

# Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding

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*This Agreement is made between the COMMONWEALTH OF AUSTRALIA (Commonwealth) and NEW SOUTH WALES, VICTORIA, QUEENSLAND, WESTERN AUSTRALIA, SOUTH AUSTRALIA, TASMANIA, the AUSTRALIAN CAPITAL TERRITORY and the NORTHERN TERRITORY (the States)*

## Preliminaries

1. This Agreement sets out the shared objective of the Commonwealth and the States (the Parties) to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.
2. We intend this agreement to build on and complement the policy and reform directions outlined in the National Healthcare Agreement (NHA) and the National Health Reform Agreement (NHRA). It is also subject to the Intergovernmental Agreement on Federal Financial Relations and should be read in conjunction with that agreement and any subsidiary schedules.
3. The Parties agree this Agreement will form the basis of negotiations leading towards a time-limited addendum of the National Health Reform Agreement (in the form of an additional schedule) to commence on 1 July 2017. The addendum will amend specified elements of the operation of the National Health Reform Agreement for a period of three years, ceasing 30 June 2020.
4. This Agreement recognises that responsibility for health is shared between the Commonwealth and the States.
  - a. The States will remain system managers for public hospitals and will remain responsible for their infrastructure, operation, delivery of services and performance.
  - b. The Commonwealth will continue to have lead responsibility for general practice (GP) and primary health care, including the Primary Health Networks, and continue to support private health services through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS), the Private Health Insurance Rebate.
  - c. All governments have a shared responsibility to integrate systems and services to improve health outcomes for Australians and acknowledging the interoperability of the system.

5. The Parties agree the reforms in this Agreement reaffirm the Medicare Principles:
  - a. eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals;
  - b. access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and
  - c. arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.
6. Specifically, this Agreement and its Schedules includes:
  - a. public hospital funding arrangements between the Parties from 1 July 2017 until 30 June 2020;
  - b. a commitment to develop an addendum to the NHRA to commence on 1 July 2017, to operate for a period of three years, ceasing 30 June 2020;
  - c. a commitment to develop by 1 July 2017, and begin to implement, reforms to improve Australians' health outcomes and decrease avoidable demand for public hospital services as set out in Schedule 2, through:
    - i. better coordinated care, particularly for patients with complex and chronic disease;
    - ii. funding and pricing for quality and safety, to avoid funding unnecessary or unsafe care;
    - iii. reducing avoidable readmissions to hospital; and
    - iv. the Commonwealth continuing to focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions.
7. The Parties agree this Heads of Agreement will lapse after the NHRA addendum is signed.
8. The Parties acknowledge that NHRA addendum anticipates the development of a longer-term public hospital funding agreement to commence 1 July 2020. This longer-term public hospital funding agreement will be developed by the Commonwealth and all jurisdictions and be considered by COAG before September 2018.

#### **Public Hospital Funding Arrangements for 2017-18 to 2019-20**

9. The Parties agree, consistent with clause A(1) of the NHRA that the Commonwealth's contribution to hospital services from 1 July 2017 until 30 June 2020 will comprise funding relating to:
  - a. hospital services provided to public patients in a range of settings, and eligible private patients in public hospitals and a range of settings, with funding provided on the basis of activity based funding (ABF);
  - b. block funding for public hospital services better funded through block grants, including relevant services in regional and rural communities and teaching, training and research functions; and



- c. public health activities.
10. The Parties agree that ABF will be the preferred basis for funding public hospital services where ever practicable.
  11. From 1 July 2017 to 30 June 2020, the Commonwealth will fund 45 per cent of the efficient growth of activity based services, subject to a cap in the growth of overall Commonwealth funding outlined in Clause 14 below. Schedule 1 outlines activity based funding arrangements.
  12. Where services or functions are more appropriately funded through block grants, the Commonwealth will provide 45 per cent of the efficient growth of providing these services.
    - a. The Independent Hospital Pricing Authority will retain its function of determining the national efficient cost of services provided on a block funded basis in public hospitals.
  13. Commonwealth payments for public health activities for the period 2017-18 to 2019-20 will be calculated consistent with the process outlined in the National Health Reform Agreement.
  14. Under this agreement, growth in Commonwealth funding for public hospitals, outlined in clause 9 above, will not exceed 6.5 per cent a year. The details of this cap will be determined by December 2016, in the context of settling the addendum of the NHRA.
  15. Where a State may receive less funding under the arrangements outlined in this Agreement than they would have received under block funding arrangements outlined in the 2014-15 Budget, the Commonwealth will work with any affected jurisdiction to consider whether there is a case to provide additional funding to that State.
  16. As part of the addendum of the NHRA, the Parties agree to incorporate a payment incentive for the prompt provision of hospital activity data to enable timely reconciliation. The details of this incentive will be determined in settling the addendum of the NHRA.
  17. States will determine the amount they pay for public hospital services and functions and the mix of those services and functions, and will meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution.
  18. The States agree to maintain, at a minimum, their current levels of funding for public hospitals, while having regard to new, appropriate models of care that may change the setting in which care is delivered.

#### **Reforms to improve the efficiency of public hospitals**

19. In addition to Commonwealth funding as set out at Clauses 11 to 16, all Parties commit to begin to implement a range of reforms designed to improve health outcomes for patients and decrease potentially avoidable demand for public hospital services as set out at Schedule 2.

20. The Reforms outlined in Schedule 2 are: (1) coordinated care for patients with chronic and complex disease, (2) incorporating quality and safety into hospital pricing and funding, (3) reducing potentially avoidable hospital readmissions, and (4) reforms to primary care to reduce potentially avoidable hospital admissions.
21. The Parties acknowledge this Agreement does not preclude pursuing other reforms to improve health outcomes and the efficiency of public hospitals in the future.

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

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

  
**The Honourable Malcolm Turnbull MP**  
Prime Minister of the Commonwealth of Australia

1 April 2016

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

  
**The Honourable Mike Baird MP**  
Premier of the State of New South Wales

1 April 2016

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

  
**The Honourable Daniel Andrews MLA**  
Premier of the State of Victoria

1 April 2016

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

  
**The Honourable Annastacia Palaszczuk MP**  
Premier of the State of Queensland

1 April 2016

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

  
**The Honourable Colin Barnett MLA**  
Premier of the State of Western Australia

1 April 2016

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

  
**The Honourable Jay Weatherill MP**  
Premier of the State of South Australia

1 April 2016

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

  
**The Honourable Will Hodgman MP**  
Premier of the State of Tasmania

1 April 2016

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

  
**Andrew Barr MLA**  
Chief Minister of the Australian Capital Territory

1 April 2016

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

  
**The Honourable Adam Giles MLA**  
Chief Minister of the Northern Territory of Australia

1 April 2016



### Activity Based Funding (ABF) Arrangements for 2017-18 to 2019-20

1. For the period 2017-18 to 2019-20, the Commonwealth's funding for each ABF service category will be calculated individually for each State by summing:
  - a. *previous year amount*—the Commonwealth's percentage funding rate for the relevant State in the previous year, multiplied by the volume of weighted services provided in the previous year, multiplied by the National Efficient Price (NEP) in the previous year;
  - b. *price adjustment*—the volume of weighted services provided in the previous year, multiplied by the change in the NEP relative to the previous year, multiplied by 45 per cent (or a lower rate if the funding cap is reached);
  - c. *volume adjustment*—the net change in volume of weighted services to be provided in the relevant State (relative to the volume of weighted services provided in the previous year), multiplied by the NEP, multiplied by 45 per cent (or a lower rate if the funding cap is reached).
2. The Commonwealth's contribution to activity based funding (including efficient growth) will be calculated at the start of each financial year, and will be updated or revised based on advice from the Administrator, including a final reconciliation of public hospital services, consistent with current arrangements under the NHRA.
3. The Administrator of the National Health Funding Pool will calculate and advise the Commonwealth Treasurer of the monthly Commonwealth payments into the National Health Funding Pool.
4. The States, in consultation with the National Health Funding Body (NHFB), will determine when state payments are made into the Pool and State managed funds.
5. Payments will be made out of the Pool accounts to Local Hospital Networks and state managed funds as set out in the National Health Reform Agreement (NHRA).
6. The Parties agree that the NEP and NEC will continue to be set by the Independent Hospitals Pricing Authority (IHPA) as set out in the NHRA and that the IHPA's:
  - a. ongoing costs will continue to be met by the Commonwealth; and
  - b. functions will continue as set out in the NHRA and existing legislation, including maintaining the independence of the IHPA.
7. The Parties also agree that the single national health funding pool will continue as set out in the NHRA and existing legislation, including that:

- a. the Administrator of the National Health Funding Pool (the Administrator) and the NHFB will continue to provide for the transparent and efficient administration of public hospital funding;
- b. the roles of the Administrator and the NHFB will continue as set out in the NHRA;
- c. the Administrator will use IHPA's determination of the National Efficient Cost to calculate the Commonwealth's funding contribution for block funding; and
- d. the States will continue to provide data on public hospital services to the Administrator as set out in the NHRA.

### **Reforms to be undertaken by the Parties**

1. In addition to the Commonwealth funding as set out in the Heads of Agreement, the Parties commit to developing and implementing these reforms intended to improve health outcomes for patients and decrease demand for public hospital services.

#### ***Coordinated Care***

2. Bilateral agreements will be signed to provide flexibility for each jurisdiction to determine the best model of care.
3. Patients with chronic and complex disease are costly to treat (10 per cent of the population account for 45 per cent of Medicare expenditure) and the system does not always provide the care they need in a coordinated way.
4. The Commonwealth will establish any necessary enabling infrastructure, governance arrangements, or systems to support a pilot of a Health Care Homes model in primary health care, consistent with the advice provided by the Primary Health Care Advisory Group. An initial first stage of activity will include:
  - a. criteria for determining patient eligibility in Commonwealth funded services;
  - b. funding levels and payment mechanisms in Commonwealth funded services;
  - c. establish data collection and associated quality improvement processes within participating general practices;
  - d. a comprehensive evaluation to determine impact on patient outcomes, hospitalisations and overall cost effectiveness of the model; and
  - e. establish early implementation of a pilot of Health Care Homes in Primary Health Network (PHN) regions, to be operational by 1 July 2017.
5. The States will work with the Commonwealth in selected regions through bilateral agreements, which may include:
  - a. establishing elements involving joint coordinated planning and, where appropriate, collaborative commissioning of services between PHNs and Local Hospital Networks (LHNs);
  - b. identifying and implementing arrangements for the sharing of patient information, with patient consent, including relevant hospitalisation, MBS and PBS data;
  - c. educating relevant state funded health service providers to work with Health Care Homes pilots in participating regions; and
  - d. where feasible, implement collaborative, joint and/or pooled funding arrangements across specified funding programmes at the local level, including PHNs/LHNs to support better coordination of care for specific patients at risk of avoidable admission.



6. Beyond the selected regions, States and Commonwealth agree to continue to support efforts to deliver better outcomes for patients with chronic and complex conditions, acknowledging the significant investment Commonwealth and states already make in this area.
7. Initial work will focus on critical enabling infrastructure and governance arrangements required to support reforms, including any ICT, and data systems. Implementation will be staged.
8. The results of this first stage will be comprehensively evaluated and brought back to COAG, through the COAG Health Council, in 2018 for further consideration of a joint national approach to enhanced care coordination for patients with chronic and complex conditions, which may include collaborative, joint and or pooled funding arrangements.

### ***Pricing for quality and safety***

9. While most health care in Australia is associated with good clinical outcomes, preventable adverse events or complications continue to occur across the health system. By reducing hospital acquired complications, there is potential to not only improve patient safety, but also achieve efficiencies.
10. The Parties, in conjunction with the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the IHPA, will develop a comprehensive and risk-adjusted model to integrate quality and safety into hospital pricing and funding.
  - a. The model will determine how funding and pricing can be used to improve patient outcomes and reduce the amount that should be paid for specified adverse events, ineffective interventions, or procedures known to be harmful.
  - b. This could include an adjustment to the amount the Commonwealth contributes to public hospitals for a set of agreed hospital acquired conditions. Any downward adjustment to an individual state would not be deducted from the available pool of funding under the overall cap of 6.5 per cent.
11. The Parties agree to develop the model for implementation by 1 July 2017.

### ***Reducing avoidable readmissions:***

12. The Parties agree to work together to reduce avoidable readmissions to hospital within 28 days of discharge, with a particular focus on avoidable readmissions within 5 days of discharge, for conditions arising from complications of the management of the original condition that were the reason for the patient's original hospital stay.
13. The Parties, in conjunction with the ACSQHC and the IHPA, will develop a comprehensive and risk-adjusted strategy and funding model that will adjust the funding to hospitals that exceed a predetermined avoidable readmission rate for agreed conditions and the circumstances in which they occur by 1 July 2017.

### *Commonwealth reforms to primary care*

14. The Commonwealth will continue to invest in programmes designed to minimise the impact of potentially preventable hospital admissions arising from shortcomings in areas within its own direct policy control including:
  - a. integrating the planning , co-ordination and commissioning of services at a regional level through PHNs, with a specific focus on the interface between primary health care, and hospital services;
  - b. investments in national implementation of co-ordination of care models for person with complex , chronic conditions, including Health Care Homes, and flexible funding model to better support persons with severe mental health conditions, consistent with the November 2015 response to the National Mental Health Commission Report - *Contributing Lives, Thriving Communities*;
  - c. accelerating national rollout of My Health Records with legislative change to enable opt out provisions, with ongoing patient safety and efficiency benefits;
  - d. implementation of the 6th Community Pharmacy Agreement to enhance primary health care management of medications and avoidance of errors; and
  - e. partnering with jurisdictions with significant responsibility for primary health care, for example, in remote and Indigenous communities.