

Australian Health Care Agreement

between

the Commonwealth of Australia

and

the State of Victoria

2003-2008

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PART 1 - TERM OF THIS AGREEMENT, VARIATION AND TERMINATION

Interpretation

1. In this Agreement, unless the contrary intention appears, words and phrases are to be interpreted by reference to Schedule A. Where any word or phrase is given a defined meaning in Schedule A, any other part of speech or other grammatical form in respect of that word or phrase has a corresponding meaning.

Term of Agreement

2. This Agreement will commence on 1 July 2003 and will continue in force until 30 June 2008, unless terminated at an earlier date in accordance with clause 4. Termination of this Agreement, on or before 30 June 2008, does not override any reporting obligation on Victoria in relation to health services provided before the date of termination.
3. This Agreement constitutes the entire agreement between the Commonwealth and Victoria for public hospital services funding, and supersedes all earlier written or oral representations, agreements, statements and understandings. It is made subject to the Commonwealth *Health Care (Appropriation) Act 1998*, as amended.

Variation or Termination of Agreement

4. This Agreement may be varied or terminated by further written agreement:
 - (a) of the parties; or
 - (b) on behalf of the parties to it by the Commonwealth Minister and the State Minister.
5. 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.

PART 2 – OBJECTIVES AND PRINCIPLES

6. The primary objective of this Agreement is to secure access for the community to public hospital services based on the following 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.

Note: "Health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals," means public hospital services as defined in this Agreement.

7. In applying the principles at clause 6, the Commonwealth and Victoria agree that:
 - (a) the range of services available to public patients should be no less than was available on 1 July 1998; and
 - (b) all public hospital services available to private patients should be accessible on a public patient basis, where there is a demonstrated clinical need.
8. Other objectives of this Agreement are to:
 - (a) improve the transparency of the Commonwealth's and Victoria's financial contributions to public hospital services;
 - (b) improve the quality and timeliness of information available to the public to enable the performance of public hospital services to be assessed;
 - (c) improve the focus of public hospital services and mental health services on safety, quality and improved patient outcomes;
 - (d) assist the move nationally to a greater focus on the care and services provided to support the transition from hospital to home;
 - (e) improve the efficiency and effectiveness of public hospital services;
 - (f) increase the responsiveness of services for people in need of mental health services; and
 - (g) improve the provision of palliative care services.

PART 3 - RESPONSIBILITIES OF GOVERNMENTS UNDER THIS AGREEMENT

Responsibilities of the Commonwealth

9. The Commonwealth will:
 - (a) contribute to the cost of State public hospital services for eligible persons, on time and at a level specified in this Agreement, subject to Victoria meeting its obligations under this Agreement;
 - (b) in consultation with the States, fund, and develop policy for, national program activities relating to mental health, palliative care and hospital information and performance information programs as set out in clauses 24 and 25 of Schedule G; and
 - (c) publish an annual report: "The State of Our Public Hospitals".

Responsibilities of Victoria

10. Victoria is responsible for the provision of public hospital services to eligible persons and will:
 - (a) ensure that public hospital services are provided in accordance with this Agreement;
 - (b) ensure that eligible persons are able to access public hospital services, free of charge, as public patients;
 - (c) continue to provide support for medical specialist training positions; and
 - (d) during the period of this Agreement, report on Victoria's financial contribution and provide performance information and contribute to the development of new performance indicators with a particular focus on health outputs and outcomes, as set out in Schedule C.
11. Victoria commits to increase its own source funding for public hospital services, such that the cumulative rate of growth will at least match the cumulative rate of growth of Commonwealth funding to Victoria under this Agreement.

12. Victoria accepts responsibility for maintaining patient entitlement to services relating to broadbanded programs.
13. Victoria accepts responsibility for maintaining a public patients' hospital charter and an independent complaints body as outlined in Schedule D.

Shared Responsibilities of the Commonwealth and Victoria

14. The Commonwealth and Victoria share responsibility for facilitating health service reform and the sharing of information to gain a better understanding of the changing dynamics of the Australian health care system. They will work together, and with other States as appropriate, to:
 - (a) develop and co-ordinate national health service reform;
 - (b) implement the Pathways Home program in accordance with Schedule B;
 - (c) implement the National Mental Health Strategy;
 - (d) implement the National Palliative Care Strategy; and
 - (e) participate in AHMAC agreed governance arrangements for information management and information technology.
15. The Commonwealth and Victoria will implement this Agreement consistent with the principles outlined in:
 - (a) the agreement on Aboriginal and Torres Strait Islander Health (Framework Agreement);
 - (b) the National Aboriginal and Torres Strait Islander Health Information Plan; and
 - (c) the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) as endorsed by State Governments.
16. Recognising the co-operative relationship between them, the Commonwealth and Victoria agree that they will not institute or sanction arrangements which unreasonably impose an additional financial burden on the other party.
17. Where it can be demonstrated that a change in service delivery arrangements would improve patient care, patient safety or patient outcomes, the Commonwealth and Victoria agree to implement such changes in an open and consultative manner and, as appropriate, recompense the other party where costs are transferred to that party.

PART 4 – REFORM

18. Victoria and the Commonwealth are committed to working with other States to progress the reform agenda agreed by Commonwealth and State Ministers for Health on 27 September 2002. The Commonwealth considers that for its part, such reform can take place within existing funding parameters.
19. In line with clause 18, the specific areas of national co-operation to deliver reform include:
 - (a) improving the interface between hospitals and primary and aged care services;
 - (b) achieving continuity between primary, community, acute, sub-acute, transition and aged care, whilst promoting consumer choice and improved responsiveness. Initial priorities for a stronger continuum of care approach will be cancer care and mental health services; and
 - (c) exploring setting up a single national system for pharmaceuticals across all settings.

20. This will be supported by ongoing joint work in the areas of information management, quality and safety improvement and workforce. Access to services for Aboriginal and Torres Strait Islander people will also be a high priority.
21. The Commonwealth and Victoria agree to continue the implementation of the arrangements agreed pursuant to clause 35 of the 1998-2003 Australian Health Care Agreements. These arrangements extend access to the Pharmaceutical Benefits Scheme (PBS) to admitted public and private patients on separation, non-admitted patients and certain chemotherapy pharmaceuticals as defined in the Commonwealth-State pharmaceutical agreements will be made available to public hospitals.

PART 5 – FINANCIAL ASSISTANCE AND ASSOCIATED TERMS AND CONDITIONS

22. Victoria and the Commonwealth acknowledge that this part provides a general overview of the financial assistance in this Agreement and the associated terms and conditions. Full details are set out in Schedule G and the information provided in that Schedule is to be the source of all calculations relating to grant entitlements under this Agreement. In the event of any inconsistency between this part and Schedule G, the provisions of Schedule G will prevail.

Sign-on Arrangements

23. The Commonwealth acknowledges that by signing this Agreement and by previous actions, Victoria has complied with the Commonwealth's pre-conditions for entering into an Agreement, including having:
 - (a) provided the Commonwealth with independently verified details of public hospital funding for each of the five years of the 1998-2003 Agreements; and
 - (b) provided the Commonwealth with all performance reporting data that was due by 31 December 2002 under the 1998-2003 Agreement.
24. Victoria agrees that in signing this Agreement it has:
 - (a) publicly committed to a specified level of funding over the five years of this Agreement and agreed to transparently report each year on progress against this commitment;
 - (b) publicly committed to the new performance reporting framework; and
 - (c) publicly committed to the principles in clause 6 including provision of free public hospital services to eligible persons, irrespective of their insurance status.

Compliance Requirements

25. In order to determine whether Victoria will qualify for the full level of funding available under this Agreement, there are three compliance assessment requirements, as set out below:
 - (a) adherence to the principles set out in clause 6;
 - (b) increasing Victoria's own source funding at a rate which at least matches the estimated cumulative rate of growth of Commonwealth funding under the Agreement. This is subject to a tolerance of 0.5 percentage points in 2003-04 and 2004-05, and 0.25 percentage points in 2005-06; and
 - (c) meeting the performance reporting requirements as set out in this Agreement.

Compliance Assessment

26. Victoria's performance each year against the compliance requirements will be assessed in the following year with a proportion of the previous year's funding being linked to performance. Thus funding in 2004-05 is dependent on performance in 2003-04, funding in 2005-06 is dependent on performance in 2004-05, and so on. In 2003-04 full funding will be available if this Agreement is signed by Victoria and received by the Commonwealth by 31 August 2003, provided that Victoria adheres to the principles at clause 6.
27. As performance in 2007-08 cannot be assessed until 2008-09, after the expiry of this Agreement, the Commonwealth reserves the right to take performance in 2007-08 into account in the first year of any subsequent funding arrangements.
28. Victoria acknowledges that in order to qualify for the full level of funding in 2004-05 and subsequent years, as outlined in Schedule G, the Commonwealth Minister must be satisfied that Victoria has met all three components of the compliance requirements, as set out in clause 25. The Commonwealth Minister will have regard to a range of information, including the minimum list of Performance Indicators at Attachment A to Schedule C.
29. The Commonwealth will allow Victoria a period of 28 days to respond to any potential finding of non-compliance with the requirements of clause 25(a), before a final assessment is made by the Commonwealth Minister.
30. Victoria agrees that the compliance requirements in relation to clause 25(c) will be assessed with reference to clauses 5 to 11 in Schedule C.
31. If the Commonwealth Minister is satisfied that Victoria has met all of the compliance requirements in a given grant year, it will, in the following grant year, receive:
 - (a) a base health care grant in accordance with Schedule G; and
 - (b) a non-base health care grant in accordance with Schedule G, including a compliance payment equivalent to approximately four per cent of its base health care grant entitlement.
32. If the Commonwealth Minister is satisfied that Victoria has failed over consecutive years to meet one or more of the compliance requirements, its health care grant will be reduced for the remaining term of the Agreement, to a level based on the 2002-03 ongoing level of Health Care Grant indexed by WCI-1 only, and no further payment will be made in respect of the compliance payment referred to in clause 31(b).

Matching Arrangements

33. Victoria agrees that for the purpose of measuring its rate of funding increase in any grant year the Commonwealth will consider the State's recurrent expenditure minus revenue in relation to public hospital services. The definition of recurrent expenditure will be agreed between the Commonwealth and Victoria before this Agreement is signed.
34. The Commonwealth considers that Victoria should not be disadvantaged when moving services to non-hospital settings where this is a more appropriate way of providing those services. In addition to information outlined in clause 33, the Commonwealth will consider other expenditure related to services moved from hospital to non-hospital services from 1 July 2003 and where the Commonwealth considers there to be

satisfactory evidence. This evidence is to be provided by 31 December each year in respect of the previous grant year.

35. Victoria agrees that all financial information relating to clauses 33 and 34 will be independently verified.
36. Victoria agrees to work with the Commonwealth and other States that have signed agreements to develop a comprehensive, standardised system for determining recurrent health expenditure in relation to the services provided under this Agreement by June 2005. If such a system cannot be developed collaboratively, the Commonwealth will determine the nature of such a system.

PART 6 – ELIGIBILITY, PATIENT STATUS, REFERRALS AND ELECTION

Note: Consideration of clauses in part 6 of this Agreement must take into account the rights of entitled veterans as set out in clause 37.

37. Arrangements for funding and provision of health care for entitled veterans in Victoria 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 in accordance with this Agreement.
38. Victoria will ensure that all eligible persons elect to receive admitted public hospital services as a public or private patient. This election will be exercised in writing before, at the time of, or as soon as possible after admission and must be made in accordance with the National Standards for Public Hospital Admitted Patient Election Processes as set out at Schedule E.
39. An eligible patient presenting at a public hospital emergency department will be treated as a public patient, regardless of whether they subsequently become an admitted private patient (unless a third party has entered into an arrangement with the hospital or Victoria 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. However:
 - (a) a choice to receive services from an alternative service provider will not be made until the patient or legal guardian is fully informed of the consequences of that choice; and
 - (b) hospital employees will not direct patients or their legal guardians towards a particular choice.
40. In those hospitals that rely on general practitioners 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 general practitioner, either as part of continuing care or by prior arrangement with the doctor.
41. 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 Victoria 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.

42. Where a patient chooses to be treated as a public patient, services that are a component of the episode of care (such as pathology and diagnostic imaging) will be regarded as a part of the public patient episode of care and will be provided free of charge as public hospital services.
43. Where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient chooses to be treated as a public patient, regardless of whether it is provided at the hospital or in private rooms.
44. Victoria acknowledges that in considering compliance with the principles in clause 6, the Commonwealth will take account of the following:
 - (a) services provided to public patients which generate charges against the Commonwealth Medicare Benefits Schedule (MBS) are in breach of this Agreement;
 - (b) except where there is a third party payment arrangement with the hospital or Victoria, emergency department patients cannot be referred to an outpatient department to receive services from a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services;
 - (c) the control of referral pathways so as to deny access to free public hospital services is in breach of this Agreement; and
 - (d) the control of referral pathways so that a referral to a named specialist is a prerequisite for access to outpatient services is in breach of this Agreement.

PART 7 - CHARGES FOR PUBLIC HOSPITAL SERVICES

Public Patient Charges

45. 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 exceptions listed in clause 46.
46. Notwithstanding the principle in clause 6(a), fees may be charged for the following services provided to non-admitted patients and, in relation to (e) 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 – in accordance with clause 12; and
 - (ii) prostheses which are surgically implanted, either permanently or temporarily or are directly related to a clinically necessary surgical procedure (including breast prostheses);
 - (e) pharmaceuticals at a level consistent with the Pharmaceutical Benefits Scheme statutory copayments;
 - (f) aids, appliances and home modifications; and
 - (g) other services as agreed between the Commonwealth and Victoria.
47. Victoria agrees to ensure that:
 - (a) where an eligible person receives Magnetic Resonance Imaging services in a public hospital as an admitted public patient, no charges will be raised against either the patient or the MBS; and

(b) Magnetic Resonance Imaging services provided on an admitted patient basis prior to 1 September 1998 will continue to be so provided.

Note: Fees may be charged against the MBS for the provision of Magnetic Resonance Imaging services to non-admitted patients, on the condition that those services are provided in accordance with the Health Insurance Act 1973 as amended.

48. Nursing-Home Type Patients may be charged a patient contribution as determined by the Commonwealth Minister for Health under paragraphs (b) and (c) of the definition of patient contribution in sub-section 3(1) of the *Health Insurance Act 1973*.

Charges for Patients other than Public Patients

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

50. Notwithstanding clause 49, pharmaceutical services to patients, while they receive services as admitted patients, will be provided free of charge and cannot be claimed against the Pharmaceutical Benefits Scheme.

Cross Border Adjustments

51. A mechanism will be agreed between Victoria and each other State to adjust for costs incurred where admitted patient services are provided to eligible persons who are residents of the respective State.

52. Victoria may enter into a bilateral arrangement with another State to adjust for costs of non-admitted services of the type covered by this Agreement.

53. Victoria agrees to work with all other States to determine and implement appropriate funding and administrative arrangements for Nationally Funded Centres by 1 July 2004. If these arrangements are not finalised by 1 July 2004, the issue will be forwarded to the Australian Health Ministers' Conference for resolution.

54. Any dispute between Victoria and any other State on cross border adjustments will be resolved by referring the matter to an independent person agreed by the disputing States. In the event that the States cannot 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 State Minister to the Productivity Commission which will appoint an independent person. The independent person will consider material presented by both States and produce a report recommending an appropriate course of action.

55. Victoria agrees that if after the report of the independent person, a State fails to make relevant payments, the Commonwealth may divert Health Care Grant payments to meet any outstanding obligation under this section.

PART 8 – FINANCIAL AND PERFORMANCE INFORMATION

56. Victoria agrees to provide financial and performance information in accordance with Schedule C.

57. The Commonwealth and Victoria will co-operate through AHMAC agreed governance arrangements for information management and information technology to:

(a) continue the development of data items and national minimum data sets;

- (b) continue the development of comparable performance indicators on efficiency, quality, appropriateness, accessibility and equity of health services; and
 - (c) report on performance indicators with a particular focus on health outputs and outcomes at the national level.
58. The Commonwealth and Victoria will each 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.
59. The Commonwealth and Victoria will each share with the other and with all other States any data element identified in the National Health Data Dictionary as a component of a national minimum data set.

SCHEDULE A – DEFINITIONS

1. A reference in this Agreement to the National Health Data Dictionary is a reference to the latest version unless otherwise advised by the Commonwealth in accordance with clause 14 of Schedule C.
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 2003 or as amended thereafter.
3. Words and phrases which are not defined in this Agreement or defined in the *Health Insurance Act 1973* are to be given their natural meaning.
4. In this Agreement, unless otherwise specified, words and phrases are to be interpreted as follows.

Admitted patient Means, “Admitted patient” as defined in the National Health Data Dictionary.

Note: All newborn days of stay (patient is aged 9 days or less) are further divided into categories of qualified and unqualified for Australian Health Care Agreements and health insurance benefit purposes. A newborn day is acute (qualified) when a newborn meets at least one of the following criteria:

- *Is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;*
- *Is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for Health for the purpose of the provision of special care;*
- *Remains in hospital without its mother;*
- *Is admitted to the hospital without its mother.*

Acute (qualified) newborn days are eligible for health insurance benefit purposes and should be counted under the Australian Health Care Agreements. Days when the newborn does not meet these criteria are classified as unqualified (if they are nine days old or less) and should be recorded as such. Unqualified newborn days should not be counted under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

Admitted patient services Means services of the kind defined in the National Health Data Dictionary, relating to “Care Type” provided to an admitted patient during an episode of care (admitted care).

Agreement Means this document inclusive of Schedules A to G which is the 2003-2008 Australian Health Care Agreement.

AHMAC	Means the Australian Health Ministers’ Advisory Council or its replacement.
Australian Health Care Agreement	Has the same meaning as the term “Agreement”. The 1998-2003 Australian Health Care Agreement is the document which has been replaced by this Agreement.
Broadbanded Programs	Means the programs listed in clause 24 of the 1998-2003 Australian Health Care Agreement and any other programs in respect of which funds were added to funding otherwise available under the 1998-2003 Australian Health Care Agreement or previous Medicare Agreements. These programs include the Artificial Limbs Scheme; the Nationally Funded Centres; the Commonwealth Pathology Laboratories; the Australian Bone Marrow Registry; and the Balmain General Practice Casualty.
Commonwealth Minister	Means the Commonwealth Minister for Health and Ageing 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: <ul style="list-style-type: none"> - receiving public hospital services for an injury, illness or disease; and - is 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 sub-section 6(2) of the <i>Health Insurance Act 1973</i>, dated 11 January 1984 remains in force, or a replacement order remains in force. <p><i>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.</i></p>
Complaints body	Means an independent entity established or commissioned to investigate complaints and/or grievances against providers of Victoria’s public hospital services.
Cumulative rate of growth	Means the sum of the nominal growth rates achieved in each year up to and including the relevant year.
Eligible person	Means, as defined in subsection 3(1) of the <i>Health Insurance Act 1973</i> .

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Emergency department	Means the dedicated area in a hospital that is organised and administered to provide a high standard of emergency care to those in the community who perceive the need for, or are in need of acute or urgent care, including hospital admission.
Entitled veteran	Means a Department of Veterans' Affairs patient referred to in the <i>Veterans' Entitlements Act 1986</i> .
Grant year	Means a period of twelve months which starts on 1 July.
Hospital Information and Performance Information Program	Means the former casemix program.
Ineligible person	Means any person who is not an eligible person.
Medicare Agreements	Means the agreements between the Commonwealth and Victoria for the provision of public hospital services that applied during the period 1988-1998.
Mental Health services	Means the services as defined in the latest agreed National Mental Health Plan.
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 Mental Health Strategy	Comprises the National Mental Health Policy, the National Mental Health Plan 2003-08 and the Mental Health Statement of Rights and Responsibilities.
National Palliative Care Strategy	Means a national framework for Palliative care service development, prepared in consultation with representatives from the Commonwealth and State governments, consumer groups, service providers, clinicians and academics and national advocacy groups. As a consensus document, it sets national priorities that are intended to inform policy and service development across Australia.
Non-admitted patient services	Means services of the kind defined in the National Health Data Dictionary, under the data element "Non-Admitted Patient Service Type".
Nursing-Home Type Patient	Has the same meaning as in section 3 of the <i>Health Insurance Act 1973</i> provided, that the order was made

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pursuant to subsection 6(2) of the *Health Insurance Act 1973*

Note: The order referred to above excludes a nursing-home type patient from being an eligible person in relation to public hospital services.

Outpatient department	Means any part of a hospital (excluding the Emergency department) that provides non-admitted patient care.
Palliative care services	Refers to services as defined in the latest National Palliative Care Strategy.
Patient election status	Means the status of patients as determined in line with Part 6 of this Agreement according to the National Standards for Public Hospital Admitted Patient Election Processes in Schedule E.
Pharmaceutical Benefits Scheme	Means the Commonwealth government's scheme to provide subsidised pharmaceuticals to Australians established under part VII of the <i>National Health Act 1953</i> (the Act) together with the National Health (Pharmaceutical Benefits) Regulation 1960 made under the Act.
Private patient	<p>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 49.</p> <p><i>Note: An eligible person who has been referred to receive outpatient 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></p>
Public hospital services	<p>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 (whether those services are provided directly or via one or more intermediate persons or bodies).</p> <p><i>Note: This relates to the minimum level of public hospital services and does not preclude States from establishing or re-establishing public hospital services.</i></p>
Public patient	Means an eligible person who receives or elects to receive a public hospital service free of charge.
Public patients' hospital	Means the document outlining how the principles of this

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charter	Agreement 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.
Separation	Means "Separation" as defined in the National Health Data Dictionary.
State Minister	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.
States	Means the States of Australia and the Australian Capital Territory and the Northern Territory.
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.
Weighted population	Means the population weighted as set out in Schedule F of this Agreement.

SCHEDULE B – PATHWAYS HOME PROGRAM

1. The Commonwealth is providing one-off funding for a Pathways Home program to assist the move nationally to a greater focus on the care and services provided to support the transition from hospital to home.
2. Through the development of the Pathways Home program the Commonwealth and Victoria will:
 - (a) aim to maximise quality of life and independence, particularly for older people, following hospital treatment;
 - (b) strengthen capacity for service provision;
 - (c) foster a culture of responding to needs of patients, particularly older Australians; and
 - (d) improve the measurement of performance in this area.

Definitions

3. Within this schedule the following definitions apply:

“plan” is a document that is to be developed by Victoria and agreed to by the Commonwealth, outlining how funds will be spent by Victoria.

Terms and conditions for accessing funds

4. One-off funding of \$63,000,000 will be available to Victoria over the next 5 years for the Pathways Home program, in accordance with the terms and conditions outlined in this schedule.

Requirements for State plans

5. In order to access available funds, Victoria will be required to submit a 5 year plan by 31 December 2003 outlining how funds will be spent over the 5 year period in line with clause 7 of this schedule. This plan could be discussed with the Commonwealth ahead of the final decision. Funds will only be provided for projects or programs conducted during the period of this Agreement, and once the Commonwealth Minister agrees to this plan. The Commonwealth will respond within three months of receipt of a plan from Victoria.
6. Any funding in 2005-06, 2006-07 and 2007-08 grant years will be conditional on Victoria meeting performance reporting requirements as outlined in clause 13 of this schedule.
7. The plan will need to propose expenditure year by year that increases step-down and rehabilitation care services for those leaving hospital and falls into one or more of the following categories:
 - (a) upgrading, modifying, relocating or refurbishing existing facilities in order to provide new services;
 - (b) construction of purpose built facilities;
 - (c) purchase and fit-out of mobile rehabilitation units to visit patients at home;
 - (d) reusable rehabilitation equipment provided by hospitals to enable discharge from hospital;

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- (e) other investment in service infrastructure such as information systems and assessment tools;
 - (f) time-limited training and recruitment strategies to increase skills and availability in the relevant part of the workforce; and/or
 - (g) other one-off expenditure which will be consistent with the objective of increasing transition services in areas such as step-down and rehabilitative care.
8. In putting forward these State plans, Victoria should make clear the relationship (if any) to Commonwealth/State programs such as those in the Home and Community Care or disability areas to ensure there is complementarity rather than overlap.
 9. The criteria outlined in clause 7 of this schedule would enable Victoria to develop proposals in line with state specific needs and infrastructure. For example Victoria could target its proposals towards those living with special needs such as mental illness, chronic disease, or people living in rural areas or indigenous people – in line with criteria outlined in clause 7 of this schedule. Victoria would also be able to develop local partnerships to support the Pathways Home program.
 10. Victoria will be able to amend the plan to meet emerging needs over the period of the Agreement, as required, in line with the requirements for use of these funds as outlined in clause 7 of this schedule. Any amended plan will need to be approved by the Commonwealth Minister. The Commonwealth will respond within three months of receipt of any proposals for amendment from Victoria.
 11. Victoria is responsible for ensuring that funding for the Pathways Home program will be expended by 30 June 2008. The Commonwealth reserves the right to withhold funding where the Commonwealth Minister is satisfied that funding is not in line with the agreed plan. Victoria agrees to repay to the Commonwealth any funding for projects or programs not conducted during the period of this Agreement.
 12. Victoria will continue to be responsible for the provision of recurrent funding to support the services for which one-off funding has been provided under the Pathways Home program in line with clauses 1 and 7 of this schedule.
 13. Victoria will also be required to commit to meet the performance reporting requirements of the program in order to receive the maximum funding available for Victoria. This includes a requirement to commit to participate in the development and implementation of national performance indicators as outlined in clause 14 of this schedule, as part of this plan.

Performance indicator development

14. An incremental approach will be adopted to develop nationally consistent performance indicators for step-down care and rehabilitation. This will involve:
 - (a) States reporting on the level of step-down care and rehabilitation services using the indicators outlined in Attachment A to Schedule C, by 31 December 2003 and 2004;
 - (b) the Commonwealth working with States as outlined in clause 13 of Schedule C to develop national performance indicators for rehabilitation and step-down care in the period to 31 December 2004;

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- (c) States reporting against the indicators in clause 14(b) of this schedule from 2005-06;
and
 - (d) Pathways Home funds for 2005-06, 2006-07 and 2007-08 being tied to submission of
data against these indicators.
15. Reporting requirements under this schedule will be in line with the relevant requirements
of Schedule C.

SCHEDULE C – PERFORMANCE MEASURES AND INFORMATION

Introduction

1. The Commonwealth and Victoria agree that the publication of performance information against agreed indicators should occur to improve the transparency of the performance of the public hospital system.
2. Publication of this information will enable the Commonwealth and States to compare performance within the acute health sector and to set benchmarks which are intended to:
 - (a) stimulate improvement in service performance and health outcomes;
 - (b) inform national and State acute health policy development and, where possible, consumer decisions;
 - (c) facilitate best practice service delivery; and
 - (d) increase community understanding about the performance of the public hospital sector.
3. Victoria agrees that provision of data to enable timely publication of performance information is an important element of its accountability to the Commonwealth and the public in relation to the funding received through this Agreement.
4. Victoria agrees that performance information, including performance against the indicators listed in Attachment A to this schedule, will be published annually by the Commonwealth (by 30 June in the subsequent year) in relation to the objectives specified in Part 2 of the Agreement. A draft publication will be provided to Victoria 28 days prior to the Commonwealth submitting it for publication.

Scope of Performance Measures for Compliance Assessment

5. Victoria agrees to report by 31 December each year in respect of the previous grant year, against the indicators listed in Attachment A to this schedule. The performance information will be derived by Victoria from the data sets provided to the Commonwealth in line with clause 6 of this schedule. Consistent with clause 13 of this schedule, publication of an increasing range of performance measures can be anticipated throughout the Agreement.
6. Victoria agrees to supply to the Commonwealth:
 - (a) unit record data on public and private hospital utilisation, including all items in the Admitted Patient Care National Minimum Data Set (NMDS), Elective Surgery Waiting Times NMDS and Emergency Department Waiting Times NMDS, by 31 December each year in respect of the previous grant year;
 - (b) all items in the Public Hospital Establishment NMDS, by 31 December each year in respect of the previous grant year;
 - (c) all items in the Community Mental Health Care NMDS and Admitted Patient Mental Health Care NMDS, by 31 December each year in respect of the previous grant year;
 - (d) non-admitted, emergency department and elective surgery hospital activity and waiting time data within three months after the end of each quarter in the format set out in Attachment B to this schedule;

SCHEDULE C

- (e) all financial information required to measure Victoria's rate of funding increase in any grant year in line with clauses 33 to 35 by 31 December each year in respect of the previous grant year;
 - (f) an emergency department NMDS, in line with clause 8 of this schedule, from 2005-06, in respect of 2004-05, and subsequent years, by 31 December each year in respect of the previous grant year; and
 - (g) a non-admitted NMDS, which includes emergency department and outpatient department services data, in line with clause 8 of this schedule, from 2006-07, in respect of 2005-06, and subsequent years, by 31 December each year in respect of the previous grant year.
7. Victoria agrees that the elective surgery waiting times NMDS data items will be integrated with, or provided in a format which can be linked to, the unit record data provided in accordance with the Admitted Patient Care NMDS.
 8. Victoria agrees that performance against additional performance indicators in relation to emergency department services will be published in respect of 2004-05 and subsequent years, and in relation to outpatient services will be published in respect of 2005-06 and subsequent years.
 9. Following consultation with States, the Commonwealth Minister reserves the right to prescribe performance reporting requirements for Victoria, if the Commonwealth Minister judges that there has been inadequate progress in the development of new data items and performance information in relation to:
 - (a) clauses 6(f) and 6(g) of this schedule; or
 - (b) any other key policy issue relating to the provision of public hospital services.
 10. Victoria agrees that any new performance reporting requirements agreed between the Commonwealth and the States under clauses 12 and 13 of this schedule be provided by 31 December each year in respect of the previous grant year, unless specified otherwise by the Commonwealth.
 11. Victoria agrees that the National Minimum Data Sets referred to in clauses 6 to 8 of this schedule will include all agreed data items and be in a format advised by the Commonwealth from time to time.

Note: Victoria agrees that for the purpose of reporting data the Commonwealth means the Department of Health and Ageing, or its replacement.

Ongoing Development of Performance Indicators

12. Victoria agrees to work together with the Commonwealth and all other States through AHMAC agreed information management and information technology governance arrangements to develop and refine appropriate performance indicators. This includes:
 - (a) continuing the development of data items, national minimum data sets and mental health outcome data; and
 - (b) continuing the development of performance indicators of effectiveness, efficiency, quality, appropriateness, accessibility, safety and equity of public hospital services.

13. These indicators will relate to both admitted and/or non-admitted patient services and will include:
- (a) waiting times for access to services, including, but not confined to elective surgery and emergency department waiting times;
 - (b) indicators of Aboriginal and Torres Strait Islander health;
 - (c) measures of safety and quality of care, including adverse events, as agreed through the Australian Council on Safety and Quality in Health Care or any successor;
 - (d) indicators of effort in medical training and medical research;
 - (e) mental health reform indicators;
 - (f) rural and remote access to public hospital services;
 - (g) indicators of access to and quality of palliative care services;
 - (h) indicators of access to and quality of rehabilitation and step-down services; and
 - (i) indicators of efficiency and effectiveness.

Data Specifications

14. The Commonwealth and Victoria agree to the use of the latest version of the National Health Data Dictionary throughout the life of this Agreement. However, the Commonwealth and Victoria agree that where there are changes to individual National Health Data Dictionary data items that impact on data provision and performance information under this Agreement, these will not be implemented for the purpose of this Agreement until satisfactory mapping arrangements between existing and proposed definitions have been agreed between the Commonwealth and States.
15. All data relating to the 1998-2003 Agreements which falls due during the 2003-2008 Agreements is to continue to be provided within agreed timeframes and in the agreed format. Additionally, all annual performance reports not completed during the 1998-2003 Agreements must be completed during the 2003-2008 Agreements using the agreed format and processes.
16. The reporting requirements under this Agreement relate to the provision of information during the period of the Agreement, irrespective of the period when the relevant services were provided. Victoria also agrees to continue to report beyond 30 June 2008 in respect of services provided up to that date.

Attachment A to Schedule C

Minimum List of Performance Indicators for the Purpose of Clause 4 of this Schedule

Note: These indicators are currently reported in the Australian Health Care Agreement Annual Performance Report (1999-2000) and/or the Report on Government Services (2002). The indicators have been grouped below against the principles in clauses 6 and 8 of this Agreement for ease of reference, although alternative categorisation is possible.

1. 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 historical, provided by hospitals.
(a) Public patient weighted separation rate per 1,000 weighted population*
(b) Same day and overnight separations by patient accommodation status*
(c) Number of separations by care types and mode of separation*
(d) Emergency department occasions of service *
(e) Outpatient occasions of service*
2. 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.
(a) Waiting times for elective surgery by urgency category*
(b) Waiting times for emergency departments by triage category*
(c) Admission from waiting lists by clinical urgency**
3. Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.
(a) Number of public and private hospital separations by Indigenous and Non-indigenous Status per 1,000 population**
(b) Mental health patient days by Psychiatric and Non-Psychiatric hospitals public and private**
(c) Psychiatric care by Indigenous and Non-indigenous Status**
4. Indicators of efficiency and effectiveness of public hospital services
(a) Recurrent expenditure, public acute and psychiatric hospitals**
(b) Revenue, public acute and psychiatric hospitals**
(c) Cost per casemix adjusted separation in public hospitals**
5. Indicators of quality and patient outcomes in relation to the delivery of public hospital services
(a) Number of accredited medical specialist training positions by specialty (using latest available data)*
(b) Public hospital accreditation status*
6. Indicators of Rehabilitation and Stepdown Services
(a) Distribution of rehabilitation episodes by mode of separation, sex, age group and accommodation status*

Key: * Currently reported in 1998-2003 Australian Health Care Agreement Annual Performance Report

**Currently reported in Report on Government Services

Note: All data to adhere as closely as possible to the National Health Data Dictionary.

Attachment B to Schedule C

Format for Quarterly Reporting

NON-ADMITTED PATIENT OCCASIONS OF SERVICE

State:

Year:

Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Total
-----------	-----------	-----------	-----------	-------

Emergency Department Patients

--	--	--	--	--

Outpatients

Dialysis

--	--	--	--	--

Pathology

--	--	--	--	--

Radiology and Organ Imaging

--	--	--	--	--

Endoscopy and Related Procedures

--	--	--	--	--

Other Medical/Surgical/Diagnostic

--	--	--	--	--

Mental

--	--	--	--	--

Alcohol and Drug

--	--	--	--	--

Dental

--	--	--	--	--

Pharmacy

--	--	--	--	--

TOTAL Outpatient

--	--	--	--	--

Other Non-Admitted Patients

Community Health

--	--	--	--	--

District Nursing Service

--	--	--	--	--

Other Outreach Services

--	--	--	--	--

TOTAL Other Non-Admitted Patients

--	--	--	--	--

TOTAL Non-Admitted Patient Occasions of Service

--	--	--	--	--

EMERGENCY DEPARTMENT WAITING TIMES

State:

Year:

Jul - Sep	Oct - Dec	Jan – Mar	Apr - Jun	Total
-----------	-----------	-----------	-----------	-------

Emergency Department Patients

1. Category 1
2. Category 2
3. Category 3
4. Category 4
5. Category 5

Long Wait Emergency Department Patients

6. Category 1
7. Category 2
8. Category 3
9. Category 4
10. Category 5

% Long Wait

11. Category 1 (6/1)
12. Category 2 (7/2)
13. Category 3 (8/3)
14. Category 4 (9/4)
15. Category 5 (10/5)

Definition:

Category 1 patients are defined as "resuscitation" and require treatment immediately;
 Category 2 patients are defined as "emergency" and require treatment within 10 minutes;
 Category 3 patients are defined as "urgent" and require treatment within 30 minutes;
 Category 4 patients are defined as "semi-urgent" and require treatment within 1 hour; and
 Category 5 patients are defined as "non-urgent" and require treatment within 2 hours.

"Long wait" means patients wait longer than clinically appropriate.

"% Long wait" is the long wait emergency department patients divided by the emergency department patients for the appropriate category.

ELECTIVE SURGERY WAITING TIMES

State:

Year:

Jul - Sep	Oct - Dec	Jan – Mar	Apr - Jun	Total
-----------	-----------	-----------	-----------	-------

Elective Surgery Admissions

1. Category 1
2. Category 2
3. Category 3

Long Wait Elective Surgery Admissions

4. Category 1
5. Category 2
6. Category 3

% Long Wait

7. Category 1 (4/1)
8. Category 2 (5/2)
9. Category 3 (6/3)

Definition:

Category 1 patients require admission within 30 days;

Category 2 patients require admission within 90 days; and

Category 3 patients require admission at some time in the future but reporting is based on patients who had waited more than 12 months for admission.

"Long wait" means patients wait longer than clinically appropriate.

"% Long wait" is the long wait elective surgery admissions divided by the elective surgery admissions for the appropriate category.

SCHEDULE D – PUBLIC PATIENTS’ HOSPITAL CHARTER AND COMPLAINTS BODY

Background

1. Under Schedule D of the 1998-2003 Australian Health Care Agreements all States agreed to:
 - (a) review and update Public Patients’ Hospital Charters, develop them in appropriate community languages and develop and implement strategies for distributing them to users of public hospital services; and
 - (b) maintain 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

2. Victoria agrees to:
 - (a) review and update the existing Public Patients’ Hospital Charter (the Charter) to ensure its relevance to public hospital services. The review should be conducted with the Australian Council for Safety and Quality in Health Care or any successor;
 - (b) develop the Charter in appropriate community languages and forms to ensure it is accessible to people with disabilities and from non-English speaking backgrounds;
 - (c) develop and implement strategies for distributing the Charter to public hospital service users and carers; and
 - (d) adhere to the Charter.
3. Victoria agrees to the following minimum standards:
 - (a) the Charter will be promoted and made publicly available whenever public hospital services are provided; and
 - (b) the Charter will set out:
 - (i) how the principles in clause 6 of this Agreement are to apply to the provision of public hospital services in Victoria;
 - (ii) the process by which eligible persons can lodge complaints about the provision of public hospital services to them;
 - (iii) 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 Victoria and the mechanisms available for user participation in public hospital services; and
 - (v) a statement of consumers’ rights to elect to be treated as either public or private patients within Victoria’s public hospitals, regardless of their private health insurance status.

Independent Complaints Body

4. Victoria agrees to maintain an independent complaints body to resolve complaints made by eligible persons about the provision of public hospital services to them.

SCHEDULE D

5. Victoria agrees to the following minimum standards:
 - (a) the complaints body must be independent of bodies providing public hospital services and Victoria's health department;
 - (b) the complaints body must be given powers to investigate, conciliate and/or adjudicate on complaints received by it; and
 - (c) the complaints body must be given the power to recommend systemic and specific improvements to the delivery of public hospital services.
6. 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 the rights that a person may have under common law or statute law.
7. To assist in making recommendations and taking action to improve the quality of public hospital services, Victoria agrees to implement a consistent national approach, agreed with the Australian Council for Safety and Quality in Health Care or any successor, to collecting and reporting health complaints data to improve services for patients.

SCHEDULE E – NATIONAL STANDARDS FOR PUBLIC HOSPITAL ADMITTED PATIENT ELECTION PROCESSES

1. In accordance with this Agreement, public hospital admitted patient election processes for eligible persons should conform to the following national standards:

Admitted Patient Election Forms

2. Admitted Patient election forms can be tailored to meet individual State or public hospital needs. However, as a minimum, forms should 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 49 of this Agreement.
 - (b) A private patient may be treated by a doctor of his or her choice, and may elect to occupy a bed in a single room. A person may make a valid private patient election in circumstances where only one doctor has private practice rights at the hospital. Further, single rooms are only available in some public hospitals, and can not be made available if required by other patients for clinical reasons. Any patient who requests and receives single room accommodation, must be admitted as a private patient.
(Note: eligible veterans are subject to a separate agreement.)
 - (c) A statement that a patient with private health insurance can elect to be treated as a public patient.
 - (d) A clear and unambiguous explanation of the consequences of public patient election. This explanation should include advice that admitted public patients (except for Nursing-Home Type Patients):
 - (i) will not be charged for hospital accommodation, medical and diagnostic services, prostheses and most other relevant services; and
 - (ii) are treated by the doctor(s) nominated by the hospital.
 - (e) A clear and unambiguous explanation of the consequences of private patient election. This explanation should include advice that private patients:
 - (i) will be charged at the prevailing hospital rates for hospital accommodation (whether a shared ward or a single room), medical and diagnostic services, prostheses and any other relevant services;
 - (ii) may not be fully covered by their private health insurance for the fees charged for their treatment and that they should seek advice from their doctor(s), the hospital and their health fund regarding likely medical, accommodation and other costs and the extent to which these costs are covered; and
 - (iii) are able to choose their doctor(s), providing the doctor(s) has private practice rights with the hospital.
 - (f) Evidence that the form was completed by the patient or legally authorised representative before, at the time of, or as soon as practicable after, admission. This could be achieved by the witnessing and dating of the properly completed election form by a health employee.

- (g) A statement that patient election status after admission can only be changed in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to, the following:
- (i) patients who are admitted for a particular procedure but are found to have complications requiring additional procedures;
 - (ii) patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health care professional; and
 - (iii) patients whose social circumstances change while in hospital (eg. 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 clause 2(g) of this schedule apply.
- (j) A statement signed by the admitted patient or their legally authorised representative acknowledging that they have been fully informed of the consequences of their election, understand those consequences and have not been directed by a hospital employee to a particular decision.
- (k) A statement signed by admitted patients or their legally authorised representatives who elect to be private, authorising the hospital to release a copy of their admitted patient election form to their private health insurance fund, if so requested by the fund. Patients should be advised that failure to sign such a statement may result in the refusal of their health fund to provide benefits.
- (l) Where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election, or actual election, these patients will be treated as public patients and the hospital will choose the doctor until such time as a valid election is made. When a valid election is made, that election can be considered to be for the whole episode of care, commencing from admission.

Multiple and Frequent Admissions Election Forms

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

Other Written Material Provided to Patients

4. Any other written material provided to patients that refers to the admitted patient election process must be consistent with the information included in the admitted patient election form. It may be useful to include a cross-reference to the admitted patient election form in any such written material.

Verbal Advice Provided to Patients

5. Any verbal advice provided to admitted patients or their legally authorised representatives that refers to the admitted patient election process must be consistent with the information provided in the admitted patient election form.
6. Admitted patients or their legally authorised representatives should be referred to the admitted Patient election form for a written explanation of the consequences of election.
7. To the maximum extent practicable, appropriately trained staff should be on hand at the time of election, to answer any questions admitted patients or their legally authorised representatives may have.
8. Through the provision of translation/interpreting services, hospitals should ensure, where appropriate, that admitted patients, or their legally authorised representatives, from non-English speaking backgrounds are not disadvantaged in the election process.

SCHEDULE F - POPULATION WEIGHTS

1. The following weights will be used to calculate “weighted population” wherever required within this Agreement.

Males

<i>Age</i>	<i>Weight</i>
0 - 4	0.915729
5 - 14	0.225421
15 - 19	0.348312
20 - 39	0.443065
40 - 59	0.829932
60 - 64	1.783737
65 - 69	2.458605
70 - 74	3.303467
75 - 79	4.441940
80 - 84	5.283180
85+	5.715956

Females

<i>Age</i>	<i>Weight</i>
0 - 4	0.733850
5 - 14	0.179159
15 - 19	0.420619
20 - 39	0.857098
40 - 59	0.843405
60 - 64	1.430257
65 - 69	1.846244
70 - 74	2.520058
75 - 79	3.277013
80 - 84	4.121366
85+	4.762230

Note: These weights have been derived by applying the estimated resident Australian population as at 31 December 2000 to hospital separation data for public and private hospitals from the 2000-01 National Morbidity (Casemix) Database.

SCHEDULE G - FINANCIAL ASSISTANCE TO VICTORIA

1. The Commonwealth will make a financial contribution to Victoria in the form of a Base Health Care Grant equal to 96% of the sum of the following three components:

(a) A general component calculated in accordance with the following formula:

$$(G_{-1}) * \left[\left(0.75 * 1.017 * \frac{WPOP}{WPOP_{-1}} * WCI-1 \right) + \left(0.25 * \frac{WPOP}{WPOP_{-1}} * WCI-1 \right) \right]$$

where:

G_{-1} is the final grant entitlement for the general component for the previous year, and in respect of the 2002-03 grant year is \$1,670,479,776;

$WPOP$ is the weighted population for the relevant year, and is an estimate of Victoria's population as at 31 December of the relevant grant year provided by the Australian Bureau of Statistics, weighted in accordance with Schedule F;

$WPOP_{-1}$ is the weighted population for the previous grant year; and

$WCI-1$ is the Commonwealth's Wage Cost Index 1.

(b) A palliative care component calculated in accordance with the following formula:

$$G_{-1} * \frac{WPOP}{WPOP_{-1}} * WCI-1$$

where:

G_{-1} is the final grant entitlement for the palliative care component for the previous grant year and, in respect of the 2002-03 grant year is \$8,208,508; and

$WPOP$, $WPOP_{-1}$, and $WCI-1$ are as defined in clause 1(a) of this schedule.

(c) A safety and quality component of \$36,645,124 in 2002-03 prices, which will be increased to current year prices using the $WCI-1$.

2. An amount equivalent to 4% of the components described in subclauses 1(a) to 1(c) of this schedule having regard to the horizontal fiscal equalisation treatment of Base Health Care Grants, will be made available in accordance with clause 3(b) of this schedule.

3. The Commonwealth will also make a financial contribution to Victoria in the form of a non-base Health Care Grant comprising:

(a) Mental health funding calculated in accordance with the following formula;

$$G_{-1} * \frac{WPOP}{WPOP_{-1}} * WCI-1$$

where:

G_{-1} is the final grant entitlement for the mental health component for the previous grant year and, in respect of the 2002-03 grant year is \$14,250,187; and

$WPOP$, $WPOP_{-1}$, and $WCI-1$ are as defined in clause 1(a) of this schedule.

(b) Subject to clause 12 of this schedule, a compliance payment of an amount calculated in the following way:

(i) A pool of funds will be created comprising the sum of:

- 4% of the amount determined in accordance with clauses 1(a) to 1(c) of this schedule; plus
- a corresponding amount in respect of every other State; and

(ii) Victoria's share of this pool of funds will be determined by the following formula:

$$S = \text{POOL} \times \frac{\text{RPOP}}{\text{ARPOP}}$$

where:

S is Victoria's share of the pool of funds in the relevant grant year.

POOL is the amount determined in accordance with clause 3(b)(i).

RPOP is Victoria's population as at 31 December of the relevant grant year provided by the Australian Bureau of Statistics and weighted by the per capita relativities used for the distribution of GST Revenue between the States, in the relevant grant year.

ARPOP is the sum of RPOP from all States in the relevant grant year.

4. Funding under clause 3(b) of this schedule is subject to Victoria complying to the satisfaction of the Commonwealth Minister, with the compliance requirements set out in this Agreement and may be paid only in accordance with clauses 9 to 12 of this schedule.
5. In addition to Health Care Grants, the Commonwealth agrees to make available \$63,000,000 over 5 years to Victoria to increase investment in service delivery infrastructure under the Pathways Home program. This funding will be available to Victoria on the basis of the terms and conditions set out in Schedule B.
6. Victoria's Health Care Grant entitlement may be reduced through the operation of clause 21.

Provisional Health Care Grant Entitlements

7. The Commonwealth Minister will make a determination of provisional Health Care Grants to Victoria before the start of each grant year based on the latest available data. When making these determinations, the Minister will, in relation to 2004-05 and subsequent grant years, assume that Victoria is entitled to the same proportion of the funding available under clause 3(b) of this schedule as in the current grant year.
8. 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 this Agreement.

Review of Provisional Health Care Grant Entitlements

9. The provisional Health Care Grants will be reviewed as soon as possible after 31 December in 2004-05 and subsequent grant years in order to finalise the State's

SCHEDULE G

entitlement to the funding available under clause 3(b) of this schedule. At this time the Commonwealth Minister will review Victoria's performance in the previous grant year in relation to:

- (a) its level of compliance with the principles set out in clause 6 (having regard to a range of information, including the minimum list of performance indicators at Attachment A to Schedule C);
- (b) its commitment to match the estimated rate of growth of Commonwealth funding as measured in accordance with clause 10 of this schedule; and
- (c) its performance in relation to the reporting requirements subject to compliance assessment under this Agreement.

10. For the purposes of clause 9(b) of this schedule, Victoria will be considered to have met its matching obligation if the cumulative rate of growth in Victoria's own source funding is at least equal to the Commonwealth funding growth level defined as:

- (a) 5.0% in respect of the 2003-04 grant year, less a tolerance allowance of 0.5 percentage points.
- (b) in respect of the 2004-05 grant year, the cumulative growth rate target advised by the Commonwealth by 31 January 2004, being the estimate of the cumulative growth in grants to Victoria under this Agreement in 2003-04 and 2004-05 based on the latest available estimates as at 31 January 2004 of weighted population and WCI-1 as defined in clause 1 of this schedule, less 0.5 percentage points.
- (c) in respect of the 2005-06 grant year, the cumulative growth rate target advised by the Commonwealth by 31 January 2005, being the estimate of the cumulative growth in grants to Victoria under this Agreement based on the actual grant payments in 2003-04 and estimates of grant payments in 2004-05 and 2005-06 based on the latest available estimates as at 31 January 2005 of weighted population and WCI-1 as defined in clause 1 of this schedule, less 0.25 percentage points.
- (d) in respect of the 2006-07 grant year, the cumulative growth rate target advised by the Commonwealth by 31 January 2006, being the estimate of the cumulative growth in grants to Victoria under this Agreement based on the actual grant payments in 2003-04 and 2004-05 and estimates of grant payments in 2005-07 and 2006-07 based on the latest available estimates as at 31 January 2006 of weighted population and WCI-1 as defined in clause 1 of this schedule.
- (e) in respect of the 2007-08 grant year, the cumulative growth rate target advised by the Commonwealth by 31 January 2007, being the estimate of the cumulative growth in grants to Victoria under this Agreement based on the actual grant payments in 2003-04, 2004-05 and 2005-06 and estimates of grant payments in 2006-07, 2007-08 based on the latest estimates as at 31 January 2007 of weighted population and WCI-1 as defined in clause 1 of this schedule.

11. Victoria agrees that the compliance requirements in relation to clause 25(c) will be assessed with reference to clauses 5 to 11 in Schedule C.

12. As a consequence of the review under clause 9 of this schedule, the Commonwealth Minister will determine Victoria's entitlement to funding under clause 3(b) of this schedule for the current grant year and if necessary, approve a revised provisional Health Care Grant.

13. If the Commonwealth Minister is satisfied that Victoria has failed over consecutive years to meet the requirements in relation to the clause 9 of this schedule, Victoria's entitlement under clauses 1 and 3(a) of this schedule will be reduced on an ongoing basis to a level equivalent to the 2002-03 funding levels identified in clauses 1 and 3(a) of this schedule, indexed by WCI-1 only.
14. Victoria acknowledges that performance in the 2007-08 grant year against the requirements of clause 9 of this schedule will be taken into account when the Commonwealth is considering 2008-09 funding for public hospital services.

Final Health Care Grant Entitlement

15. The Commonwealth Minister will determine Victoria's final Health Care Grant entitlement under this Agreement before the end of each grant year. The final grant entitlement will have regard to:
 - (a) any revision of any relevant data which has occurred since the last provisional Health Care Grant determination was made; and
 - (b) any adjustment required by the operation of clause 21, irrespective of the period to which the adjustment applies.

Cash Flow

16. When determining provisional grants, the Commonwealth Minister will also determine cash flow arrangements.
17. The cash flow arrangements approved in conjunction with the first provisional Health Care Grant determination for each grant year will provide for weekly payments of:
 - (a) 51 equal instalments of $7/365$ of the amount determined in accordance with clause 7 of this schedule; and
 - (b) one payment of the difference between the sum of 51 payments calculated in accordance with clause 17(a) of this schedule and Victoria's provisional Health Care Grant entitlement.
18. The cash flow arrangements approved in conjunction with subsequent Health Care Grant determinations for each grant year will provide for weekly payments of:
 - (a) equal instalments up to the 51st week of the grant year of $7/365$ of the portion of the Health Care Grant entitlement which has not already been paid; and
 - (b) one payment of the balance of the Health Care Grant entitlement.
19. In determining the first cash flow arrangements in respect of each Grant year, the Minister will:
 - (a) in respect to 2003-04 arrangements approve initial payments based on the 2002-03 funding amounts specified in clauses 1 to 3 of this schedule indexed by WCI-1 only. Victoria's payments will be adjusted in accordance with clause 18 of this Schedule as soon as practicable after signing this Agreement; and
 - (b) in respect of subsequent grant years:
 - (i) assume that Victoria's entitlement to payments under clause 3(b) of this schedule will be the same as its entitlement to those funds in the current grant year; and
 - (ii) have regard to any reduction in Victoria's entitlement through the operation of clause 21.

20. Cash flow relating to funding available in accordance with clause 5 of this schedule will be as determined by the Commonwealth Minister from time to time, having regard to the cash flow requirements of the plan referred to in Schedule B.

Acquittal of Grants

21. Victoria agrees to provide to the Commonwealth the following reports, within five months of the end of each grant year, in the format specified at Attachment A to this schedule:
- a statement to acquit the amount of funds provided under this Agreement 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 in accordance with the provisions of this Agreement; and
 - separate acquittance statements in respect of funds provided for the Pathways Home program and Mental Health Reform program.
22. Victoria acknowledges that acquittance requirements set out in the 1998-2003 Australian Health Care Agreements are not removed or diminished by this Agreement.

National Programs

23. The Commonwealth will make funding available to support national initiatives which are consistent with Commonwealth objectives in relation to the Hospital Information and Performance Information Program (formerly casemix), Mental health reform and Palliative care programs. Where such funds are provided to Victoria they will be subject to specific conditions and reporting arrangements negotiated on a bilateral basis.
24. The Commonwealth may make funds available to Victoria in respect of the following national programs:
- Hospital Information and Performance Information Program (formerly casemix);
 - Mental health reform; and
 - Palliative care.
25. In each of the grant years, the amounts available in respect of each of the above national programs will be determined in accordance with the following formula:

$$\text{FUNDS}_{-1} * \frac{\text{AWPOP}}{\text{AWPOP}_{-1}} * \text{WCI}_{-1}$$

where:

FUNDS_{-1} is the funding for the relevant national program in the previous grant year where the 2002-03 base amount is:

- \$4,871,802 in respect of the Hospital Information and Performance Information Program;
- \$11,715,593 in respect of Mental health reform; and
- \$2,343,119 in respect of Palliative care.

AWPOP 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 Schedule F;

AWPOP₋₁ is the Australian total weighted population for the previous grant year; and
WCI-1 as defined in clause 1(a) of this schedule.

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

26. 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 a subsequent grant year. For the purposes of this clause, any amounts in respect of a compliance payment that is not paid in accordance with clauses 9 to 12 of this schedule and any reductions made to final Health Care Grant entitlements under clauses 12 and/or 13 of this schedule or clause 21 are not considered to be amounts of financial assistance payable under this Agreement in that grant year.

Attachment A to Schedule G



**2003-08 AUSTRALIAN HEALTH CARE AGREEMENT
HEALTH CARE GRANT**

**Statement of acquittal and certification of expenditure
pursuant to Clause 21 of Schedule G**

I certify that:

- 1) The following amounts were received by
under the terms of the Agreement in / as Health Care Grants:

BASE GRANT

General Component	\$
Palliative Care	\$
Safety and Quality	\$
Total Base Grant	\$

NON-BASE GRANT

Mental Health	\$
Torres Strait (Qld only)	\$
Woomera (SA only)	\$
Compliance payment	\$
Total Non-Base Grant	\$

TOTAL HEALTH CARE GRANT \$

- 2) The Health Care Grant funding received was expended on the provision
of public hospital services in accordance with the provisions of the Agreements.

Signature	Designation	Date



Commonwealth Department of
Health and
Ageing

2003-08 AUSTRALIAN HEALTH CARE AGREEMENT

PATHWAYS HOME PROGRAM

Statement of acquittal and certification of expenditure
pursuant to Clause 21 of Schedule G

I certify that:

- 1) The following amount was received by
on / / from the Pathways Home Program.

\$

- 2) The funding received was expended in accordance with an agreed plan
in accordance with Clause 5, Schedule B.

Signature	Designation	Date



Commonwealth Department of
Health and
Ageing

2003-08 AUSTRALIAN HEALTH CARE AGREEMENT

MENTAL HEALTH REFORM

Statement of acquittal and certification of expenditure
pursuant to Clause 21 of Schedule G

I certify that:

- 1) The following amount was received by
on / / from the Mental Health Reform Program.

\$

- 2) The funding received was expended in accordance with the National
Mental Health Reform Strategy in accordance with Clause 14(c).

Signature	Designation	Date

THIS AGREEMENT WAS SIGNED BY THE PARTIES ON THE FOLLOWING DATE/S:

SIGNED FOR AND ON BEHALF OF)
THE COMMONWEALTH OF AUSTRALIA)
BY SENATOR THE HONOURABLE)
KAY PATTERSON)
MINISTER FOR HEALTH AND AGEING)
)
)

IN THE PRESENCE OF

)
)
)
)
)
)
)
)

ON THE _____ DAY OF _____ 2003

SIGNED FOR AND ON BEHALF OF)
VICTORIA BY)
THE HONOURABLE BRONWYN PIKE MP)
MINISTER FOR HEALTH)
)
)
)

IN THE PRESENCE OF

)
)
)
)
)
)
)

ON THE _____ DAY OF _____ 2003.