National Digital Health 2023-27, or relevant cross-jurisdictional expert committee will develop a proposed implementation plan for activities agreed in this Schedule for HCEF and HMM consideration. The DHOC will:

a. be responsible for providing advice to HCEF and HMM on the scope, tasking and timeframes for progressing the delivery of digital reforms with consideration of the costs of reform and relative jurisdictional priorities and capacity

b. engage with other national oversight committees as needed to support tasking for national and expert data bodies

c. report on measurable progress, barriers and risks against the implementation plan to HCEF and other relevant sub-committees.

Enabling other reforms in the Addendum

H62. When designing or implementing other health system reforms as part of this Addendum, the relevant program leads will be responsible for identifying any new or emerging requirements for digital enablement in consultation with the DHOC and advising HCEF and relevant sub-committees.

H63. Where existing digital health funding or national digital capability is insufficient to meet the policy objectives, HCEF and relevant sub-committees, the DHOC and the program leads will collaborate to find a pragmatic solution or escalate appropriately. Where an appropriate solution is unable to be identified, the relevant implementation plans may require adjustment.

Deliverables

Consistent Digital Healthcare Identifiers to enable care co-ordination

H64. Healthcare Identifiers underpin national digital health services and information exchange and sharing across borders and care settings, so that patients' records can be easily accessed by their healthcare provider. They are a base architecture for a modern, connected healthcare system. At present, there is varied uptake of Healthcare Identifiers across all jurisdictions.

H65. All Parties agree to work towards the adoption of nationally consistent Healthcare Identifiers, in alignment with the principles, for:

a. Consumers (Individual Healthcare Identifier or IHI)

b. Health Care Providers (Healthcare Provider Identifier – Individual or HPI-I)

c. Health Care Provider Organisations (Healthcare Provider Identifier – Organisation or HPI-Os).

H66. The Parties agree that nationally consistent Healthcare Identifiers to identify patients, providers and organisations will be used when:

a. health information is exchanged or shared across healthcare settings, organisations or jurisdictional borders

b. designing and implementing consumer access to key health information from across all health and care settings for a joined-up view of their information regardless of where care was provided

c. providing health National Minimum Data Sets (NMDS) to national bodies, subject to implementation of relevant Commonwealth commitments in clause H59. This will allow for better patient identification and health service mapping across the system in line with data commitments in this Schedule and to support payment reforms in Schedule D and clause I31.

H67. It is recognised that each jurisdiction's approach and timeframes for adopting Healthcare Identifiers (IHI, HPI-I and HPI-O) will be subject to consideration of the resourcing implications and relative jurisdictional capacity noting difference in underlying digital architecture.

H68. The Australian Digital Health Agency will coordinate development of a Healthcare Identifier Implementation Roadmap with each jurisdiction that includes appropriate phasing and milestones, to be developed under the DHOC for consideration by HCEF and HMM. An initial high-level Roadmap or detailed updates on progress will be provided to DHOC or relevant cross-jurisdictional expert committee, by 30 June 2027.

H69. Subject to these considerations, a more detailed implementation Roadmap will be developed for HCEF and HMM consideration, including jurisdiction level plans by 30 June 2028.

H70. The Australian Institute of Health and Welfare, in partnership with the Australian Digital Health Agency, will support all jurisdictions to include Healthcare Identifier fields in health NMDS by 30 June 2031.

Digitisation and sharing of hospital discharge summaries

H71. All Parties agree to enable the sharing of high-quality hospital discharge information at clinical transfer of care, as outlined in Schedule C and Schedule D.

H72. Parties agree that through digitisation and by utilising existing or emerging technologies for information sharing, discharge summaries can be completed more frequently with greater accuracy and shared in a more timely manner, while reducing manual effort for the hospital workforce.

H73. All Parties agree to automate, where possible, the population of discharge information from internal systems into the draft discharge summary ready for clinical review and sharing.

Sustainability of funding for ICT uplift and maintenance

H74. To better understand the costs associated with digital solutions, the IHACPA will define a distinct ledger cost category and any additional business rules required for operational Information and Communications Technology (ICT) in the National Hospital Cost Data Collection (NHCDC). This will better depict ICT cost contribution to the National Efficient Price (NEP) and provide greater transparency for any emerging issues to be addressed.

H75. The Parties agree there will be no change to the scope of ICT costs included in the standalone ledger category for Commonwealth funding under the Addendum.

SCHEDULE I – NATIONAL BODIES

I1. For the purposes of this Addendum, the national bodies are those that have a role in the delivery of this Addendum. These bodies are the:

a. Independent Health and Aged Care Pricing Authority (the IHACPA)

b. Administrator of the National Health Funding Pool (the Administrator) and the National Health Funding Body (the NHFB)

c. Australian Commission on Safety and Quality in Health Care (the ACSQHC)

d. Australian Institute of Health and Welfare (the AIHW).

I2. The national bodies are established by relevant Commonwealth and State legislation to undertake specific functions including under this Addendum. The Parties acknowledge that the clauses in this Schedule relate only to the functions of the national bodies under this Addendum.

I3. For avoidance of doubt, any jurisdiction that enacts or amends legislation that is inconsistent with the provisions of this Addendum relating to national health reform funding arrangements, including the establishment, appointment, powers and functions of the Administrator, will be in breach of this Addendum.

I4. The Parties will consult HMM on any proposed amendments to legislation establishing the position and functions of the national bodies and the operation of the National Health Funding Pool.

Objectives

I5. This Schedule is intended to enable a collaborative approach between the independent national bodies and the Parties to respond to the evolving needs of the health system.

I6. Roles and responsibilities under this Schedule are in accordance with the relevant establishing legislation for national bodies as well as those set out in the Preliminaries and other Schedules, which pertain to the functions and reform activities to be undertaken by national bodies.

I7. National bodies are required to contribute to and progress the system reform objectives and commitments in this Addendum as well as respond to the identified priorities of Health Ministers.

I8. National bodies may be invited to participate in setting strategic directions and planning activities, including by HMM, and contribute their skills and data into national policy development processes. Additionally, national bodies may be invited to other HMM, HCEF and sub-committee meetings when needed, to share their expertise and views on national health policy issues, including areas for system improvement, reform and challenges.

I9. As part of ongoing monitoring of the Addendum, national bodies will provide regular updates to HCEF and its relevant sub-committees regarding progress on relevant commitments for which they are responsible, including any risks, delays or new opportunities.

I10. National bodies' responsiveness to Ministerial priorities should not encroach on their independence in performing their functions.

Standard consultation and dispute resolution

I11. The Parties expect national bodies to carry out their functions in a timely manner and regularly consult with each other, Parties to this Addendum and other relevant stakeholders. Consultation requirements and operational processes set out in this Addendum are not intended to be exhaustive.

I12. Consistent with the principles articulated in this Addendum:

a. national bodies should work collaboratively and with Parties as appropriate and have regard to advice provided by Parties

b. Parties and national bodies should use existing and any new governance mechanisms including Jurisdictional Advisory Committees, relevant working groups and technical advisory groups productively and transparently.

I13. 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.

I14. Commonwealth and State departments of health will be the primary contacts for the national bodies on matters relating to this Addendum 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).

I15. Prior to raising a matter, Parties should follow the consultation requirements and processes under this Addendum and work together with the relevant national bodies to understand the different perspectives and attempt to resolve the matter.

I16. Parties may raise any issues or disputes related to the functions of the national bodies with the primary contacts in clause I14 and/or directly with the relevant national body. Where processes for addressing issues are not specified in this Schedule, the resolution processes detailed in the Preliminaries (clauses 50 to 52) will apply, noting clause I10.

National funding bodies

Consultation and transparency

I17. For the purposes of this Addendum, the national funding bodies are the IHACPA, the Administrator and the NHFB.

I18. The Commonwealth established the national funding bodies under the *National Health Reform Act 2011* (the Act) on behalf of all Parties to facilitate and administer the public hospital and health service funding arrangements under the Act and this Addendum. The Commonwealth Minister for Health must consult and have regard to the views of Health Ministers (HMM) on any direction to the IHACPA that relate to its functions under this Addendum.

I19. Given the significance to all Parties of the functions discharged by the national funding bodies, the bodies will consult with HMM on changes that materially impact the application of the national pricing or funding models.

I20. Pursuant to clause I12, the national funding bodies must consult with Parties and provide relevant analysis and documentation through Statements of Impact as per clause I48 on decisions that could materially impact Parties.

a. In reviewing submissions from Parties, national bodies cannot take action, amend policy or rules or act otherwise in response to a submission that would result in unfair disadvantage to other parties.

I21. Where one or more Parties has raised a matter formally in writing outside the standard consultation and issue resolution processes outlined in this and other Schedules, the relevant funding body will provide a timely written response to the matter.

I22. The Commonwealth or two or more States may request that the national funding bodies present for HMM 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 take into account existing consultation requirements and processes on funding matters (such as those in clause I12 and I48) to avoid duplication of effort. This process provides no less than 45 days for response by Health Ministers.

Resolving national funding body matters

I23. The Commonwealth, or a State (with the support of another Party) or national funding body can raise a dispute on funding matters under this section with HMM, noting clause I10.

I24. Once a dispute is raised, the appropriate national funding 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 HMM and HCEF 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 based on the submissions from Parties.

I25. After receiving the statement on the dispute from the national body, HCEF may provide additional advice to HMM within 45 days. The additional advice will cover the same matters as in clause I24(a).

Independent Health and Aged Care Pricing Authority

Functions

I26. The Independent Health and Aged Care Pricing Authority (IHACPA) 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 and health services, and aged care services.

I27. In performing its functions, the IHACPA must:

a. have regard to this Addendum

b. follow the processes and meet the conditions or requirements set out in this Addendum

c. publicly call for submissions from interested parties annually

d. have regard to any submissions from Parties to the Addendum regardless of when they are made

e. draw on relevant expertise and best practice within Australia and internationally.

I28. The main functions of the IHACPA in relation to public hospitals and health care pricing and costing 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

c. publish this, and other information, for the purpose of informing decision makers in relation to the funding of public hospitals.

I29. The IHACPA 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 I79, 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

ii. patient demographic characteristics and other information that is relevant to classifying, costing and paying for public hospital functions

c. subject to clause I79, 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 annually 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 (see Schedule A, Part 3 – Scope of services)

j. determining the Block Funded Criteria to be applied to agreed hospitals, functions and services that would be better funded in that way (see clause A68)

k. resolving disputes on cross-border issues, where parties are unable to reach bilateral agreement and either party seeks a determination from the IHACPA

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

I30. The IHACPA has the following advisory functions:

a. advising HMM 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)

    ii. mixed ABF and Block Funding

b. making recommendations to the Treasurer to adjust Commonwealth contributions to implement cross-border recommendations under clause A195

c. making an assessment in relation to cost-shifting.

I31. Subject to provisions in Schedule H, IHACPA may use Healthcare Identifiers to inform pricing and payment reforms for hospital and health services.

a. Parties agree that more consistent identification of patients and healthcare providers across borders and care settings will enable improved data matching and linkage and facilitate more accurate pricing and costing determinations.

b. Parties agree the consistent use of Healthcare Identifiers is critical for developing pricing of capitation and bundled payments, value-based pricing reforms, and for improving safety and quality pricing adjustments.

I32. In relation to the safety and quality reforms described in this Addendum the IHACPA will undertake commitments, in consultation with the ACSQHC as appropriate, in line with Schedule A and Schedule D provisions.

I33. Parties may request the IHACPA provide monitoring and support for the development of innovative models of care and funding for inclusion into the national funding model under clauses A82 and A83.

I34. In line with clauses A82, A83 and D15, IHACPA will support the Parties, where requested, with the design, implementation and evaluation of projects to be funded through the Service Model Reform Funding (SMRF) stream.

a. IHACPA will work collaboratively with the Service Model and Funding Reform Collaboration and any nominating State that requests IHACPA assistance in providing advice and technical expertise in the development of pricing or costs for a proposed SMRF project.

b. In line with clause A9, IHACPA will determine a process for scaling and embedding relevant service delivery projects into the National Funding Model as part of developing the Funding Models Framework.

I35. The IHACPA will improve transparency by publicly reporting, in an easily accessible format that promotes understanding of the reporting by the public, 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

c. its findings and supporting analysis on cost-shifting and cross-border issues raised by the Parties, following consultation with the relevant jurisdictions.

I36. The IHACPA will provide the Parties with draft copies of its reports before they are released publicly. In line with legislation, Parties will have 45 days in which to comment on the reports.

I37. The IHACPA may undertake data collection and research, including by commissioning others to undertake specified studies and research.

a. In undertaking data collection and research IHACPA must have regard to privacy and cybersecurity requirements of Parties and take relevant advice pertaining to such requirements from Parties.

I38. Should the IHACPA, 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 IHACPA may consult with the relevant jurisdiction. If the matter is unresolved following consultation with the relevant jurisdiction, the IHACPA 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 IHACPA (as set out in clauses I39 to I44).

Cost-shifting

I39. Any Party to this Addendum may make submissions to the IHACPA requesting it advise whether another Party has transferred costs in a manner which is contrary to the intent of this Addendum.

I40. The IHACPA will provide the other Party a copy of the submission and request a responding submission to be provided within 60 days. The IHACPA will provide this response to the initiating Party.

I41. The IHACPA will then assess the submissions, consult further with affected Parties and publicly release its assessment should it consider that cost-shifting has occurred.

I42. Should the IHACPA identify anomalies in service volumes or other data which suggest that services have been transferred from the community to public hospitals, the IHACPA will analyse those services and provide a report to HMM. In performing the analysis, the IHACPA will consult with the relevant State, LHN, PHN, Aboriginal and Torres Strait Islander stakeholders (as set out in Schedule B), and other stakeholders.

I43. Following an appropriate consultation period, the IHACPA may determine that those specific services provided by that hospital have been transferred for the dominant purpose of making that service eligible for Commonwealth funding and those services will not be eligible for Commonwealth funding.

I44. Any information provided through consultation under clause I42 by a Party to IHACPA can only be used to resolve the matter in relation to which the information was provided.

Governance

I45. The IHACPA comprises an independent board and chief executive officer. The ongoing costs of the IHACPA will continue to be met by the Commonwealth.

I46. In seeking to make an appointment to the position of the IHACPA CEO, the IHACPA Board will consult with the Parties.

Consultation

I47. Pursuant to clauses I12 and I27, the IHACPA seek guidance and consult in relation to the national funding model. Escalation of issues will be resolved in line with clauses I23 to I25, where a dispute is raised on funding matters, or I15 to I16 generally.

I48. In line with clause I20, the IHACPA 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.

I49. The Statement of Impact must be timely in relation to the matter raised and:

a. include a clear set of objectives that identifies why intervention or change is needed and benefits of the changed approach

b. include a risk assessment of the proposed changes or adjustments

c. outline appropriate transition arrangements

d. be informed by consultation with the Parties

e. have input from the Administrator.

I50. The IHACPA will provide HCEF with a clear understanding of IHACPA's processes, governance arrangements and its committees on national funding model matters.

Administrator of the National Health Funding Pool

Functions

I51. 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*.

I52. 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

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

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

j. calculate value-based pricing adjustments to be made using the pricing and funding models nominated for this purpose by the Parties, where these pricing adjustments are to be introduced from 1 July 2029

k. advise the Commonwealth Treasurer of (h), (i) and (j) during annual reconciliation.

Governance

I53. As per the *National Health Reform Act 2011*, the Chief Executive Officer of the National Health Funding Body is appointed by the Commonwealth Minister.

I54. In seeking to make an appointment to this position, the Commonwealth Minister will consult with the States.

Consultation

I55. The Administrator must have regard to the intent and objectives of the Addendum and avoid unnecessary administrative burden for Parties when considering implementation.

I56. The Administrator will provide HCEF 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

I57. The Australian Commission on Safety and Quality in Health Care (ACSQHC) 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).

a. The ACSQHC is jointly funded by the Parties through a Multi-Party Funding Agreement (MPFA). Activities required of the ACSQHC through this Addendum, and as prescribed under *the National Health Reform Act 2011*, as set out in the Commission's Work Plan, will be appropriately funded by the Parties through the MPFA.

I58. The role of the ACSQHC is to:

a. lead and coordinate improvements to the safety and quality of health care in Australia, across care sectors, by identifying issues and policy directions and recommending priorities for action

b. recommend, formulate, promote, monitor and report on: standards, guidelines, best practice care, clinical pathways and indicators related to healthcare safety and quality matters, including through the national model accreditation scheme

c. disseminate knowledge and advocate for health system safety and quality

d. report publicly on the safety and quality of the health system including performance against national standards

e. recommend national data sets for monitoring, assessing and reporting the safety and quality of the health care system, working within current multilateral governmental arrangements for data development, standards, collection and reporting

f. provide strategic advice to HMM on best practice thinking to drive improved system quality, including implementation strategies

g. recommend nationally agreed standards for a safe, high performing health system.

I59. The ACSQHC will:

a. formulate and monitor national 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

b. provide advice to HMM about which of the standards are suitable for implementation as national clinical standards or clinical pathways.

I60. The ACSQHC does not have regulatory functions.

I61. The ACSQHC will develop, in consultation with the Parties, the first agreed versions of a low-value and high-value care lists by 30 June 2028, as per the governance structures outlined in A94 and I67. Parties agree to promptly provide any relevant input and advice, including relevant data, if requested, to support the ACSQHC to meet these deadlines.

I62. The ACSQHC will co-design Aboriginal and Torres Strait Islander safety and quality pricing measures with Aboriginal and Torres Strait Islander stakeholders, taking into consideration the nationally consistent cultural safety measures (as described in Schedule B). This work should occur after cultural safety measures have been in place for one year and be co-evaluated two years post-implementation.

I63. In relation to the safety and quality reforms in this Addendum, the ACSQHC will:

a. curate and maintain the Sentinel Events, HAC and AHR lists for the purposes of ensuring they remain robust and relevant for clinical improvement purposes, within its existing governance arrangements and in conjunction with IHACPA Technical Advisory Committee advice

b. develop and maintain new safety and quality reforms that arise out of the safety and quality review of clauses D51 to D55

c. maintain a Clinical Advisory Group (or groups, at the discretion of the ACSQHC) to advise on new and existing complications and conditions on the HAC and AHR lists, and new and existing events, procedures and pathways on the low-value care and high-value care lists. The Clinical Advisory Group(s) will have regard to the recommendations of specialty Clinical Panels established by the ACSQHC where necessary

d. consult with ACSQHC committees to ensure proposals forwarded to HCEF and HMM best represent matters that are supported by the relevant committees

e. advise on clinician engagement.

I64. As required, ACSQHC will assist IHACPA in developing nationally consistent pricing and classification approaches for capitation or bundled services funded under the SMRF stream, by providing advice on:

a. appropriate risk adjustments

b. designing the clinical pathways, cohort eligibility, and models of care to be priced

c. designing and specifying interactions with safety and quality measures

d. interactions with outcomes-based payments or design of evidence-based pathways where appropriate.

I65. In line with clause D15, ACSQHC will assist the Parties in providing advice and technical expertise to support designing, implementing, and evaluating projects to be funded through the SMRF stream. In doing this, the ACSQHC will work collaboratively with the Service Model and Funding Reform Collaboration and any nominating State that requests assistance, including providing advice on evidence-based pathways, and interactions of proposed innovations with safety and quality measures, as appropriate.

I66. The ACSQHC will assist in the development of the Performance Framework, particularly the safety and quality indicators (see clause H17).

Consultation

I67. The Parties expect that, in performing its functions, the ACSQHC will provide advice to HCEF and HMM on best practice evidence to drive quality improvement, including implementation strategies. In developing this advice, the ACSQHC will collaborate with Parties via its Interjurisdictional Committee(s) and through participation in setting strategic directions and planning (see clause I8).

I68. The ACSQHC is expected to liaise with HCEF 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

I69. 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).

I70. The AIHW is an independent agency that provides reliable, regular and relevant information on Australia's health and welfare. The role of the AIHW is to:

a. collect, produce, coordinate and assist in the collection and production of health- and welfare-related information and statistics

b. conduct and promote research into Australians' health and their health services

c. develop specialised standards and classifications for health, and health and welfare services

d. provide access to health- and welfare-related information and statistics, subject to confidentiality provisions.

I71. The AIHW leads the health system performance assessment framework and reporting for this Addendum, specified in Schedule H.

I72. The AIHW is an Accredited Data Service Provider (formerly accredited Integration Authority) and will continue to develop linked health, disability and aged care assets.

I73. The AIHW will also contribute to developing the National Health Data System specified in Schedule H.

Consultation

I74. The Parties expect that, in performing its functions under this Addendum, the AIHW will collaborate with Parties via relevant HCEF governance groups.

I75. The AIHW will provide HCEF and its relevant sub-committees with regular reports on its progress against commitments under this Addendum including as outlined in Schedule H.

Data requirements for the national bodies

I76. 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. National bodies will be involved in and contribute to developing a national health data system as outlined in Schedule H.

I77. The AIHW will use its national collections for the purpose of performance reporting and other roles under this Addendum.

I78. The national bodies established under the *National Health Reform Act 2011* will each 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 aligns with the objectives of this Addendum and the requirements in clause I79

b. each national body will provide its data plan to the HMM.

c. the plan will be considered final and complete 30 calendar days after release, unless the process referred to in clause I81 is invoked

d. for this purpose, the Administrator and the NHFB will be considered one national body.

I79. 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. ensure its data requirements will enable data reporting of a sufficient volume and quality, in order to undertake its legislated functions, and those outlined in this Addendum

e. 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

f. balance the national benefits of access to the requested data against the impact on jurisdictions providing that data

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

I80. HCEF will periodically review the national bodies' three-year data plans 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 I79

b. the review of three-year data plans will be conducted at least once every three years.

I81. HMM may direct the national bodies in respect of specific elements of their data plans:

a. if it determines that a plan does not meet the requirements set out at clause I79

b. provided that such a direction would not diminish transparency, comparability or other objectives of this Addendum or materially delay implementation.

I82. If a Party intends to request HMM to consider changes to the data plan under clause I81, the following procedure will be used:

a. within 45 calendar days of the release of the plan, the Party must lodge a submission with HMM, setting out its reasons for seeking the direction

b. the Party must provide the body that developed the data plan with a copy of the submission

c. within 21 calendar days of receiving the submission, HMM will consider the matter out of session and agree its response.

I83. Data requested by a national body from a jurisdiction, additional to the requirements of the published three-year data plans, can only be used to resolve the matter for which the information and/or data was provided, or other purposes agreed by the Parties.

I84. Subject to clauses I76 and I79, the Commonwealth and States will provide data that the national bodies determine is required to carry out their functions in accordance with their data plans.

a. Parties will ensure timely data is made available, either directly, through another national body or through the Commonwealth, in line with clause I76.

b. Each national body in I78 will publish details of Commonwealth and State compliance with their data requirements on a quarterly basis.

I85. Where patient identified data is required for purposes of the compliance function, including calculation of the national efficient price, States will continue to 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.

I86. The Commonwealth Department of Health, Disability and Ageing 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.

I87. For non-compliance purposes such as payment reforms, data provision and use, including use of personal or government identifiers such as Healthcare Identifiers, will be agreed between Parties and/or national bodies in line with the appropriate legislation. New governance arrangements for data sharing may be established in line with Schedule H.

I88. To ensure States can effectively fulfil their responsibilities in public hospital and health service management and planning, the Commonwealth will provide reasonable access to LHN-level and PHN-level data about Commonwealth programs in accordance with arrangements under Schedule C (System interface reform), Schedule H (Performance, data and digital reforms) and Schedule E (Local governance). HMM will agree appropriate protocols and procedures to govern operation of this arrangement, including compliance with Commonwealth legislative obligations.

I89. As set out in clause I12 and I79(e), 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 and as set required in their data plans

b. the Australian Bureau of Statistics will be able to access relevant data required to meet its legislative and contractual reporting requirements

c. the AIHW will be able to access relevant data to allow it 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

e. the Commonwealth Department of Health, Disability and Ageing, the Commonwealth Department of Veterans' Affairs, the Commonwealth Treasury, State health departments and State treasuries will be able to access all de-identified data for the purposes of policy analysis and planning.

I90. The agencies in clause I89(e) will not publish, use in any way publicly, or provide data to a third party without the express written approval of the originating jurisdiction, except where there is a legislative basis to do so.

I91. In using the data available, all agencies listed in clause I89 will have regard to the caveats and limitations of the collected data.

I92. The Commonwealth and the States will take responsibility for 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 health services. Parties will notify the Administrator of established oversight mechanisms related to data provided under I84 by 30 June 2027 and will then provide annual updates.

Statement of Assurance

I93. States will provide the IHACPA with a Statement of Assurance from a senior health department official on the completeness and accuracy of approved data submissions provided under clauses A134, I89 and I92 of this Addendum:

a. consistent with clause I89, the IHACPA will provide statements of assurance to the Administrator

b. States will use the Statement of Assurance template agreed by HCEF

c. 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.

I94. Data provided to the Administrator by the Commonwealth under clauses A8 and A9 will also require a Statement of Assurance on data completeness and accuracy submitted by the relevant Divisional Data Steward in the Department of Health, Disability and Ageing.

SCHEDULE J – BUSINESS RULES

J1. 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

J2. 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

   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

h. other services as agreed between the Commonwealth and States.

J3. 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

J4. Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by the State.

J5. Notwithstanding clause J4, 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.

Public health services

J6. 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 bodies

J7. 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

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

J8. States agree to:

a. maintain the existing Charter to ensure its relevance to public hospital services in consultation with the Australian Commission on Safety and Quality in Health Care (ACSQHC)

b. provide 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

d. adhere to the Charter.

J9. States agree to the following minimum standards:

a. the Charter will be promoted and made publicly available whenever public hospital services are provided

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

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 Bodies

J10. States agree to maintain an independent complaints body to resolve complaints made by eligible persons about the provision of public hospital services to them.

J11. 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

c. the complaints body must be given the power to recommend systemic and specific improvements to the delivery of public hospital services.

J12. States agree each complaints body will provide an annual report on complaints received to the ACSQHC. These reports will include the volume and type of complaints received as well as any key trends.

J13. The ACSQHC may establish more detailed minimum requirements for inclusion in these reports.

J14. 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.

J15. 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

J16. Election by eligible patients to receive admitted and non-admitted public hospital and health services as a public or private patient will be exercised in writing before, at the time of, or as soon as possible after presentation to a hospital or health service and must be made in accordance with the minimum standards set out in this Addendum.

J17. Where a public or private patient requires multiple episodes of care as part of a course of treatment, including in both admitted and non-admitted care, the patient election will apply to those related episodes unless unforeseen circumstances occur.

J18. Private patients have a choice of doctor and all patients will make an election based on informed financial consent.

J19. Where services are related to an episode of care or course of treatment, and the patient chooses to be treated as a public patient, they should be provided free of charge as a public hospital service, regardless of whether it is provided at the hospital or in private rooms.

J20. 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, public patients cannot be referred to receive a component of their public hospital service from a medical specialist exercising a right of private practice under an agreement 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

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

J21. An eligible patient presenting at a public hospital emergency department will be treated as a public patient before admission. 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 and Non-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

b. hospital employees will not direct patients or their legal guardians towards a particular choice

c. a service that would otherwise be provided at a public hospital emergency department should not be postponed so that it can be provided as a private service.

J22. 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.

J23. Where a patient chooses to be treated as a public patient, all components of the public hospital service will be regarded as a part of the patient's treatment and will be provided free of charge, regardless of:

a. the mix of the care (for example, procedures, consultations, and diagnostic tests)

b. the type of healthcare practitioner (for example, medical, allied health, and nurse practitioners)

c. the number of healthcare practitioners involved.

J24. 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.

J25. 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.

J26. In accordance with this Addendum, public hospital admitted and non-admitted patient election processes for eligible persons should conform to the national standards set out in this schedule.

Data provision to private health insurers

J27. Hospitals will continue to provide data on privately insured patients treated in a public hospital to insurers, consistent with the forms described in clause J30.

J28. 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*.

J29. 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.

Public hospital patient election forms

J30. States agree that while 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 J2 of this Schedule

b. a private patient may be treated by a doctor of their choice. A person may make a valid private patient election in circumstances where only one doctor has private practice rights at the hospital

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 public patients (except for care and accommodation type patients as referred to in clause J2):

   i. will not be charged for hospital accommodation, medical and diagnostic services, prostheses and most other relevant services

   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

    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, presentation to the hospital or health service

g. a statement that patient election status after admission or, in the course of multiple outpatient episodes at the same hospital or hospital network, can only be changed in the event of unforeseen circumstances and only once. Examples of unforeseen circumstances include, but are not limited to, the following:

    i. patients who are receiving care for a particular procedure but are found to have complications requiring additional procedures

    ii. patients whose length of stay or course of treatment has been extended beyond those originally and reasonably planned by an appropriate health care professional

    iii. patients whose social circumstances change while admitted or during a course of treatment (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 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 patients or their legally authorised representatives who elect to be private, authorising the hospital or health service to release a copy of their 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

l. where 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 applied retrospectively for the whole episode of care or course of treatment.

J31. To support the implementation of the new patient election requirements under clauses J16 and J17, the Commonwealth will consult with States to jointly develop guidance material, to be agreed by HCEF by no later than June 2027.

J32. Administration of the new patient election requirements will not commence until the guidance material is finalised. The Administrator of the National Health Funding Pool and Commonwealth will consult States about any potential breach of these requirements before further action is taken.

Multiple and frequent admissions election forms

J33. The State or hospital must develop a form suitable for individuals who require multiple episodes of care or a course of treatment not limited to one attendance. 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

J34. Any other written material provided to patients that refers to the patient election process must be consistent with the information included in the patient election form. It may be useful to include a cross reference to the patient election form in any such written material.

J35. All parties agree that written material provided to patients by public hospitals and health services 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

b. refrain from directing the patient to a particular choice.

Verbal advice provided to patients

J36. Any verbal advice provided to patients or their legally authorised representatives that refers to the patient election process must be consistent with the information provided in the patient election form.

J37. Patients or their legally authorised representatives should be referred to the patient election form for a written explanation of the consequences of election.

J38. To the maximum extent practicable, appropriately trained staff should be on hand at the time of election, to answer any questions patients or their legally authorised representatives may have.

J39. Verbal advice provided to patients by public hospitals and health services 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

b. refrain from directing the patient to a particular choice.

J40. Through the provision of translation/interpreting services, hospitals should ensure, where appropriate, that patients, or their legally authorised representatives, from non-English speaking backgrounds are not disadvantaged in the election process.

Rights of private practice agreement

J41. The Parties agree that a right of private practice agreement between a medical practitioner and a public hospital, is the primary mechanism for private billing in public hospitals.

J42. The Commonwealth asserts its responsibility for Medicare compliance where services are provided under a right of private practice agreement with a public hospital.

J43. States agree to the following minimum requirements for right of private practice agreements:

a. rights of private practice are granted only when services offered under the agreement are also available at the hospital, free of charge as public hospital services

b. a record of a patient's decision to receive services from a practitioner exercising their right of private practice (this could be through the patient election form)

c. the Commonwealth may request a copy of the record for Medicare compliance purposes

d. audit (information requesting) rights only relate to understanding whether patient elections are captured ("the record") and obtaining a copy of the election to ensure the information captured meets the requirements under the NHRA

e. this Addendum, specifically clause J43(d), does not provide the Commonwealth with any responsibility for, oversight of, or rights to veto contractual or industrial arrangements between hospitals and practitioners.

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 2026 or as amended thereafter.

B. A reference in this Addendum to the 2020-2025 Addendum and its arrangements includes the one-year extension of these arrangements for the period 2025-2026.

C. 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.

D. Unless otherwise specified, words and phrases are to be interpreted as follows.

Aboriginal and Torres Strait Islander ('Indigenous') Cultural and Intellectual Property (ICIP)	Means Aboriginal and Torres Strait Islander people's rights to their heritage, cultural knowledge and cultural expression that originates from a family or community group and is passed on from generation to generation. These rights may exist in literary, performing and artistic works; languages; types of knowledge, including spiritual knowledge; tangible and intangible cultural property; cultural environmental resources; and documentation of Indigenous heritage created, performed, expressed or contributed to by Aboriginal and Torres Strait Islander people.
Aboriginal and Torres Strait Islander Health Sector	Means the National Indigenous Health Leadership Alliance (NIHLA) and the National Aboriginal Community-Controlled Health Organisation (NACCHO), the State and Territory Affiliate peak health bodies and ACCHOs.
Aboriginal Community Controlled Health Organisations (ACCHOs)	Means Aboriginal Community Controlled Health Organisations or ACCHOs which are non-government and not-for-profit incorporated Aboriginal or Torres Strait Islander organisations that are initiated by a local Aboriginal or Torres Strait Islander community; based in a local Aboriginal or Torres Strait Islander community; governed by an Aboriginal or Torres Strait Islander body which is elected by the local Aboriginal or Torres Strait Islander community; and deliver holistic and culturally appropriate health service to the community which controls it. Through their unique corporate structure, ACCHOs are an expression of self-determination that aim to improve health and wellbeing and mitigate the processes of ongoing colonisation by offering comprehensive community-controlled primary health care described in the Core Services Framework published by NACCHO in 2021. The terms ACCHO, Aboriginal Community Controlled Health Service (ACCHS), Aboriginal Medical Service (AMS) and Aboriginal and Torres Strait Islander Health Organisations (A&TSIHOs) are used interchangeably. In some jurisdictions like Victoria, these services are also known more broadly as Aboriginal Community Controlled Organisations (ACCO). While this NHRA refers to ACCHOs,

	this is intended to be inclusive of services across the community-controlled health services sector.
Aboriginal and Torres Strait Islander community-controlled health sector	Means NACCHO, Affiliates and all ACCHOs which meet the criteria for delivering comprehensive community-controlled primary health care as stated in the Core Services and Outcomes Framework.
Activity Based Funding (ABF)	Means the system for funding public hospital and health services provided to individual patients using national classifications, cost weights and nationally efficient prices developed by the Independent Health and Aged Care Pricing Authority (IHACPA) and specified in the National Efficient Price Determination.
ABF Service	Means a public hospital or health service funded under the ABF funding stream.
Activity-based funding Commonwealth Contribution Rate (ABF CCR)	Means the output CCR for the ABF funding stream, calculated as per clause A32(a) of this Addendum.
Administrator	Means the Administrator of the National Health Funding Pool, who is appointed in accordance with section 232 of the *National Health Reform Act 2011*, and performs the functions set out in this Addendum, including Schedule I.
Admitted patient	Means "Admitted patient" as defined in the Australian Institute of Health and Welfare's (AIHW) Metadata Online Registry (METEOR).
Affiliates	Means the eight community-controlled peak health bodies each based in a state or territory within Australia ('jurisdiction') supporting and amplifying NACCHO in its leadership of the Aboriginal and Torres Strait Islander community-controlled health sector. Each Affiliate supports the Aboriginal Community- Controlled Health Organisations (ACCHOs) in their jurisdiction through the provision of support and practical advice in the areas of organisational governance and services, continuous quality improvement (CQI) accreditation, program implementation, workforce development and building capacity. Affiliates facilitate partnerships between the ACCHOs, the respective government departments and other service providers in the development and application of co-designed health policies, plans and evaluations.
Australian Commission on Safety and Quality in Health Care (ACSQHC)	Means the Commission established under the *National Health Reform Act 2011* performing the functions set out in this Addendum, including Schedule I.

Term	Definition
Avoidable Hospital Readmission	Means a condition identified on the AHR list, as approved by HMM and maintained by the ACSQHC. Defining criteria for AHRs are found in Appendix B.
Avoidable Hospital Readmission list	Means the Avoidable Hospital Readmission List maintained by the ACSQHC, as amended from time to time.
Block-funded service	Means a public hospital and health service funded under the Block Funding stream.
Block Funding Commonwealth Contribution Rate (Block CCR)	Means the output CCR for the Block Funding stream, calculated as per clause A32(b) of this Addendum.
Bundled payment	Means payments which cover the entire patient journey within eligible public hospital services across all the locations and transitions of care for a defined and end to end pathway. They are an expanded form of ABF Diagnosis Related Group bundling, but the unit of activity or the model of care is broader in duration and may cross health settings.
Capitation	Means payments that follow the patient through eligible service episodes and allocate a fixed price per person enrolled in the model over a defined period, regardless of what care is required. Payments are stratified according to patient complexity/risk, and enrolment can be based on a cohort or specific conditions.
Closing the Gap Priority Reforms	Means the National Agreement on Closing the Gap, which includes four Priority Reforms to change the way governments work. These include: • Formal partnerships and shared decision making - Aboriginal and Torres Strait Islander people are empowered to share decision-making authority with governments to accelerate policy and place-based progress on Closing the Gap through formal partnership arrangements. • Building the community-controlled sector – There is a strong and sustainable Aboriginal and Torres Strait Islander community-controlled sector delivering high quality services to meet the needs of Aboriginal and Torres Strait Islander people across the country. • Transforming government organisations, Governments their organisations and their institutions are accountable to Closing the Gap and are culturally safe and responsive to the needs for Aboriginal and Torres Strait Islander people, including through the services they fund. • Shared access to data and information at the regional level – Aboriginal and Torres Strait Islander people have access to, and the capability to use, locally-relevant data and information to set and monitor the implementation of

	efforts to close the gap, their priorities and drive their own development.
Coalition of the Peaks	Means the national network of more than 80 Aboriginal and Torres Strait Islander community-controlled peak bodies and members across Australia who represent some 800 organisations. The Coalition of the Peaks bring forward the views of their members and communities to all their discussions with governments.
Co-design	Means an equitably resourced partnership process that is Aboriginal and Torres Strait Islander-led and build on authentic relationships, communicating through agreed mechanisms, two-way understanding, cumulative evaluation and reflection to generate and sustain shared development pathways to outcome delivery and reform. To be described as co-design respective activities, arrangements and claims must: • Ensure early and consistent involvement of Aboriginal and Torres Strait Islander people and/or communities through the design process for transparency and accountability. • Prioritise and respect the voices of Aboriginal and Torres Strait Islander people to determine and drive the agenda and design solutions for health reform; and address the interface between the health, disability and aged care sectors. • Facilitate knowledge-sharing, power-sharing, shifts in control consistent with the National Agreement and capability building between the healthcare system, Aboriginal and Torres Strait Islander experts and patients. Examples of co-design processes include the development of the National Agreement on Closing the Gap, National Aboriginal and Torres Strait Islander Health Plan, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 and the Health Sector Strengthening Plan.

Commissioning	Means a continual and iterative cycle of developing and implementing 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 this Addendum, these could include co-commissioning arrangements between health agencies and agencies and organisations from other service sectors, 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 budgets, may also be used.
Commonwealth Funding Entitlement	Means the amount of Commonwealth funding a State is entitled to receive under the Addendum for the delivery of public hospital and health services in a relevant financial year, adjusted for the impact of the Funding Cap, and other adjustments. This may be expressed on a preliminary, post-reconciliation or final basis.
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 – the individual's estate, provided that the order under subsection 6(2) of the *Health Insurance Act 1973*, dated 11 January 1984 remains in force, or a replacement order remains in force. *Note: The order referred to above excludes compensable patients from eligibility for Medicare in relation to public hospital services related to the compensable injury, illness or disease.*
Complaints body	Means an independent entity established or commissioned to investigate complaints and/or grievances against providers of States' public hospital services.
Cost shifting	Means when costs are incurred by a jurisdiction that are attributable to one or more changes that have been made to the policies, programs or practices of another jurisdiction.

Course of treatment	Means a sequence of clinical interventions or services aimed at managing a specific health condition.
Cultural safety	Means acknowledging the two-part definition of cultural safety developed by the Australian Health Practitioner Regulation Authority (AHPRA) for the National Registration and Accreditation Scheme namely: • Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities • Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism This definition also acknowledges that cultural safety requires organisational change through critically analysing and addressing racism, biases, assumptions, stereotypes and prejudices expressed through the organisations structures, values, policies and procedures that create barriers to provide good health care and good health outcomes.
Cyber resilience	Means the ability to adapt to disruptions caused by cyber security incidents while maintaining continuous business operations. This includes the ability to detect, manage and recover from cyber security incidents.
Cyber security	Means measures used to protect the confidentiality, integrity and availability of systems and data.[3]
Eligible person	Means, as defined in subsections 3(1), 6, 6A and 7 of the *Health Insurance Act 1973*, excluding compensable patients.
Eligible private patient	Means an eligible patient who chooses to be treated as a private patient. Includes admitted, non-admitted and hospital in the home settings. Excludes compensable patients and other patients funded by third parties.
Emergency department	Means admission level three or above emergency service under the Australian College for Emergency Medicine guidelines, or as otherwise recommended by the IHACPA and agreed by HMM.
Entitled veteran	Means a Department of Veterans' Affairs patient referred to in the *Veterans' Entitlements Act 1986*.
Ex Officio	Means a non-voting member with the authority to attend meetings, receive the meeting agenda and relevant documents in advance, participate and contribute views and insights.

[3] https://www.cyber.gov.au/resources-business-and-government/essential-cyber-security/ism/cyber-security-terminology

Final (Commonwealth) Entitlement	Means the final amount of Commonwealth NHR funding a State is entitled to receive for a relevant financial year, as determined by the Commonwealth Treasurer.
Fixed-plus-variable model	Means the model used to determine the efficient cost of a small rural hospital under the Block Funding stream. It consists of the sum of a fixed cost component, and a variable cost component as determined by the IHACPA in the National Efficient Cost Determination.
Formal Partnership	Means as defined in the National Agreement on Closing the Gap clauses 28 to 33 enshrine agreed joint decision-making by setting out who makes decision, how decisions are made, and what decisions will be about. Formal Partnerships provide Aboriginal and Torres Strait Islander entities with a level of power that is equal to or higher than other parties. In Formal Partnerships, Aboriginal and Torres Strait Islander people choose their own representatives. Formal Partnerships require formal signed agreements between Aboriginal and Torres Strait Islander people, governments, and/or other parties that sets out how they will each work to together to achieve agreed goals and aims. As states in the National Agreement on Closing the Gap, adequate funding is needed to support Aboriginal and Torres Strait Islander parties to be partners with government in Formal Partnerships for activities to: 1. Engage independent policy advice 2. Meet independently of governments to determine their own policy positions 3. Support strengthened governance between and across Aboriginal and Torres Strait Islander organisations and entities 4. Engage with and seek advice from Aboriginal and Torres Strait Islander people from all relevant groups within affected communities, including but not limited to, Elders, Traditional Owners and Native Titles Holders.
Funding cap	Means the maximum Commonwealth funding entitlement for a State for a given year, calculated in accordance with clause A41, Part 1 of Schedule A of this Addendum.
General List	Means the list of in-scope services, curated and maintained by the IHACPA as set out in Part 3 of Schedule A of this Addendum.
Glide path	Means a funding model whereby the Commonwealth's funding input contribution rate is increased over time according to a set trajectory towards an agreed target percentage.

HAC List	Means the Hospital Acquired Complication List maintained by the ACSQHC, as amended from time to time.
Health and wellbeing	Means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-passing-life.
Health Ministers Meeting (HMM)	Means the forum established to facilitate provision of advice by Health Ministers, including to National Cabinet if requested.
Health system performance assessment framework	Means the framework established in accordance with Schedule H.
Health Technology Assessment (HTA)	Means the systematic evaluation of the best available evidence concerning the quality, safety, efficacy, cost-effectiveness and total costs of a health technology compared to the existing standard of care. Health technologies include tests, devices, medicines, vaccines, procedures, programs and systems.
High cost, highly specialised therapies	Means TGA approved medicines and biologicals delivered in a public hospital setting where: • the therapy and its conditions of use are recommended by the Medical Services Advisory Committee (MSAC), • the average annual treatment cost (including ancillary services) exceeds $200,000 per patient (with input from the IHACPA as relevant), • there is a deed of agreement in place between the Commonwealth and Sponsor outlining the conditions of public funding, and • where the therapy is not otherwise funded through a Commonwealth program or the costs of the therapy would not be appropriately funded through a component of an existing pricing classification.
High-value care	Means care considered high benefit to specific patients or cohorts, provided in the appropriate setting, based on clinically-agreed best practice process and high-quality evidence, or patient outcomes (where available).
High-value care list	Means the list of high-value care events and/or pathways, and associated specific patient criteria, that will be developed and maintained by the ACSQHC. Care following these pathways will be subject to a positive pricing adjustment following the pricing principles outlined in this Addendum, and as determined by IHACPA.

Hospital Acquired Complication (HAC)	Means a condition identified on the HAC list, as approved by HMM and maintained by the ACSQHC. Defining criteria for HACs are found in Appendix B.
Independent Health and Aged Care Pricing Authority (IHACPA)	Means the authority established under the *National Health Reform Act 2011* to perform the functions set out in this Addendum, including in Schedule I.
Indigenous Data Sovereignty	Means the right of Aboriginal and Torres Strait Islander people, communities and organisations to maintain, control, protect, develop, and use data affecting self-determination. Five principles convey these rights to: 1. Exercise control of the data ecosystem including creation, development, stewardship, analysis, dissemination and infrastructure. 2. Data that are contextual and disaggregated. 3. Data that are relevant and empowers sustainable self-determination and effective self-governance. 4. Data structures that are accountable to Aboriginal and Torres Strait Islander people. 5. Data that are protective and respects our individual and collective interests. Indigenous Data Sovereignty guarantees that the rights of Indigenous peoples, their experiences, values and understanding are developed and reflected in any data and information gathered about Aboriginal and Torres Strait Islander people, communities and their knowledges. Indigenous Data Sovereignty is practiced through Indigenous data governance.
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 or health service.
Input contribution rate	Means the percentage amount the Commonwealth will fund for the delivery of public hospital and health services delivered under this Addendum, subject to the application of the funding cap. The rate for different services may vary each year in accordance with the glide path and other funding arrangements set out in this Addendum.
In-scope service	Means public hospital and health services that are eligible to receive a Commonwealth funding contribution under this Addendum, listed in the General List, or subcomponent thereof, as determined by IHACPA.

Interoperability	Means information can move easily between people, organisations, and systems. It enables a connected healthcare system that shares health information securely, safely and without any special effort from the people and organisations involved. There are three layers where interoperability should be considered: external to an organisation, internal to an organisation and at the point of care.
Joint Council	Means the group that supports the national leadership, coordination and cooperation for the National Agreement on Closing the Gap. Joint Council has two co-chairs, namely a government minister with responsibility allocated on a rotational basis and an Aboriginal and Torres Strait Islander representative nominated by Coalition of the Peaks, with broad geographic and subject matter coverage.
Local Hospital Network	Means an organisation established in accordance with Schedule E and providing public hospital and health services.
Low-value care	Means care (events, procedures and/or pathways) with low or no benefit to that specific patient, or unacceptably high risk to that specific patient, based on best available clinical evidence and/or patient outcomes.
Low-value care list	Means the list of low-value care events, pathways, and associated specific patient criteria, that will be developed and maintained by the ACSQHC and will be subject to a pricing adjustment as determined by IHACPA.
Medical Services Advisory Committee (MSAC)	Means the independent non-statutory committee established by the Australian Government that provides advice on evidence relating to the safety, efficacy and cost-effectiveness of new medical technologies and procedures.
Medicare Benefits Schedule (MBS)	Means the list of services subsidised by the Commonwealth in accordance with Part II of the *Health Insurance Act 1973*.
Medicare Principles	Means the principles set out in clause 21 of this Addendum.
Minimum funding guarantee (MFG)	Means the minimum Commonwealth funding entitlement for a State for a given year, calculated in accordance with this Addendum.
National Aboriginal Community Controlled Health Organisation (NACCHO)	Means the national community-controlled peak body for Aboriginal and Torres Strait Islander people's health and wellbeing operating at national level to co-design and provide guidance to the Australian Government on policy and budget matters while advocating for community-developed health solutions that contribute to the quality of life and improved health outcomes for Aboriginal and Torres Strait Islander people. Almost all ACCHOs in Australia are NACCHO Members. NACCHO contributes significantly to closing the

	gap in health outcomes between Aboriginal and Torres Strait Islander people and other Australians.
National bodies	Means the functions and bodies established and existing from time to time for the purposes of implementing the Addendum, including, without limitation, the Administrator, the National Health Funding Body, the Independent Health and Aged Care Pricing Authority and the Australian Commission on Safety and Quality in Health Care.
Nation Building	Means the efforts enhancing Aboriginal and Torres Strait Islander people's capacities for self-governance and self-determined economic development and, according to the Social Justice Report (2014), is achieved when local Aboriginal and Torres Strait Islander people, Nations, communities, authorities and organisations have power and control over decision making and resources.
National Cabinet	Means the peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers and Territory Chief Ministers.
National efficient cost (NEC)	Means the model that underpins funding for services that are not suitable be funded based on activity such as small rural hospitals. The national efficient cost determines the Commonwealth's funding contribution to the block funding stream.
National efficient price (NEP)	Means the base price(s) which will be determined by the IHACPA and applied to those services funded based on activity for the purpose of determining the amount of Commonwealth funding to be provided to Local Hospital Networks. The IHACPA 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. If there are multiple national efficient prices, the IHACPA will determine which national efficient price applies.

National Funding Model	Means the calculation, payment and reconciliation of Commonwealth national health reform funding entitlements for public hospital and health services, by the Administrator of the National Health Funding Pool (Administrator) applying the agreed methodology, business rules and policies set out in this Addendum. This is calculated using State-reported service delivery, the IHACPA’s National Efficient Price and National Efficient Cost determinations, and other inputs related to the Service Model Reform Funding stream. 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, IHACPA's Pricing Framework and National Pricing Model specifications, classification systems, counting rules, data, coding and costing standards.
National healthcare specific purpose payment (SPP) growth factor	Means the product of: a) a health specific cost index (a five-year average of the Australian Institute of Health and Welfare health price index), b) growth in population estimates weighted for hospital utilisation, and c) a technology factor (Productivity Commission derived index of technology growth). Source: *Schedule D of the Intergovernmental Agreement on Federal Financial Relations*
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 *National Health Reform Act 2011* to assist the Administrator in carrying out their functions under Commonwealth and State legislation, in accordance with this Addendum.
National Health Funding Pool	Means the pool established by enabling Commonwealth and State legislation in accordance with this Addendum.
National Health Reform (NHR) Funding	Means Commonwealth or State payments made under this Addendum into the National Health Funding Pool or State Managed Fund.

National Indigenous Health Leadership Alliance (NIHLA)	Means a partnership of Aboriginal and Torres Strait Islander health and wellbeing organisations, whose purpose is to drive systemic and structural transformation of mainstream government systems, including addressing institutional racism and advancing the human rights of Indigenous peoples in alignment with the National Agreement on Closing the Gap, the National Aboriginal and Torres Strait Islander Health Plan, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan. Each member of NIHLA has their own membership who work across the public and private hospital system through to primary health through ACCHOs and general practice, and private practice. The breadth of locational practice, scopes of professional practice and lived experience provides NIHLA with a broad understanding of the strengths, weaknesses and failing of our health systems. Thus, NIHLA plays an important role in advocating for and supporting improved outcomes for Aboriginal and Torres Strait Islander people: 1. sharing their knowledge, expertise and insights to strengthen the capability of governments and mainstream organisations to deliver more effective policies and programs 2. providing advice on matters relating to Aboriginal and Torres Strait Islander health from the perspective of the mainstream service system, education and training systems.
National Pricing Model	Means the classification, costing, and pricing of public hospital and health services by the IHACPA, for funding through the National Funding Model. The pricing model comprises of multiple sub-models and includes an NEP or NEC, price weights and adjustments, and each is based wherever possible on actual cost and activity. The agreed methodology and policies are independently maintained and published by the IHACPA.
National Weighted Activity Unit (NWAU)	Means a measure of hospital activity expressed as a common unit, against which the National Efficient Price is paid. It is a point of relativity for the pricing of public hospital and health services, weighted for clinical complexity.
Non-admitted patient services	Means “Non-Admitted Patient” as defined in METEOR (the AIHW’s Metadata Online Registry).

Normative pricing	Means a pricing approach for calculating the cost of care in accordance with current evidence-based clinical guidelines and/or agreed best practice, for IHACPA to consider in cases where the weighted national average cost is not an appropriate mechanism, or there is insufficient data, to determine the price paid for a care pathway, procedure or episode of care within NHRA scope.
Optimal models of care	Means models of care that demonstrate best-practice, safe, high-value and quality care as an end-to-end integrated patient journey across care settings and acuity levels to deliver better patient outcomes and improved system sustainability.
Outpatient department	Means any part of a hospital (excluding the emergency department) that provides non-admitted patient care.
Output Commonwealth contribution rate	Means the percentage amount the Commonwealth funded for the delivery of public hospital and health services delivered under this Addendum, after the application of the funding cap. This rate is calculated by funding stream following the annual reconciliation for a financial year and is based on actual activity delivered, including application of the funding cap and any funding adjustments. There is no output CCR for the Public Health Funding stream.
Parties	Means the signatories to this Addendum, being the Commonwealth and each State and Territory government.
Patient election status	Means the status of patients according to the National Standards for Public Hospital Admitted and Non-admitted Patient Election Processes in Schedule J.
Patient Reported Measures	Means information collected about the experience of health services, and the outcomes of health services, as described by patients.
Pharmaceutical Benefits Advisory Committee (PBAC)	Means an independent expert body appointed by the Australian Government that has a primary role to recommend new medicines for listing on the Pharmaceutical Benefits Scheme (PBS) and new vaccines for delivery through the National Immunisation Program (NIP).
Pharmaceutical Benefits Scheme (PBS)	Means the Commonwealth government's scheme to provide subsidised pharmaceuticals to Australians established under part VII of the *National Health Act 1953* (the Act) together with the *National Health (Pharmaceutical Benefits) Regulations 2017* made under the Act.

Term	Definition
Pharmaceutical Reform Agreements	Means arrangements which provide for public hospitals that are either Approved Hospital Authorities under Section 94 of the *National Health Act 1953* (the Act) or a hospital authority that has been registered with the Department of Health, Disability and Ageing to supply pharmaceuticals funded by the PBS for specific categories of patients. These arrangements include access to the following PBS medicines categories listed in the Act: • Section 85 General Schedule medicines for non-admitted patients and admitted patients on discharge. • Medicines delivered through the Section 100 Efficient Funding of Chemotherapy (EFC) Program for day-admitted and non-admitted patients.
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 sub-populations, and comparisons of the health of different populations.
Preliminary (Commonwealth funding) entitlement	Means the initial amount of Commonwealth funding a State is entitled to receive for a relevant financial year, based on estimated or anticipated volume of hospital and health service delivery in that State for the relevant financial year, as calculated by the Administrator according to the arrangements set out in this Addendum.
Preliminary Uncapped Commonwealth Funding Entitlement	Means the amount of Commonwealth funding a State is entitled to receive under the Addendum for delivery of public hospital and health services in a relevant financial year, excluding the impact of their funding cap or other adjustments.
Priority care loadings	Means pricing adjustments to incentivise services, types of care, services for priority populations and delivery in specific settings that the Parties consider to be priority areas.
Private Health Insurance Rebate	Means the Commonwealth Government's scheme to provide private health insurance rebates established under the *Private Health Insurance Act 2007* together with relevant regulations and rules made under the Act.
Public health activities	Means the activities performed within each State directed at improving the overall health of the population that are funded under the Public Health Funding stream.
Public hospital and health services	Means the services, functions and activities funded by the Commonwealth under this Addendum.

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 process undertaken for each State by the Administrator, to compare the estimated volume of public hospital and health service delivery to the actual volume delivered. This occurs annually at a minimum for each State.
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 data required to facilitate the accurate classification, pricing and funding of public hospital and health services by the IHACPA, the Administrator and the NHFB, as specified in their three-year data plans and in accordance with the *National Health Reform Act 2011*.
Safety and Quality Adjustment	Means a pricing adjustment from the Commonwealth for Public Hospital Services, funded either under ABF or Block Funding, following the occurrence of an adverse event which has an active pricing adjustment model associated with it.
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 ACSQHC and approved by HMM.
Service Agreement	Means an agreement between a State and a Local Hospital Network consistent with this Addendum.
Service category	Means a grouping of related public hospital and health services for the purposes of classification, funding calculation and reporting purposes. Service categories may be based on type of service (ABF), cohort (bundled) or setting (some block funded services).
Service Model Reform Funding (SMRF) stream	Means the dedicated reform funding stream to be established from 1 July 2027 to fund activities and projects in line with agreed national reform priorities, as per arrangements in Schedule D.
Shared decision-making	Means processes mutually described as shared between government and Aboriginal and Torres Strait Islander people. Activities characterised as shared decision-making must adhere to the definition of shared decision-making in the National Agreement on Closing the Gap, namely:

	1. by consensus, where the voice of Aboriginal and Torres Strait Islander entities hold as much weight as the governments 2. transparent, where matters for decision are in terms that are easily understood by all entities and where there is enough information and time to understand the implications of the decision 3. where Aboriginal and Torres Strait Islander representatives can speak without fear of reprisals or repercussions 4. where a wide variety of groups of Aboriginal and Torres Strait Islander people, including women, young people, Elders and Aboriginal and Torres Strait Islander people with a disability can have their voice heard 5. where self-determination is supported, and Aboriginal and Torres Strait Islander lived experience is understood and respected 6. where relevant funding for programs and services align with jointly agreed community priorities, noting governments retain responsibility for funding decisions 7. where all entities have access to the same data and information, in an easily accessible format, on which any decisions are made.
Soft Cap	Means the limit in growth in Commonwealth funding for public hospital services in a State of 6.5 per cent per annum, as part of the 2020-2025 Addendum to the NHRA.
Statement of Assurance	Means the statement as to the completeness and accuracy of data submitted, issued in accordance with clauses I93 and I94.
State managed fund(s)	Means a fund(s) or account(s) established by State legislation for the purpose of receiving funding for block-funding.
States	Means States and Territories.
Third Party	Means any party other than the Commonwealth (including Department of Veterans' Affairs) and the State Department administering the Agreement that enters into an arrangement for the purchase of public hospital services.
Trauma-aware, healing-informed practice	Means an approach has been developed to address the high prevalence of trauma amongst Aboriginal and Torres Strait Islander people and support journeys of individual, family, and community healing. It recognises the co-existence of trauma with intergenerational trauma, built within individual and collective experiences of colonialism and racism. It is strengths based and grounded in Aboriginal and Torres Strait Islander people's ways of knowing, being, and doing. The

	approach is non-linear and cyclical, reflective of the story and journey of each individual, family, community and Country. In practice, it emphasises cultural, spiritual, physical, psychological, and emotional safety, when engaging with issues of high importance that are likely to be sensitive and triggering of trauma responses. It requires a reflective practice and an awareness of cultural and unconscious bias, privilege, and the ongoing impacts of colonialism. Its principles are: 1. Stolen Generations survivors have complex needs related to their experiences of trauma 2. Aboriginal and Torres Strait Islander people's ways of knowing, being and doing encompass belonging, (re)connection, collectivity, intergenerational learning, knowledges, and relationships 3. an understanding of engagement with collective and interconnected trauma and intergenerational trauma experienced by First Nations peoples 4. culture and cultural expression are central to healing 5. strengths based interconnected approaches 6. healing informed is a nonlinear, holistic journey that addresses physical, emotional, and spiritual needs.
Treasurer's Determination	Means the legislative instrument that sets out the final Commonwealth NHR funding entitlement amount for each State for the relevant financial year as determined by the Commonwealth Treasurer.
Unspent cap funding	Means the difference between a State's funding cap and their final entitlement for a financial year if their final Commonwealth entitlement is less than their funding 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 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.
Value-based pricing	Means pricing adjustments made under the high-value care, low-value care, normative pricing and priority care loading initiatives within this Addendum.
Weighted services	Means services of a particular category where each service may count as more or less than one service as determined by the cost weight determined by the IHACPA to be applicable to that service.

APPENDIX B – SAFETY AND QUALITY CRITERIA

A. The following clauses specify:

   a. the criteria for determining Sentinel Events, Hospital Acquired Complications and Avoidable Hospital Readmissions for ongoing safety and quality pricing adjustments, originally included in the 2017-20 and 2020-25 Addenda and related guidance from national bodies

   b. parameters for review of safety and quality measures.

Sentinel Events

B. Sentinel Event criteria include instances where:

   a. adverse patient safety events are wholly preventable

   b. the event results in serious harm to, or death of, a patient.

Hospital Acquired Complications

C. The following criteria define Hospital Acquired Complications (HACs) and related pricing adjustments:

   a. Preventability:

      i. Clinical evidence is available to demonstrate that the HAC can be prevented with 'best clinical practice'

      ii. Evidence supports that individual Local Hospital Networks (LHNs, including single campus and specialist hospitals) can prevent the HAC and that the causes of such conditions 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

      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

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:

i. Reporting mechanisms are sufficiently robust to ensure that any benefit obtained through under reporting is minimised

ii. 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

iii. Sufficient processes, systems, policies, feedback mechanisms and data collections are in place to support the reduction of the HAC across each LHN

iv. 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

D. Avoidable Hospital Readmissions (AHRs) are a measure of potential issues with the quality, continuity and integration of care provided to patients during or subsequent to their original hospital admission (the index admission).

E. AHRs are defined based on the following criteria, where the subsequent admission:

a. relates to the index admission

b. is avoidable by improved clinical management in the index admission and/or suitable discharge planning and follow-up

c. is measurable through coded data generated from the patient medical record.

Review of safety and quality measures

F. The focus of the review in clauses D51 to 55 is to retain and strengthen the existing safety and quality indicators and pricing adjustments, by considering whether and how they drive improvements in safety and quality. This review will consider at least the following principles.

a. The existing safety and quality pricing measures are evidence-based, effective, fit-for-purpose and prioritise patient outcomes.

i. Review scope of existing adverse event lists and whether they continue to meet the criteria set out in A to E of this Appendix.

ii. Assess timeframes associated with AHRs, and risk categorisation for HACs and AHRs, to determine whether they are appropriately designed to drive improvements in patient safety and quality.

iii. Review downward pricing adjustments to ensure they are driving improvements in safety and quality, based on robust evidence of a causal link to the condition or complication and use an appropriate risk adjustment methodology to consider different patient complexity.

iv. Assess pricing measures to see if they have effectively driven down rates of negative events.

v. Assess pricing measures to see if they have improved outcomes for patients (where data is available).

vi. Determine how to include safety and quality measures in new payment and service delivery reforms included in this Addendum (including but not limited to bundling/capitation, expanded scope of services) and considering extending safety and quality measures to non-admitted care, where required.

vii. Assess if upward pricing adjustments would be an appropriate complement to existing downward pricing adjustments. This could include considering situations such as avoidance of a high-risk HAC or LVC event, or to support investment in improving safety and quality of care.

viii. Assess if rates of clinical variation provide an effective indicator for targeted safety and quality improvement activities.

ix. Determine if safety, quality or value-based pricing mechanisms are appropriate to encourage public hospitals to provide hospital discharge summaries (clauses D44 to D48), and if so, which pricing mechanism is most appropriate.

x. Determine whether there are appropriate mechanisms that could support the reinvestment of pricing adjustments towards safety and quality improvement activities, if adjustments are found to be fit-for-purpose and effective.

b. Limitations and other controlling factors.

i. Detail any data limitations that are present, including those that limit the ability to evaluate effectiveness of existing pricing adjustments.

ii. Ensure the results are controlled for other state/LHN/hospital level strategies to improve safety and quality for patients.

iii. Acknowledging that mechanisms other than pricing and funding have a role in achieving the reform intention and that complementarity of all mechanisms is desirable.

c. Reforms are consistent with whole-of-system efforts to deliver improved patient health outcomes, including culture change.

i. 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.

ii. 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.

iii. Awareness of overarching safety and quality requirements among clinical and LHN staff, including clinician engagement in measures to drive high-quality, safe care.

iv. Where local governance structures are successfully driving cultural change.

d. Reforms are supporting improvements in safety and quality for Aboriginal and Torres Strait Islander people. To enable this the ACSQHC will partner with the Aboriginal and Torres Strait Islander Monitoring and Accountability Group to:

   i. assess the extent to which inequity exists in existing safety and quality indicators and pricing adjustments for Aboriginal and Torres Strait Islander people (e.g. if people are disproportionately represented in experiencing any adverse event, or adverse event type), and detail these identified inequities

   ii. identify and detail any data limitations that limit ability to evaluate safety, quality and effectiveness of pricing adjustments for Aboriginal and Torres Strait Islander people

   iii. develop safety and quality measures that will drive improvement in Aboriginal and Torres Strait Islander outcomes, particularly focused on Sentinel Events, HACs and AHRs

   iv. consider how to measure, and drive improvement in, experiences of cultural safety and racism for Aboriginal and Torres Strait Islander patients. For example, the ACSHQC and Monitoring and Accountability Group may consider, in collaboration with the AIHW, metrics such as Discharge Against Medical Advice and Did Not Wait rates, disaggregated where appropriate.