

Australian Health Care Agreement

between

the Commonwealth of Australia

and

the State of Victoria

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PART 1 – INTRODUCTION

Preamble

1. In recognition of the co-operative relationship between the Commonwealth and Victoria in the provision of health services, this Australian Health Care Agreement is an agreement to provide and jointly fund health care for eligible persons who choose to use State funded health services.
2. The Commonwealth and Victoria jointly commit to improving the health of the Australian population. This commitment includes striving for continuous improvement in State funded health services and developing an agreed broad strategy for the reform and improvement of mental health and palliative care services across Australia.
3. The Commonwealth and Victoria recognise and support the significant and legitimate role that the private sector plays in the provision of health services in Australia and the right of Australians to choose private health care.

Objectives

4. The Commonwealth and Victoria are committed to ensuring that the Australian health care system is a world class system which:
 - maximises the health of individuals and the community;
 - reflects a balance between investment in the health of individuals and the health of the community;
 - responds flexibly to community and consumer needs;
 - is integrated and co-ordinated;
 - achieves best practice, evidence based health care; and
 - matches proven health services with health services priorities.

Interpretation

5. In this Agreement, unless the contrary intention appears, words and phrases are to be interpreted by reference to Schedule A.

PART 2 - TERM OF AGREEMENT, VARIATION AND TERMINATION

Term of Agreement

6. This Agreement will commence on 1 July 1998 and will continue in force until 30 June 2003, unless terminated at an earlier date in accordance with clause 8.
7. This Agreement constitutes the entire agreement between the Commonwealth and Victoria and supersedes all earlier written or oral representations, agreements, statements and understandings. It is made subject to the Commonwealth *Health Care (Appropriation) Act 1998*.

Variation or Termination of the Agreement

8. This Agreement may be varied or terminated by further written agreement:
 - of the parties; or
 - on behalf of the parties to it by the Commonwealth and the State Ministers for Health.

Variations may include but are not limited to Commonwealth provision of additional financial assistance to Victoria in the event of unforeseen and catastrophic circumstances which would significantly increase the cost of providing public hospital services. These circumstances would include, but are not limited to, natural disasters and epidemics.

Resolution of Disputes Protocol

9. The Commonwealth and Victoria agree that where either party considers that either:
 - there has been a substantial breach of a term of the Agreement; or
 - there is evidence of adverse financial impact arising from a change in any health services policy (by either party on the other) of such a magnitude as to warrant a variation in financial assistance under this Agreementthey will raise the matter with the other party and suggest a course of action. If agreement on a course of action cannot be reached in three months, the parties may agree to refer the matter to an independent person appointed under clause 10.
10. An independent person may be proposed by either the Commonwealth or Victoria to the other party. If agreement on an independent person cannot be reached within eight weeks of the proposal, the Productivity Commission may be asked to appoint a person.

11. The independent person will consider material presented by both the Commonwealth and Victoria, and produce a report as expeditiously as possible recommending on an appropriate course of action, including where necessary amendments to this Agreement. The parties will use their best endeavours to reach a settlement within the spirit of the Agreement.
12. The Commonwealth and Victoria agree that the Commonwealth may not reduce the amount of financial assistance to be provided to Victoria under this Agreement except:
 - where there is agreement with Victoria; or
 - where an independent person appointed under clause 10 or clause 63 has reported that a reduction is appropriate.

PART 3 - PRINCIPLES OF THE AGREEMENT

13. This Agreement commits the Commonwealth and Victoria to the following principles.
 - (1) Eligible persons must be given the choice to receive public hospital services free of charge as public patients.
 - (2) Access to public hospital services by public patients is to be on the basis of clinical need and within a clinically appropriate period.
 - (3) Eligible persons should have equitable access to public hospital services, regardless of their geographical location.

The Commonwealth and Victoria agree that principles 2 and 3 are met if Victoria is using its best endeavours to achieve the outcomes sought in those principles to the greatest extent practicable.

PART 4 - ROLES AND RESPONSIBILITIES OF GOVERNMENTS UNDER THIS AGREEMENT

National Health Policy

14. The Commonwealth and Victoria agree that the national interest encompasses those objectives, programs and policy parameters which:
 - should be consistent across Australia for reasons of efficiency, effectiveness and equity;

- have implications for wider national social and economic objectives; or
- have implications for international relations.

A national approach to health policy is founded on four key issues: equity of access, standards of access and care, patient outcomes and the cost effective use of health resources.

15. The Commonwealth and Victoria recognise that there are elements of health policy that can be best advanced by a national approach, and other elements that may benefit by approaches determined within each jurisdiction.

Roles of the Commonwealth and Victoria

16. The roles of the Commonwealth are to:
- contribute to the cost of State funded health services for eligible persons;
 - fund and develop policy in relation to health services for which the Commonwealth has direct responsibility; and
 - work collaboratively with all States and Territories to develop and co-ordinate national health policy.
17. The roles of Victoria are to:
- ensure that public hospital services are provided in accordance with the terms of this Agreement;
 - work in collaboration with the Commonwealth and other States and Territories to develop and co-ordinate national health policy; and
 - ensure that eligible persons are able to access public hospital services as public patients.

Responsibilities of the Commonwealth and Victoria

18. The Commonwealth and Victoria share responsibility for meeting the costs of State funded health services, facilitating national health reform and the sharing of information to gain a better understanding of the changing dynamics of the Australian health system. They will work together, and with other States and Territories as appropriate, to:
- implement the Second National Mental Health Plan in line with Schedule B;
 - implement an agreed National Palliative Care Strategy;

- participate in a forum convened by the Commonwealth to advise on overall directions for the Casemix Program; and
- explore options to assess the impact of Reciprocal Health Care Agreements on State funded health services, and confirm the consultation procedures already in place under the arrangements for international treaties.

The Commonwealth and Victoria will implement this Agreement consistent with the principles outlined in the Aboriginal and Torres Strait Islander Health Framework Agreement.

19. Recognising the co-operative relationship between themselves, the Commonwealth and Victoria agree that they will not institute or sanction arrangements which unreasonably impose an additional financial burden on the other party. However, where it can be demonstrated that a change in service delivery arrangements would improve patient care or patient outcomes, the Commonwealth and Victoria undertake to implement such changes and modify financial responsibilities by agreement.
20. The responsibilities of the Commonwealth are to:
 - ensure that the Commonwealth contribution to funding is made on time and at a level specified in the Agreement; and
 - report and share information on a regular basis and contribute to the development of national performance indicators with particular focus on health outputs and outcomes, as set out in Schedule C.
21. The responsibilities of Victoria are to:
 - ensure that eligible persons are able to access public hospital services as public patients;
 - deliver services in accordance with the principles of this Agreement; and
 - report and share information on a regular basis and contribute to the development of national performance indicators with particular focus on health outputs and outcomes, as set out in Schedule C.
22. In 1998-99 Victoria commits to provide services to public patients at an indicative public patient weighted separation rate of 276.76/1000 applicable weighted population. In subsequent grant years the rate will be increased for utilisation drift of 2.1% per annum.
23. If the number of weighted separations provided in any grant year to residents of Victoria is less than 95% of the indicative public patient weighted separation rate, the Commonwealth and Victoria will review the reasons for the shortfall. This will include consideration of factors which are beyond the reasonable control of Victoria

including industrial action. If, following review, the Commonwealth is satisfied that the reduction is ongoing and not a result of action by Victoria providing public hospital services in other settings, the Commonwealth may propose a variation to the Agreement to reflect the changed pattern of service delivery.

24. Victoria accepts responsibility for the services previously funded in Victoria under the former Commonwealth programs: the Artificial Limbs Scheme; the Nationally Funded Centres; the Commonwealth Pathology Laboratories; and the Australian Bone Marrow Donor Registry - funding for which has been incorporated under this Agreement into the Health Care Grant.
25. Victoria accepts responsibility for maintaining a Public Patients' Charter and an independent Complaints Body as outlined in Schedule D.

PART 5 – REFORM

26. Victoria and the Commonwealth are committed to continuing their own reforms and to working in partnership to achieve agreed service delivery reform.

Measure and Share Reform Proposals

27. The Commonwealth and Victoria recognise the need for service delivery reform and ongoing exploration of additional initiatives under a measure and share model. Victoria will work with the Commonwealth in evaluating the outcomes from the Co-ordinated Care Trials to provide information to guide future directions for the reform of health service delivery.
28. The Commonwealth and Victoria will consider proposals which move funding for specific services between Commonwealth and State funded programs on the basis that each proposal meets the following criteria:
 - the proposal must be consistent with accepted evidence based best practice care models;
 - there should be a sound basis for believing that the reform will lead to improved patient outcomes and/or more cost effective care;
 - the impact of the proposal should be measurable in terms of change in services delivered and costs to the health system as a whole and to each party to this Agreement;
 - if the proposal is expected to lead to net savings, these should be shared equitably between the Commonwealth and Victoria;

- the proposal should have potential to be replicated, be on a scale such that extension can be realistically tested and be evaluated in terms of such extension; and
- the proposal must preserve eligible persons' current access to Medicare Benefits Schedule services or their equivalent.

Reform proposals may result in the cashing out of State funded programs and/or Commonwealth funded programs, including the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme.

Quality Improvement and Enhancement

29. The Commonwealth and Victoria agree that there is a need for national commitment, in partnership with clinicians and consumers, to health care safety and quality improvement and recognise that there are some safety and quality issues which are best dealt with at a national level.
30. Within this context, the Commonwealth and Victoria are committed to the development and implementation of quality improvement and enhancement practices which reward or promote quality in the delivery of public hospital services. Accordingly, the Commonwealth and Victoria agree that:
- the Commonwealth will support quality improvement and enhancement of public hospital services through the provision of funding under this Agreement;
 - the State Minister and the Commonwealth Minister will jointly agree, in the first grant year of the Agreement, a strategic plan to advance quality improvement and enhancement of public hospital services during the term of this Agreement; and
 - the Commonwealth and Victoria will jointly review progress under the plan during the 2000-01 financial year.

National Health Development Fund

31. The Commonwealth and Victoria acknowledge that significant health system restructuring is necessary to improve the performance of the system. Accordingly, the Commonwealth will establish a National Health Development Fund to pursue projects and programs consistent with the strategic plan in clause 32 which:
- improve patient outcomes in relation to such services;
 - improve the efficiency and effectiveness, or reduce the demand for, the delivery of public hospital services; or

- improve integration of care between public hospital services and broader health and community care services.
32. The State Minister and the Commonwealth Minister will jointly agree, in the first grant year of the Agreement, a strategic plan for use of the National Health Development Fund paid under the Agreement. The Commonwealth and Victoria will jointly review progress under the plan during the 2000-01 financial year.

Information Technology Reform

33. The Commonwealth and Victoria agree that priority should be given to investment in information technology and information management across the health system to improve patient outcomes and system efficiency.
34. The Commonwealth and Victoria agree to work in collaboration with other jurisdictions to:
- develop standards for the design and implementation of electronic data interchange between jurisdictions and related standards for the effective integration of health information systems and service provision within Australia; and
 - address information privacy, confidentiality and security requirements in the design and implementation of electronic data interchange between jurisdictions.

Pharmaceutical Policy Reform

35. Subject to agreement between the Commonwealth and Victoria on issues including the rate of reimbursement, appropriate clinical guidelines, data requirements and risk sharing arrangements, pharmaceuticals may be provided through the Pharmaceutical Benefits Scheme to admitted public and private patients on discharge and non-admitted patients.

PART 6 - FINANCIAL ASSISTANCE

Financial Assistance to Victoria

36. In 1998-99 the Commonwealth will pay Victoria a Base Health Care Grant of \$1,327,893,696, which includes:
- \$12,229,526 for mental health;
 - \$7,044,551 for palliative care; and
 - \$18,869,332 for quality improvement.

37. For 1999-2000 the Commonwealth will pay Victoria a Base Health Care Grant of \$1,344,826,510 (in 1998-99 prices), which includes:

- \$12,229,526 for mental health;
- \$7,044,551 for palliative care; and
- \$25,159,109 for quality improvement;

and will be indexed in accordance with clause 39 for population growth and ageing, change in output costs, change in private health insurance coverage, change in the entitled veterans' population, and demand growth.

38. For each of the years 2000-01 to 2002-03 the Commonwealth will pay Victoria a Base Health Care Grant based on the grant payable in the previous grant year, plus an annual increment in the quality improvement funds of \$6,289,777 (in 1998-99 prices), indexed in accordance with clause 39.

39. There will be two indices, A and B.

Index A is to apply to 83.928% of the base grant in 1998-99 excluding the identified components for mental health, palliative care and quality improvement, and will adjust for:

- a) change in Victoria's applicable weighted population;
- b) movement in the hospital output cost index; and
- c) a utilisation growth factor of 1.021.

Index B is to apply to:

- 16.072% of the base grant in 1998-99 excluding the identified components for mental health, palliative care and quality improvement;
- mental health;
- palliative care; and
- quality improvement;

and will adjust for

- a) growth in Victoria's weighted population; and
- b) movement in the hospital output cost index.

40. The Commonwealth and Victoria commit to work together on the development of a suitable index for adjusting Health Care Grants to reflect changes in hospital output costs.
41. If the Commonwealth and Victoria cannot identify and agree on a suitable index because of serious technical impediments by 31 March 1999, the cost index applied will be 1.005. In this case either party may invoke clause 10 to review the cost index.
42. If the agreed hospital cost index in the relevant grant year falls below 0.97943, (being the inverse of the utilisation growth factor of 1.021), the Commonwealth and Victoria agree that the hospital cost index will remain at 0.97943 for the relevant grant year. If an independent person is used under clause 41, the independent person cannot recommend a cost index at lower than 0.97943 for the relevant grant year.
43. In addition to the Base Health Care Grant payable in accordance with clauses 36 to 39, the Health Care Grant payments to Victoria will include adjustments of the following amounts (in 1998-99 prices):
- an increase of \$38,111,756 in 1998-99
 - an increase of \$6,000,000 in 1999-2000
 - a decrease of \$6,000,000 in 2001-02
 - a decrease of \$13,000,000 in 2002-03
- indexed to current year prices using Index B as described in clause 39.
44. In addition to the Base Health Care Grant and adjustments payable under this part, the Commonwealth will make \$63,000,000 available to Victoria from the National Health Development Fund over the life of the Agreement in accordance with clause 31. Funds drawing will be linked to cash flow requirements for projects identified by the State and consistent with the agreed strategic plan.
45. The Commonwealth and Victoria agree that it is appropriate for amounts payable in relation to mental health, adjustments under clause 43 and the National Health Development Fund to be quarantined from horizontal fiscal equalisation processes, noting that the programs broadbanded under clause 24 in 1998-99 have been appropriately treated by the Commonwealth Grants Commission in the construction of the relativities that apply in 1998-99.
46. Arrangements for funding and provision of health care for entitled veterans in Victoria will be the subject of a separate Commonwealth-State agreement. In addition, the Commonwealth and Victoria agree Victoria may provide preferential access for entitled veterans provided care of public patients is not impaired, consistent with Principle 2 of clause 13.

47. Methodology and timing of payments, together with further details on indexation, funding adjustments and acquittance requirements are set out in Schedule E.

National Program Funds

48. In addition to the financial assistance to Victoria, the Commonwealth will provide funds for the following national programs as set out in Schedule E:
- the Casemix Program - to develop systems for the classification of health services and associated cost weights;
 - national mental health projects; and
 - national palliative care projects.

Roll-over of Financial Assistance to Victoria and National Program Funds

49. Any financial assistance payable under this Agreement in any relevant grant year, which is not paid in that year, is to be made available on the same terms in the subsequent grant year. Conversely, any payment provided in excess of Victoria's entitlement is to be recovered in the subsequent grant year. A grant year is a period of twelve months which starts on 1 July.

PART 7 – PRIVATE HEALTH INSURANCE

50. In recognition of the relationship between the costs of public hospital services and levels of private health insurance, the Commonwealth and Victoria agree to adjust funding to reflect movements in private health insurance. Adjustments to funding will be made through the calculation of the applicable weighted population as set out in Schedule E. The Commonwealth and Victoria agree that based on current estimates of movements in population, and the cost index and assuming that those leaving insurance have the same age/sex profile as those remaining, a 1% national uniform fall in private health insurance will provide approximately \$82,000,000 in additional funding nationally.
51. The Commonwealth and Victoria agree that adjustments in funding will be made to reflect changes in the private health insurance participation rate relative to the December 1998 level, except that there will be no reduction in financial assistance for increases in the insurance participation rate in Victoria between the December 1998 level and 32.2%. The methodology for determination of the private health insurance participation rate is detailed in Schedule E.
52. The Commonwealth will work with Victoria to explore the relationship between private health insurance participation and utilisation of hospital services as a private patient. This will include consideration of the difference between utilisation and participation rates by examining the use by persons with private health insurance of

public and private hospitals as public and private patients in Victoria. The Commonwealth will also work with the States and Territories to ensure that health insurance fund data collected by the Private Health Insurance Administration Council accurately measure the different insurance product types (with particular reference to front end deductible and exclusionary products).

PART 8 - PATIENT ELECTION

Patient Election

53. Victoria will ensure that all eligible persons may elect to receive public hospital services as a public or private patient.
54. A patient election in relation to admitted patient services:
- will be exercised by written election before, at the time of, or as soon as practicable after, admission;
 - will not be made until the patient or legal guardian is fully informed of the consequences of election;
 - will not be directed by a hospital employee towards a particular decision; and
 - may only be reversed as a result of unforeseen circumstances. Examples of unforeseen circumstances include:
 - a) patients who are admitted for a particular procedure but are found to have complications requiring additional procedures; or
 - b) patients whose length of stay has been extended beyond those originally planned.
55. Agreed national standards of information for patients relating to admission and patient election forms will be maintained over the life of the Agreement.

PART 9 - CHARGES FOR PUBLIC HOSPITAL SERVICES

Public Patient Charges

56. Victoria agrees to ensure that where an eligible person receives public hospital services as a public patient no charges will be raised, subject to the following exceptions. Notwithstanding principle (1) in clause 13, fees may be charged for the following services provided to non-admitted patients and admitted patients upon discharge:

- dental services;
- spectacles and hearing aids;
- surgical supplies;
- prostheses - however, this does not include the following classes of prostheses, which must be provided free of charge:
 - a) artificial limbs – in accordance with clause 24;
 - b) prostheses which are surgically implanted, either permanently or temporarily;
- pharmaceuticals at a level consistent with the Pharmaceutical Benefits Scheme statutory copayments;
- aids, appliances and home modifications; and
- other services as agreed between the Commonwealth and Victoria.

Charges for Patients Other Than Public Patients

57. Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by Victoria.

58. However, pharmaceutical services to private patients, while they receive services as admitted patients, will be provided free of charge and cannot be claimed against the Pharmaceutical Benefits Scheme.

Patients Recommended for Residential Aged Care

59. Within the context of the on-going development of policy on meeting community needs for residential aged care, the Commonwealth and Victoria recognise the need to develop a fair and effective framework to facilitate the transfer of admitted patients recommended by an Aged Care Assessment Team for residential aged care, to an

appropriate care setting. The Commonwealth and Victoria agree they will work jointly on such a framework during the term of the Agreement.

60. The Commonwealth will pursue regulatory amendment to permit Victoria to charge residential care charges up to the level, assessed on the same basis, as those applicable in a Commonwealth funded nursing home to patients who:

- are assessed by Victoria against agreed criteria as no longer needing acute care; and who
- qualify for nursing home care, on the basis of an Aged Care Assessment Team recommendation,

providing that Victoria puts in place legislative appeal rights on a basis agreed with the Commonwealth for patients who wish to challenge an assessment that they are no longer in need of acute care.

Nursing Home Type Patients who do not qualify for nursing home care on the basis of an Aged Care Assessment Team recommendation may be charged a patient contribution as determined by the Commonwealth Minister for Health under paragraph (b) of the definition of patient contribution in sub-section 3(1) of the *Health Insurance Act 1973*.

Cross Border Adjustments

61. A mechanism will be agreed by Victoria with other States and Territories to adjust for costs incurred where admitted patient services are delivered to eligible persons who are residents of other States/Territories.
62. Victoria may enter into a bilateral arrangement with another State or Territory to adjust for costs of non-admitted services of the type covered by this Agreement.
63. Any dispute between Victoria and any other State or Territory will be resolved by referring the matter to an independent person agreed by the disputing States/Territories. In the event that the States can not agree on an independent person within eight weeks of one State seeking the appointment of the independent person, then the matter can be referred by either Minister(s) to the Productivity Commission to appoint an independent person. The independent person will consider material presented by both States/Territories and produce a report recommending on an appropriate course of action.
64. Victoria agrees that if after the report of the independent person, a State or Territory fails to make relevant payments, the Commonwealth may divert grant payments to meet any outstanding obligation under this section.

PART 10 - SUPPLY OF DATA AND PERFORMANCE INFORMATION

65. The Commonwealth and Victoria will comply in a timely way with any reasonable request by the other to supply, or arrange to make available, data or information about the utilisation of health services or the costs of provision of health services.
66. The Commonwealth and Victoria will share with the other and with all other States any data element identified in the National Health Data Dictionary as a component of the national minimum data set.
67. The Commonwealth and Victoria agree to continue the development of performance indicators on efficiency, quality, appropriateness, accessibility and equity of health services.
68. Victoria agrees to report on selected high level performance indicators with a particular focus on health outputs and outcomes at the national level. Victoria is committed to working towards improving performance against a range of broad indicators as set out in Schedule C.
69. Victoria will provide statistical data and de-identified unit record data on public and private hospital activity in accordance with Schedule C.
70. The Commonwealth will provide to Victoria de-identified unit record data on Medicare Benefits Schedule and Pharmaceutical Benefits Scheme utilisation and costs for medical and pharmaceutical services provided within Victoria in accordance with Schedule C.
71. The Commonwealth and Victoria agree that they will share data relevant to proposed measure and share initiatives.
72. The Commonwealth and Victoria will:
 - develop and implement a non-admitted patient morbidity data set by 30 June 2003; and
 - work towards expanding the admitted patient hospital morbidity data set to gain an improved understanding of the components of admitted patient episodes.

SCHEDULE A - DEFINITIONS

1. In this Agreement, unless otherwise specified, words and phrases are to be interpreted as follows.

<i>admitted patient</i>	means, as defined in the National Health Data Dictionary version 6, data element no 23 'Admitted patient', a patient who undergoes a hospital's formal admission process as either an over-night stay patient or a same-day patient, and excludes unqualified babies as defined in that data element.
<i>admitted patient services</i>	means services of the kind defined in the National Health Data Dictionary version 6, data element numbers 332 to 333 relating to 'Type of admitted patient care'.
<i>Agreement</i>	means this document including Schedules A to E inclusive.
<i>applicable weighted population</i>	means the weighted uninsured population excluding persons entitled to comprehensive medical and allied health treatment for all medical conditions at the expense of the Department of Veterans' Affairs as defined in clause 12 of Schedule E. <i>Note: the calculation of the applicable weighted population in 1998-99 will be adjusted to reflect the number of additional persons who become members of the entitled veterans' population as a result of the introduction of the Gold Card extension on 1 January 1999.</i>
<i>casemix weighted separations</i>	means the sum of admitted public patient separations in a specific period where separations are weighted by the AN-DRG version 3.0 national public cost weights.
<i>Commonwealth Minister</i>	has the same meaning as the term 'Commonwealth Minister for Health'.
<i>Commonwealth Minister for Health</i>	means the Minister for Health and Family Services or any other Commonwealth Minister who administers matters to which this Agreement relates, and includes any other Commonwealth Minister who may be acting for and on behalf of any of those Ministers.

compensable patient

means an eligible person who is:

- receiving public hospital services for an injury, illness or disease; and
- who has received, or has established a right to receive, payment by way of compensation or damages (including payment in settlement of a claim for compensation or damages) under a law that is or was in force in a State or States (other than Veterans' Affairs legislation) in respect of the injury, illness or disease for which he or she is receiving care and treatment; 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.

Co-ordinated Care Trials

means those trials established by the Commonwealth in 1996-97, in co-operation with the States and other parties, to test new models for funding and co-ordination of health and related services to specific populations.

eligible person

means, as defined in section 3 of the *Health Insurance Act 1973* (the Act), an Australian resident or an eligible overseas representative, and includes:

- a person, or a class of persons, declared by the Commonwealth Minister for Health to be treated as an eligible person, under section 6 of the Act; and
- persons to whom a reciprocal health care agreement relates, under section 7 of the Act, to the extent required or implied by the reciprocal health care agreement.

emergency services

means services of the kind defined in category A9.1 of the National Health Data Dictionary version 6, data element no 231 'Type of non-admitted patient care'.

<i>entitled veteran</i>	means any person entitled to comprehensive medical and allied health treatment for all medical conditions at the expense of the Department of Veteran's Affairs as defined in clause 12 of Schedule E.
<i>grant year</i>	means a period of twelve months which starts on 1 July.
<i>indicative public patient weighted separation rate</i>	means the indicative rate of casemix weighted separations per 1000 applicable weighted population for a specific grant year.
<i>ineligible person</i>	means any person who is not an eligible person.
<i>mental health services</i>	refers to services as defined in the Second Mental Health Plan.
<i>non-admitted patient</i>	means, as defined in the National Health Data Dictionary version 6, data element no 31 'Non-admitted patient', a patient who does not undergo a hospital's formal admission process.
<i>non-admitted patient services</i>	means services of the kind defined in the National Health Data Dictionary version 6, data element no 231 'Type of non-admitted patient care', and includes: <ul style="list-style-type: none">• emergency services;• outpatient services; and• other non-admitted patient services.
<i>nursing home type patient</i>	has the same meaning as in section 3 of the <i>Health Insurance Act 1973</i> (the 35 day rule) provided, however, that the order made pursuant to subsection 6(2) of the <i>Health Insurance Act 1973</i> dated 11 January 1984 remains in force, or a replacement order remains in force. <i>Note: the order referred to above excludes a nursing home type patient from being an eligible person in relation to public hospital services.</i>
<i>other non-admitted patient services</i>	means services of the kind defined in categories A9.12 to A9.14 of the National Health Data Dictionary version 6, data element no 231 'Type of non-admitted patient care'.

<i>outpatient services</i>	means services of the kind defined in categories A9.2 to A9.11 of the National Health Data Dictionary version 6, data element no 231 'Type of non-admitted patient care'.
<i>palliative care services</i>	refers to services as defined in the National Palliative Care Strategy.
<i>patient election forms</i>	means those forms completed by patients or their legal representatives to answer a series of questions in order to confirm patient election status.
<i>private patient</i>	means an eligible 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 57. <i>Note: an eligible person who has been referred to receive services from a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services, is not a patient of the hospital.</i>
<i>public hospital services</i>	means services of a kind or kinds (including admitted patient services and non-admitted patient services) that are currently provided or were so provided on 1 July 1998 by hospitals that are wholly or partly funded by a State or Territory (whether those services are provided directly or via one or more intermediate persons or bodies).
<i>public patient</i>	means an eligible person who receives or elects to receive a public hospital service free of charge.
<i>State Minister</i>	has the same meaning as the term 'State Minister for Health'.
<i>State Minister for Health</i>	means the State Minister for Health or any other State Minister who administers, for the State, matters to which this Agreement relates, and includes any other State Minister who may be acting for and on behalf of any of those State Ministers.
<i>States</i>	includes the Australian Capital Territory and the Northern Territory.
<i>Veterans' Affairs Legislation</i>	means legislation administered from time to time by the Commonwealth Minister for Veterans' Affairs or the Repatriation Commission or any of their successors.

weighted population means the raw population weighted as set out in Schedule E of this Agreement.

2. A reference in this Agreement to the *Health Insurance Act 1973* or the *National Health Act 1953* is a reference to the Acts as at 1 July 1998.
3. Words and phrases which are not defined in this Agreement are as defined in the *Health Insurance Act 1973*.

SCHEDULE B – MENTAL HEALTH REFORMS

Introduction

1. All Health Ministers have endorsed the National Mental Health Policy, the Second National Mental Health Plan and the Mental Health Statement of Rights and Responsibilities, which together constitute the renewed National Mental Health Strategy. The National Mental Health Policy is an agreed broad strategy for the reform of the mental health sector across all States and Territories. The Second National Mental Health Plan outlines a five year program of action in specific areas. The Commonwealth and Victoria will work towards the development of output based performance indicators and targets over the life of the Agreement. Both the Policy and the Plan represent a co-operative approach to mental health reform in Australia.

Definitions

2. Within this Schedule the following definitions apply unless the contrary intention appears:

“Agreed Data” means that data agreed by the Working Group or between the Commonwealth and Victoria, as amended from time to time, as being appropriate and feasible for States and Territories to provide annually for analysis and publication by the Commonwealth in the National Mental Health Report;

“Plan” means the Second National Mental Health Plan, as agreed by Health Ministers;

“Policy” means the National Mental Health Policy agreed by Health Ministers at their conference in April 1992;

“Strategy” means the National Mental Health Strategy, which comprises the National Mental Health Policy, the Second National Mental Health Plan, the Mental Health Statement of Rights and Responsibilities and this Schedule; and

“Working Group” means the Australian Health Ministers' Advisory Council National Mental Health Working Group, which comprises representatives from each of the States and Territories, the Commonwealth, a consumer or carer representative, and the Chair of the Mental Health Council of Australia.

3. Unless the contrary intention appears, all terms used in this Schedule will carry the same meaning as those used in the Plan.

Operation of the Schedule

4. The Commonwealth and Victoria agree to pursue a program of mental health reform consistent with the objectives of the Policy and the strategies outlined in the Plan.
5. Within three months of the end of each grant year, Victoria will forward to the Commonwealth an acquittal on the use of mental health reform funding in a form agreed between the Commonwealth and Victoria.
6. By 31 December in 1998-99, and by 30 June prior to each subsequent grant year, the Commonwealth and Victoria will agree on indicators and performance targets in the areas of:
 - promotion and prevention;
 - partnerships in service reform and delivery; and
 - quality and effectiveness.
7. The performance indicators and targets developed under clause 6 of this Schedule will cover, but not be restricted to, Victoria's activity in relation to:
 - collection of data for the National Mental Health Minimum Data Set;
 - implementation of National Standards for Mental Health Services;
 - collection of consumer outcome and satisfaction data; and
 - maintenance and enhancement of consumer and carer involvement at State and local levels.
8. Victoria agrees to establish, and maintain over the term of this Agreement, a separate program budget for mental health services covering relevant services provided in public hospitals, psychiatric hospitals and the community.
9. Victoria agrees that Commonwealth funds will not be used to replace, or lead to a reduction in, existing Victorian expenditure on mental health.
10. Victoria agrees to maintain a mental health consumer advisory group to provide open and independent advice to the Victorian Minister and the Victorian Department on mental health issues.

National Monitoring and Reporting

11. The Commonwealth and Victoria agree that within the term of the Agreement, a national system of reporting on mental health activity and progress in implementing the Strategy will be maintained through the production of a National Mental Health

Report to be published by the Commonwealth as soon as practicable in the year following each grant year.

12. To facilitate publication of the National Mental Health Report, Victoria will provide to the Commonwealth, no later than six months after the end of each year or after receiving the format, whichever is the latest, Agreed Data for the preceding grant year including:
- progress against the objectives of the Strategy;
 - performance against indicators and targets developed in accordance with clauses 6 and 7 of this Schedule;
 - National Minimum Data Set - Institutional Mental Health Care and National Minimum Data Set - Community Mental Health Care data collected by Victoria; and
 - details on other mental health activity undertaken by Victoria as agreed between the Commonwealth and Victoria.

SCHEDULE C – PERFORMANCE MEASURES AND INFORMATION

Introduction

1. The Commonwealth and Victoria agree that the publication of performance against agreed indicators should occur to demonstrate that overall funding is contributing to better health outcomes for all Australians.
2. Publication of this information will enable the Commonwealth and States and Territories to compare performance within the acute health sector and to set benchmarks which are intended to:
 - stimulate improvement in service performance and health outcomes;
 - inform national and State acute health policy development and, where possible, consumer decisions; and
 - facilitate best practice service delivery.

Scope of Performance Measures

3. The Commonwealth and Victoria agree to work together to develop and refine appropriate high level performance indicators where these do not presently exist. These indicators could include:
 - waiting times for access to services;
 - indicators of Aboriginal and Torres Strait Islander health;
 - indicators of integration of care processes and indicators of access to primary care;
 - measures of quality of care, including patient satisfaction;
 - indicators of effort in medical training and medical research;
 - mental health reform indicators; and
 - indicators of access to and quality of palliative care services.
4. In the first instance Victoria agrees to report waiting times for access to emergency department services and elective surgery. The report will be based upon definitions in the appropriate version of the National Health Data Dictionary.

5. The parties agree to a suite of performance indicators for emergency department and elective surgery waiting times not less than those agreed in the 1997-98 Performance Targets document under Schedule D1 of the 1993-98 Medicare Agreement.
6. Victoria agrees to provide data on emergency department and elective surgery waiting times to the Commonwealth on multilaterally agreed performance indicators three months after the end of the quarter. The Commonwealth undertakes to publish the data on a quarterly basis.
7. The Commonwealth and Victoria note that in August 1997 all Health Ministers agreed to report against a set of Aboriginal and Torres Strait Islander health performance indicators, noting that further refinement was required. In March 1998 the Australian Health Ministers' Advisory Council (AHMAC) endorsed a refined set of indicators. All jurisdictions will report annually, but refinement will continue over the next two years. This work will be funded by the Commonwealth.
8. The Commonwealth and Victoria agree that if there is multilateral agreement to additional performance information over the life of the Agreement, then they will work with other States and Territories to collect and report on agreed performance indicators.

Data

9. Victoria will provide to the Commonwealth de-identified unit record data on public and private hospital utilisation, including as a minimum all items in the Institutional Health Care minimum data set and relevant items from the Waiting List minimum data set and any other items necessary for use by an agreed DRG grouper, no later than six months after the end of each financial year.
10. Victoria will also provide to the Commonwealth quarterly hospital activity data, in a form no less than that required for the 1997-98 Performance Targets document, agreed under clause 5.2 of Schedule D1 of the 1993-98 Medicare Agreement, within three months of the end of the quarter in an agreed format.
11. The Commonwealth will provide to Victoria, Commonwealth de-identified unit record data, in accord with privacy requirements, on Medicare Benefit Schedule and Pharmaceutical Benefits Scheme utilisation and costs within Victoria no later than six months after the end of each financial year.

SCHEDULE D – PUBLIC PATIENTS’ HOSPITAL CHARTER AND COMPLAINTS BODY

Background

1. Under clause 4 of the 1993-98 Medicare Agreements all States and Territories agreed to:
 - develop Public Patients’ Hospital Charters as statements of what consumers should expect from public hospital services; and
 - establish complaints bodies independent of the public hospital system to resolve complaints made by eligible persons in respect of public hospital services received by them.

The Public Patients' Hospital Charter

2. Victoria agrees to:
 - review and update the existing Public Patients' Hospital Charter to ensure its relevance to public hospital services;
 - develop the Public Patients' Hospital Charter in appropriate community languages; and
 - develop and implement strategies for distributing the Charter to public hospital service users.
3. Victoria agrees to the following minimum standards:
 - the Public Patients’ Hospital Charter will be promoted and made publicly available wherever public hospital services are provided;
 - the Charter will set out:
 - a) how the Principles in clause 13 of this Agreement are to apply to the provision of public hospital services in Victoria;
 - b) the process by which eligible persons can lodge complaints about the provision of public hospital services to them; and
 - c) how complaints may be referred to an independent complaints body.
4. Victoria agrees that the updated Charter will be publicly available by no later than 1 July 1999.

Independent complaints body

5. Victoria agrees to maintain an independent complaints body to resolve complaints made by eligible persons about the provision of public hospital services to them.
6. Victoria agrees to the following minimum standards:
 - the complaints body must be independent of bodies providing public hospital services and Victoria's health department;
 - the complaints body must be given powers to investigate, conciliate and/or adjudicate on complaints received by it; and
 - the complaints body must be given the power to recommend systemic and specific improvements to the delivery of public hospital services.
7. The Commonwealth and Victoria agree that the powers of the complaints body will not interfere with or override the operation of registration boards or disciplinary bodies in Victoria and that the exercise of powers by the complaints body will not affect rights that a person may have under common law or statute law.
8. To assist in making recommendations and taking action to improve the quality of public hospital services, Victoria agrees to implement a consistent national approach, to be agreed between the Commonwealth and all States, to collecting and reporting health complaints data.

SCHEDULE E – FUNDING**PART 1 – CALCULATION OF GRANTS TO VICTORIA****Introduction**

1. This schedule sets out the basis for the calculation of the financial assistance which, subject to other provisions in this Agreement, will be paid to Victoria in each grant year covered by this Agreement.
2. The following forms of financial assistance will be available:
 - a Base Health Care Grant which includes identified amounts for mental health, palliative care and quality improvement;
 - adjustments to the Health Care Grant; and
 - funding from the National Health Development Fund.
3. This Schedule also sets out the basis for the calculation of funding for national programs. These national programs include casemix, mental health and palliative care.

Base Health Care Grant

4. In the 1998-99 grant year the Commonwealth will pay Victoria a Base Health Care Grant of \$1,327,893,696, which includes:
 - \$12,229,526 for mental health;
 - \$7,044,551 for palliative care; and
 - \$18,869,332 for quality improvement.
5. For each of the years 1999-2000 to 2002-03, the Base Health Care Grant will be indexed to adjust for population growth and ageing, change in hospital output costs, change in private health insurance coverage, change in the entitled veterans' population, and demand growth through the application of two indices calculated by the following formulae:

$$\text{INDEX A} = \left(\frac{\text{AWPOP}}{\text{AWPOP-1}} * \text{CI} * 1.021 \right)$$

where:

AWPOP is the applicable weighted population for the relevant grant year determined in accordance with clause 12 of this Schedule;

AWPOP-1 is the applicable weighted population for the previous grant year; and

CI is a hospital output cost index for the relevant grant year determined in accordance with clause 40 to 42 of this Agreement.

$$\text{INDEX B} = \left(\frac{\text{WPOP}}{\text{WPOP-1}} * \text{CI} \right)$$

where:

WPOP is the weighted population for the relevant grant year, and is an estimate of the Victorian population as at 31 December of the relevant grant year provided by the Australian Bureau of Statistics, weighted in accordance with clause 14 of this Schedule;

WPOP-1 is the weighted population for the previous grant year; and

CI is a hospital output cost index for the relevant grant year determined in accordance with clause 40 to 42 of this Agreement.

6. For the 1999-2000 grant year the Commonwealth will pay Victoria a Base Health Care Grant of \$1,344,826,510 (in 1998-99 prices), which includes (in 1998-99 prices):

- \$12,229,526 (in 1998-99 prices) for mental health;
- \$7,044,551 (in 1998-99 prices) for palliative care; and
- \$25,159,109 (in 1998-99 prices) for quality improvement:

These amounts will be brought to 1999-2000 prices as follows:

- the mental health component by the formula

$$\$12,229,526 * \text{INDEX B}$$

- the palliative care component by the formula

$$\$7,044,551 * \text{INDEX B}$$

- the quality improvement component by the formula

$$\$25,159,109 * \text{INDEX B}$$

- the remaining component by the formula

$$(\$1,091,394,109 * \text{INDEX A}) + (\$208,999,215 * \text{INDEX B})$$

7. For the 2000-01 grant year the Commonwealth will pay Victoria a Base Health Care Grant which is the sum of the following components:

- a mental health component calculated by the formula

$$\text{MH-1} * \text{INDEX B}$$

where MH-1 is the mental health component for 1999-2000

- a palliative care component calculated by the formula

$$\text{PC-1} * \text{INDEX B}$$

where PC-1 is the palliative care component for 1999-2000

- a quality improvement component calculated by formula

$$\$31,448,886 * \text{INDEX B1} * \text{INDEX B2}$$

where INDEX B1 and INDEX B2 are INDEX B for 1999-2000 and 2000-01 respectively.

- the remaining component calculated by the formula

$$(\text{RC-1} * 0.83928 * \text{INDEX A}) + (\text{RC-1} * 0.16072 * \text{INDEX B})$$

where RC-1 is the remaining component for 1999-2000

8. For the 2001-02 grant year the Commonwealth will pay Victoria a Base Health Care Grant which is the sum of the following components:

- a mental health component calculated by the formula

$$\text{MH-1} * \text{INDEX B}$$

where MH-1 is the mental health component for 2000-01

- a palliative care component calculated by the formula

$$\text{PC-1} * \text{INDEX B}$$

where PC-1 is the palliative care component for 2000-01

- a quality improvement component calculated by the formula

$$\$37,738,666 * \text{INDEX B1} * \text{INDEX B2} * \text{INDEX B3}$$

where INDEX B1, INDEX B2 and INDEX B3 are INDEX B for 1999-2000, 2000-01 and 2001-02 respectively

- an other component calculated by the formula

$$(\text{RC-1} * 0.83928 * \text{INDEX A}) + (\text{RC-1} * 0.16072 * \text{INDEX B})$$

where RC-1 is the remaining component for 2000-01

9. For the 2002-03 grant year the Commonwealth will pay Victoria a Base Health Care Grant which is the sum of the following components:

- a mental health component calculated by the formula

$$\text{MH-1} * \text{INDEX B}$$

where MH-1 is the mental health component for 2001-02

- a palliative care component calculated by in the formula

$$\text{PC-1} * \text{INDEX B}$$

where PC-1 is the palliative care component for 2001-02

- a quality improvement component calculated by the formula

$$\$44,028,441 * \text{INDEX B1} * \text{INDEX B2} * \text{INDEX B3} * \text{INDEX B4}$$

where INDEX B1, INDEX B2, INDEX B3 and INDEX B4 are INDEX B for 1999-2000, 2000-01, 2001-02 and 2002-03 respectively

- an other component calculated by the formula

$$(\text{RC-1} * 0.83928 * \text{INDEX A}) + (\text{RC-1} * 0.16072 * \text{INDEX B})$$

where RC-1 is the remaining component for 2001-02

Health Care Grant Adjustment

10. In addition to the Base Health Care Grant payable in accordance with clauses 4 to 9 of this Schedule, the Health Care Grant payments to Victoria will include adjustments of the following amounts:

- an increase of \$38,111,756 in 1998-99
- an increase in 1999-2000 calculated by the formula
\$6,000,000 * INDEX B1
- a decrease in 2001-02 calculated by the formula
\$6,000,000 * INDEX B1 * INDEX B2 * INDEX B3
- a decrease in 2002-03 calculated by the formula
\$13,000,000 * INDEX B1 * INDEX B2 * INDEX B3 * INDEX B4

where INDEX B1, INDEX B2, INDEX B3 and INDEX B4 are INDEX B in respect of 1999-2000, 2000-01, 2001-02 and 2002-03 respectively.

National Health Development Fund

11. In addition to the Base Health Care Grant and adjustments, the Commonwealth will make \$63,000,000 available to Victoria from the National Health Development Fund over the life of the Agreements. Funds drawing will be linked to cash flow requirements for projects identified by Victoria and consistent with the agreed strategic plan.

Population definitions

12. The “applicable weighted population” (AWPOP) is calculated by the formula:

$$AWPOP = WPOP - WINPOP - WVPOP$$

where:

WPOP is the weighted population for the relevant grant year, and is an estimate of the Victorian population as at 31 December of the relevant grant year provided by the Australian Bureau of Statistics, weighted in accordance with clause 14 of this Schedule;

WINPOP is the weighted insured population for the relevant grant year, calculated in accordance with clause 13 of this Schedule; and

WVPOP is the entitled veterans' population for the relevant grant year, and is the number of persons entitled to comprehensive medical and allied health treatment for all medical conditions, irrespective of whether they are war caused or not, at the expense of the Department of Veterans' Affairs (currently holders of a gold coloured "Repatriation Health Card - For All Conditions") in Victoria as at 31 December of the relevant grant year, as notified by Department of Veterans' Affairs, weighted in accordance with clause 14 of this Schedule. For 1998-99, WVPOP will equal:

- the number of such persons in Victoria, as at 31 December 1998; plus
- the number of such persons who receive such entitlements as a result of the Commonwealth Government decision to extend such entitlements to World War II servicemen with qualifying service from that conflict, as at 31 December 1999.

13. The weighted insured population will be calculated as follows:

- If the private health insurance participation rate as at 31 December in the relevant grant year in Victoria is lower than or equal to the participation rate for Victoria as at 31 December 1998, then the weighted insured population for the relevant grant year will be equal to the number of persons in Victoria covered by an Applicable Benefit Arrangement under paragraph 5A(1)(a) of the *National Health Act 1953* as at 31 December of the relevant grant year as notified by the Private Health Insurance Administration Council, weighted in accordance with clause 14 of this Schedule.
- If the private health insurance participation rate as at 31 December in the relevant grant year in Victoria is higher than the participation rate for Victoria as at 31 December 1998, but less than or equal 32.2%, then the following formula will apply in order to calculate the weighted insured population:

$$\frac{\text{WINPOP}}{\text{RRATE}} * \text{RATE98}$$

where:

WINPOP is the number of persons in Victoria covered by an Applicable Benefit Arrangement under paragraph 5A(1)(a) of the *National Health Act 1953* as at 31 December of the relevant grant year as notified by the Private Health Insurance Administration Council, weighted in accordance with clause 14 of this Schedule.

RATE98 is the private health insurance participation rate as at 31 December 1998.

RRATE is the private health insurance participation rate as at 31 December of the relevant grant year.

- If the private health insurance participation rate as at 31 December in the relevant grant year in Victoria is higher than 32.2%, then the following formula will apply in order to calculate the weighted insured population:

$$\text{APOP} * (1 - \frac{0.322 - \text{RATE98}}{\text{RRATE}})$$

where:

APOP is the actual number of persons in Victoria covered by an Applicable Benefit Arrangement under paragraph 5A(1)(a) of the *National Health Act 1953* as at 31 December of the relevant grant year as notified by the Private Health Insurance Administration Council, weighted in accordance with clause 14 of this Schedule;

RRATE is the private health insurance participation rate as at 31 December of the relevant grant year; and

RATE98 is the private health insurance participation rate as at 31 December 1998.

Population weights

14. The following weights will be used to calculate “weighted population” wherever required within this Schedule:

Males

Age	Weight
0 - 4	0.874032
5 - 14	0.237617
15 - 19	0.328502
20 - 39	0.455793
40 - 59	0.864987
60 - 64	1.885101
65 - 69	2.634457
70 - 74	3.541862
75 - 79	4.395498
80 - 84	5.175927
85+	5.864020

Females

Age	Weight
0 - 4	0.694806
5 - 14	0.180782
15 - 19	0.437328
20 - 39	0.908562
40 - 59	0.894467
60 - 64	1.424386
65 - 69	1.957997
70 - 74	2.528326
75 - 79	3.301255
80 - 84	4.080193
85+	4.855440

Note: These weights have been derived by applying the estimated resident Australian population as at 31 December 1995 to hospital separation data for public and private hospitals from the 1995-96 national hospital morbidity data collection.

PART 2 - ADMINISTRATIVE ARRANGEMENTS**Provisional Grants**

15. Pending the availability of all data necessary to determine Victoria's Health Care Grant entitlements under this Agreement, the Commonwealth Minister will determine provisional Health Care Grants in respect of each grant year.
16. The Commonwealth Minister will make a determination of provisional grants to Victoria before the start of each grant year based on the best estimate of the final grant entitlement for Victoria under the terms of this Agreement.
17. The Commonwealth Minister may revise the provisional Health Care Grant at any time so that it more accurately reflects Victoria's estimated grant entitlement under the terms of this Agreement.

Final Grant Entitlement

18. When all necessary data is available the Commonwealth Minister will issue a determination of Victoria's final grant entitlement under the terms of this Agreement.
19. If the final grant determination is made after the end of the relevant grant year, any variation between the final grant entitlement and the provisional grant actually paid in the relevant grant year will become a liability payable by the Commonwealth or Victoria as appropriate.

Cash Flow

20. When determining provisional grants, the Commonwealth Minister will also determine cash flow arrangements in respect of the provisional grants.
21. The cash flow arrangements for Health Care Grants:
- must provide for at least 95% of Victoria's provisional grant entitlement to be paid weekly in:
 - 51 equal instalments of 7/365ths of the provisional grant entitlement; and
 - one payment for the balance of the entitlement.
22. National Health Development Fund payments will be linked to the cash flow requirements of projects nominated by Victoria and consistent with the approved Strategic Plan.

Acquittal of Grants

23. Victoria agrees to provide to the Commonwealth the following reports, within five months of the end of each grant year:
- a statement to acquit the amount of funds provided under this Schedule in the relevant grant year as Health Care Grants under the terms of this Agreement;
 - a certification that the Health Care Grant funding received in the relevant grant year was expended on the provision of public hospital services; and
 - separate acquittance statements in respect of funds provided from the National Health Development Fund.
24. Victoria agrees that the reports referred to in clause 23 of this Schedule will be in a form agreed between Victoria and the Commonwealth from time to time.

PART 3 - NATIONAL PROGRAMS

25. The Commonwealth will make funding available for casemix, mental health and palliative care national programs.

26. In the 1998-99 grant year the Commonwealth will make the following amounts available in respect of national programs:

- \$5,141,500 for casemix;
- \$10,000,000 for mental health; and
- \$2,000,000 for palliative care.

27. In each of the years 1999-2000 to 2002-03, the Commonwealth will make amounts available in respect of each of the above national programs in accordance with the following formula:

$$\text{FUNDS-1} * \text{INDEX C}$$

where:

FUNDS-1 is the funding for the relevant national program in the previous grant year; and

INDEX C is the national program index for the relevant grant year calculated by the formula:

$$\frac{\text{NWPOP}}{\text{NWPOP-1}} * \text{WCI-1}$$

where:

NWPOP is the Australian total weighted population for the relevant grant year, and is an estimate of the Australian population as at 31 December of the relevant grant year provided by the Australian Bureau of Statistics, weighted in accordance with clause 14 of this Schedule;

NWPOP-1 is the Australian total weighted population for the previous grant year; and

WCI-1 is the most recent estimate, as at 1 June in the grant year prior to the relevant grant year, of the movement in the Wage Cost Index No 1 (WCI-1) as defined in the Commonwealth Department of Finance Estimates Memorandum 1995/16.