The Parliament of the Commonwealth of Australia

Review of Auditor-General's Report No. 19 (2006-2007)

Administration of State and Territory Compliance with the Australian Health Care Agreements

House of Representatives
Standing Committee on Health and Ageing

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Canberra

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Foreword

The Auditor-General, as an independent officer of the Parliament, provides Parliament with an independent assessment of whether public money is being spent efficiently, effectively and in compliance with the standards of accountability and financial reporting.

One of the largest and fastest growing areas of government activity at both the Commonwealth and state level is the provision of health care. The health sector is characterised by complex financial arrangements, a multitude of public and private health providers and millions of episodes of patient care each year. At the core are five year bilateral funding agreements between the Commonwealth and each state and territory to jointly fund free access to public hospitals. These agreements are called Australian Health Care Agreements (AHCAs) and the current ones commit the Commonwealth, states and territories to collectively spend $100 billion from 2003 to 2008 on public hospital services.

The committee examined the AHCAs closely during its inquiry into health funding. In the report of that inquiry, entitled *The Blame Game*, the committee made a number of recommendations to amend the funding arrangements the AHCAs perpetuate. Thus, it was with great interest that the committee chose to review the Australian National Audit Office's performance audit of the administration of state and territory compliance with the AHCAs. As a result of the review, the committee has made several recommendations to bolster the audit findings.

One of the committee's themes is that public hospitals and health departments need to be more accountable to the community for their performance. Australians expect to receive the best possible health attention when required and wherever

they live. As its final recommendation in this report, the committee proposes that, in the next round of AHCAs, the Australian Government require the states and territories to agree that their auditors-general be empowered to conduct full performance audits of AHCA expenditure within their respective public hospital systems. The work of auditors-general adds value to public sector administration and provides greater transparency and accountability of government to parliaments and the public.

The enthusiasm of my colleagues on the committee to improve the health system has driven the inquiry. I would like to pay tribute to their efforts, particularly the Deputy Chair, Steve Georganas MP, and thank the secretariat for their support.

Hon Alex Somlyay MP
Chair

Membership of the Committee

Chair	Hon Alex Somlyay MP
Deputy Chair	Mr Steve Georganas MP
Members	Hon Alan Cadman MP
	Mrs Justine Elliot MP
	Mrs Kay Elson MP
	Hon Warren Entsch MP
	Ms Jill Hall MP
	Mr Michael Johnson MP
	Ms Catherine King MP
	Mr Ross Vasta MP

Committee Secretariat

Secretary	Mr James Catchpole
Inquiry Secretary	Ms Margaret Atkin
Administrative Officer	Ms Lauren Walker

Terms of reference

The House of Representatives Standing Committee on Health and Ageing resolved on 7 February 2007 to conduct an inquiry.

"The Committee resolved to conduct a review of the following Australian National Audit Office performance audit:

> Administration of State and Territory Compliance with the Australian Health Care Agreements, Audit Report No. 19, 2006-2007."

List of abbreviations

ACT	Australian Capital Territory
AHCA/s	Australian Health Care Agreement/s
AHMC	Australian Health Ministers' Conference
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
ANAO Audit Report	Australian National Audit Office, *Administration of State and Territory Compliance with the Australian Health Care Agreements,* Audit Report No. 19 2006-2007, Commonwealth of Australia, 2007.
Blame Game, the	House of Representatives Standing Committee on Health and Ageing (HAA), *The Blame Game: Report on the inquiry into health funding,* Parliament of the Commonwealth of Australia, Canberra, 2006.
COAG	Council of Australian Governments
committee	House of Representatives Standing Committee on Health and Ageing
Commonwealth	Australian Government
FAGs	Financial Assistance Grants
Framework	*Compliance Monitoring and Assessment Framework*
Health	Department of Health and Ageing

MBS	Medicare Benefits Schedule
Minister	Minister for Health and Ageing (Australian)
NMDS	National minimum data set
PBS	Pharmaceutical Benefits Scheme
SPPs	Specific Purpose Payments
states	State and Territory governments

List of recommendations

3. Adherence to clause 6 principles

Recommendation 1

That in negotiating the 2008-2013 Australian Health Care Agreements (AHCAs), the Australian Government require a reporting framework that provides the Commonwealth with regular and compatible data from the states and territories on the number and nature of complaints and allegations they receive about non compliance with the AHCAs.

Recommendation 2

That in negotiating the 2008-2013 Australian Health Care Agreements (AHCAs), the Australian Government offer a structure of financial incentives to allow it to reward those states and territories that significantly exceed benchmarks associated with meeting AHCA objectives.

Recommendation 3

That in negotiating the 2008-2013 Australian Health Care Agreements, the Australian Government include dispute resolution procedures.

6. Conclusion

Recommendation 4

That in negotiating the 2008-2013 Australian Health Care Agreements (AHCA), the Australian Government require the parties to the AHCAs to agree that state and territory auditors-general be empowered to conduct full performance audits of AHCA expenditure within the public hospital systems of their respective states.

1

Introduction

People might say that a billion here or there does not matter too much but, actually, $1 billion is $1 billion.[1]

1.1 In 2006 the Australian National Audit Office (ANAO) conducted a performance audit of the Department of Health and Ageing's ('Health') administration of state and territory compliance with the Australian Health Care Agreements (AHCAs). The report of the audit was tabled on 25 January 2007.[2]

1.2 On 7 February 2007 the House of Representatives Standing Committee on Health and Ageing ('the committee') resolved to review the audit report. The committee held two private briefings with the ANAO to examine the report and then held a public hearing on 28 March 2007 to take evidence from both the ANAO and Health.

Australian health care agreements

1.3 State governments are responsible for providing hospital services, for public patients, either through ownership or funding of public hospitals or contract arrangements with private hospitals.[3] The Commonwealth contributes to the costs of state public hospital

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1 Private briefing.

2 Australian National Audit Office (ANAO), *Administration of State and Territory Compliance with the Australian Health Care Agreements*, Audit Report No. 19 2006-2007, Commonwealth of Australia, 2007 ('ANAO, Audit Report').

3 State and territory governments are referred to as 'states' for the purposes of this report.

services on the condition that the states will comply with certain principles and conditions.[4]

1.4 The principles and conditions are set out in the AHCAs, which are bilateral five-year agreements between the Commonwealth and each of the states.[5] The principles and conditions are the same in each agreement, although the agreements do differ in the levels of funding provided to each state.[6] The present AHCAs commenced on 1 July 2003 and are due to expire on 30 June 2008. The 2008-2013 agreements were being negotiated as the committee conducted its inquiry.

1.5 The Commonwealth is contributing an estimated $42 billion during the life of the 2003-08 agreements while the states are collectively contributing some $58 billion.[7] Thus total government expenditure on public hospital services under the AHCAs over the five years will be some $100 billion.[8]

1.6 Clause 6 of the AHCAs sets out their primary objective, which is to secure community access to public hospital services, based on three principles drawn from the *Health Care (Appropriation) Act 1998*. The principles are that:

- 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;
- 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
- arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of geographical location.

Commonwealth responsibilities

1.7 Under the AHCAs, Health administers three main responsibilities on behalf of the Commonwealth:

- ensuring that the terms of the AHCAs are complied with by the states before Commonwealth funds to them are disbursed;

4 The Australian Government is referred to as 'the Commonwealth' for the purposes of this report as that is the term used in the Australian Health Care Agreements (AHCAs).

5 Copies of the AHCAs for each state and territory are available on Health's website at: www.health.gov.au/internet/wcms/publishing.nsf/Content/health-ahca-agreement.htm viewed on 16 July 2007.

6 The AHCAs are considered identical for the purposes of this report; see also Appendix D footnote at p 43.

7 ANAO, Audit Report, pp 11, 23.

8 ANAO, Audit Report, p 11.

- providing policy development for national program activities initiated under the auspices of the AHCAs; and
- publishing the annual *The state of our public hospitals*, which 'considers how the states…are performing in the delivery of public hospital services and records their expenditure on public hospitals'[9].

State and territory responsibilities

1.8 In turn, to obtain the full level of funding available from the Commonwealth, each state government must:

- adhere to principles set out in clause 6 of the AHCAs;
- increase their own source funding at a rate which at least matches the estimated cumulative rate of growth of Commonwealth funding under the AHCAs; and
- meet the performance reporting requirements outlined in the AHCAs.[10]

1.9 If the Commonwealth Minister, currently the Minister for Health and Ageing ('the Minister'), is satisfied that a state has met all the compliance requirements, it will receive in addition 'a compliance payment' equivalent to approximately four per cent of its base health care grant entitlement.[11]

1.10 AHCA payments are transferred directly to the state governments, so states are responsible for ensuring that their hospitals (or other providers) comply with the agreements.

Committee report – *The Blame Game*

1.11 During the period of the audit, the committee was conducting a broad-ranging inquiry into health funding. The report of the inquiry, entitled *The Blame Game*, was tabled in the Parliament on 4 December 2006.[12]

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9 AHCAs, clause 9; see also Minister's foreword, Department of Health and Ageing (Health), *The state of our public hospitals, June 2006 report*, Commonwealth of Australia, 2006, p iii.

10 AHCAs, clause 25.

11 AHCAs, clause 31.

12 House of Representatives Standing Committee on Health and Ageing (HAA), *The Blame Game: Report on the inquiry into health funding*, Parliament of the Commonwealth of Australia, Canberra, 2006.

1.12 That report commented directly on the function and future of AHCAs. The committee recommended, among other things, the adoption of a national health agenda. As part of that agenda, the committee wanted a rationalisation of the roles and responsibilities of governments, including their funding responsibilities. In turn, several recommendations were made to change the current AHCA model of public hospital financing.

1.13 At the tabling of this report, there was still no government response to the recommendations of *The Blame Game.* Accordingly, the committee considered it prudent to review the audit report on the assumption that the 2008-2013 AHCAs, at least, will be similar to the current ones. However, Members recognise that the recommendations in this report may become redundant if those in *The Blame Game* become government policy.

Structure of the report

1.14 The next chapter reviews the ANAO's findings and Health's response to the ANAO recommendations. The following three chapters discuss key issues arising from the audit report and the committee's inquiry.

1.15 Chapter three focuses on the states' compliance with their obligations to provide public hospital services to the standard specified in clause 6 of the AHCAs.

1.16 Chapter four examines the difficulties associated with measuring whether the states have matched the growth rate of the Commonwealth's recurrent expenditure under the AHCAs.

1.17 In Chapter five, the committee discusses performance reporting and the need for greater public accountability for hospital performance.

1.18 The final chapter returns to the recommendations in *The Blame Game* and concludes by encouraging all levels of government to consider adopting a national health agenda.

1.19 The appendices list the witnesses who appeared at the single public hearing for the inquiry, relevant recommendations from *The Blame Game* report, State and Territory Auditors-General reporting, and contain the New South Wales agreement as an example of an AHCA.

2

Auditor-General's report

The Auditor-General makes an essential contribution to the system of public accountability, serving as the external auditor of the Executive Government with a duty to report directly to Parliament on 'the financial stewardship and the economy and efficiency of the operations of Commonwealth entities.'[1]

Audit objectives

2.1 The objective of the performance audit was to assess whether the states were complying with their obligations under the terms of the 2003-2008 AHCAs and whether Health was adequately administering the billions of dollars provided to the states through the AHCAs.[2] In the audit the focus was on Health's role, rather than on the activities of the states. As an additional benefit, the findings of the audit report were intended to assist Health when it was developing the next agreements.

2.2 An earlier ANAO performance audit of the AHCAs operating between 1998 and 2003 found that Health only had limited information about the extent to which the states were meeting their obligations to provide free and equitable access to public hospital services. The ANAO also found that Health had only partial

1 Auditor-General, *Annual Report 1994-95*, p 3.

2 ANAO, Audit Report, p 27.

performance information to determine the effectiveness and efficiency of the then AHCAs.[3]

2.3 In conducting the more recent audit, the ANAO investigated whether Health had assessed if the states were:

- adhering with clause 6 of the agreements that all eligible people have equitable access to free public health and emergency services on the basis of clinical need, within a clinically appropriate period and regardless of location;
- increasing their own source funding at the rate specified in the AHCAs; and
- meeting the performance reporting requirements set out in the AHCAs.[4]

2.4 The ANAO did not examine Health's responsibility for national policy development which is also outlined in the AHCAs.[5]

Audit conclusion

2.5 The ANAO found that, overall, Health had developed and implemented a suitable framework to administer the AHCAs. Health did have procedures in place to monitor whether the states were complying with their obligations under the AHCAs. However, Health relied on the states to conduct investigations of non compliance and also to provide performance data in the correct format by the due date. Health also needs to clarify several issues of definition with the states in order to improve the level of assurance it has about each jurisdiction's contribution to public hospital funding.[6]

2.6 The ANAO identified several provisions of the AHCAs that made it difficult for Health to assess the states' compliance with their obligations. These are discussed in greater detail in chapters three, four and five of this report.

3 ANAO, *Performance Information in Australian Health Care Agreements*, Audit Report No. 21 2002-2003, Commonwealth of Australia, 2002, p 14.

4 ANAO, Audit Report, pp 27-28.

5 ANAO, Audit Report, p 14.

6 ANAO, Audit Report, pp 12-14.

Audit recommendations

2.7 The ANAO made three recommendations.

Guidance to the states on assessment principles

2.8 The ANAO's first recommendation was that, 'to assist the States and Territories clearly understand Health's processes and expectations in its assessment of compliance with the AHCAs, Health provide more detailed guidance of its procedures and assessment principles to the State and Territory Governments'.[7]

2.9 Health agreed with this recommendation and committed to preparing a high level principles document based on its *Compliance Monitoring and Assessment Framework* and distributing it to the states.[8]

Improve data on emergency and inpatient waiting times

2.10 Secondly, the ANAO recommended 'that Health work with the States and Territories to improve the consistency and accuracy of their data on emergency department and inpatient waiting times, and regularly analyse the quarterly performance data provided by the States and Territories to assist in confirming their adherence to the AHCAs' principles'.[9]

2.11 Health also agreed with this recommendation. It noted that it had now established consistent processes for calculating waiting times for elective surgery and emergency departments. However, Health also noted that the different ways in which states manage their waiting lists can affect how patient status may be counted and recorded. Health committed to continuing to work with the states to improve data collection.[10]

Role of external auditors

2.12 The ANAO's final recommendation:

> …that Health:
>
> - clarify with the States and Territories the level and nature of assurance it requires from independent audits of State and Territory recurrent expenditure on public hospital services; and

7 ANAO, Audit Report, p 35, para 2.18.
8 ANAO, Audit Report, p 35, para 2.19.
9 ANAO, Audit Report, p 40.
10 ANAO, Audit Report, p 40.

- review future auditors' statements on State and Territory recurrent expenditure on public hospital services to identify the impact of any limitations or adverse findings on its assessment of compliance with the AHCAs.[11]

2.13 Health agreed too with the third recommendation. It advised that the Commonwealth and states now have guidelines for reporting financial information. The assurances given by external auditors will have to meet consistent standards and Health 'will review future auditors' statements and fully investigate any limitations or adverse findings raised by verifiers.'[12]

11 ANAO, Audit Report, p 57.

12 ANAO, Audit Report, p 57.

3

Adherence to clause 6 principles

The primary objective of this Agreement is to secure access for the community to public hospital services 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.[1]

Clause 6 principles of the AHCAs

3.1 The heart of the AHCAs is clause 6 which sets out the primary objective of the agreements. In essence, the community is to have access to public hospital services, free of charge, within a clinically appropriate time, and regardless of location.

3.2 In applying the principles in clause 6, clause 7(a) commits the Commonwealth and states to agree that the range of services available to public patients will be no less than was available on 1 July 1998. Clause 25 requires the Minister to be satisfied that the states have adhered to the principles set out in clause 6, among other

1 AHCAs, clause 6.

requirements, before they can qualify for full funding. Full funding includes the four per cent compliance payment.

3.3 In its report, the ANAO discussed Health's assessment of the states' adherence to the clause 6 principles and its management of non compliance. This was of particular interest to the committee as it had taken evidence during its inquiry into health funding suggesting a lack of compliance with clause 6 in some states.

3.4 In its audit, firstly, the ANAO considered whether Health identified potential breaches of the clause 6 principles and then whether it obtained sufficient information to assess whether a breach had in fact occurred. Secondly, the ANAO examined whether Health had adequate procedures in place to follow up potential breaches and ensure that they were being addressed. The ANAO also considered how Health assessed state overall compliance with clause 6 and whether the assessments provided sufficient information to the Minister to inform his determination of compliance.[2]

Assumption of adherence

3.5 The AHCAs do not specify how the Commonwealth is to measure the extent to which the states are complying with clause 6.

3.6 The ANAO found that Health assumed that the states were complying with the AHCA principles and did not actively check for compliance. Health was also confident that the states had sufficient incentive to remain compliant:

> Given that there is this penalty clause within the current health care agreements, it really does prompt a whole lot voluntary compliance. Our expectation is that states do not want to lose that four per cent. Four per cent of a large number is still a large amount of dollars.[3]

3.7 Action was only taken by Health when specific complaints or allegations about public hospital services were made to the department or the Minister, or when Health identified potential non-compliance from other sources such as media reports, hospital circulars or state government websites.[4] Health had initiated some

2 ANAO, Audit Report, p 37.

3 Kalisch D, transcript, p 5.

4 ANAO, Audit Report, p 38.

investigations but had to be mostly reactive and dependent upon cases being drawn to its attention.[5]

Complaints and allegations

3.8 Public hospital emergency departments collectively treat just over four million people per year and nearly the same numbers are admitted to hospitals as public patients each year.[6]

3.9 Complaints units, in public hospitals and state health departments or independent bodies, regularly receive complaints from people about their experience as public patients. These complaints are generally about the quality of medical treatment or hospital care that public patients have (or have not) received and are addressed at the state level.

3.10 The Commonwealth, on the other hand, can only receive complaints specifically about non compliance with the AHCAs themselves. For this reason, in the first three years of the AHCAs, a total of only 133 complaints or allegations about public hospital services were received at the Commonwealth level by Health or its Minister.[7]

3.11 Those complaints about clause 6 non compliance that are made to Health or the Minister, tend to come from public hospital staff, medical practitioners or private health insurance companies[8]. This corroborates the committee's experience during its inquiry into health funding and examples of alleged breaches of the AHCAs are listed in *The Blame Game*. Examples of breaches included in public hospitals: billing patients or the Medicare Benefits Schedule (MBS) for services that should have been provided free or charge; pressuring patients to elect to be treated as private patients; and outpatient departments seeking referrals to a named doctor to ensure they can be billed to the MBS.[9]

Health follow up

3.12 When it receives a complaint concerning compliance with the clause 6 principles, Health raises it with the appropriate state health department and relies on their cooperation to confirm whether the

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5 ANAO, Audit Report, pp 38-39.

6 Health, *The state of our public hospitals, June 2007 report*, Commonwealth of Australia, 2007, pp 27, 48; ANAO, Audit Report, p 38.

7 Kalisch D, transcript, p 6.

8 ANAO, Audit Report, p 38. See also Kalisch D, transcript, p 3.

9 Health, *The Blame Game*, Box 7.2. See also ANAO, Audit Report, p 43.

complaints have merit.[10] However, only some half of the 133 complaints could be pursued by Health, mainly because complainants were reluctant to have their identity revealed to state health departments during investigations.[11]

3.13 Health told the committee that, of those complaints it could investigate, only a relatively small number had turned out to be breaches and that some of these were technical breaches.[12] In the cases where the state health department agreed that a breach had occurred in a hospital, Health considered the matter closed once remedial action was taken by the state. Health told the committee it was confident that:

> …if there was rampant non-compliance, we are assuming that we would receive far more than 133 complaints, given that there are over four million admissions a year.[13]

3.14 On this basis, Health advised the ANAO that it would need evidence of 'systemic' and 'on going' breaches rather than isolated cases before deeming a state non compliant with its AHCA.[14]

3.15 Health does not have access to state health departments' data to determine whether complaints about the AHCAs are being dealt with at the state level without being brought to the Commonwealth's attention. Health's access to complaints data generated at the state level is via public information:

> It is still a state system; we do not get access to their internal working documents or internal information…
>
> We get access to the public documents, but there is no further requirement.[15]

3.16 The committee suspects that many complaints that potentially involve breaches of the AHCAs are being dealt with at the state level without coming to the notice of the Commonwealth. To ensure that the Commonwealth is at least aware of the true volume and scope of complaints about AHCA breaches, the committee recommends that the Commonwealth seek greater access to state health departments' complaints data for public hospitals.[16]

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10 ANAO, Audit Report, pp 38-39.

11 ANAO, Audit Report, p 40.

12 Kalisch D, transcript, p 4. See also ANAO, Audit Report, p 42.

13 Kalisch D, transcript, p 6.

14 ANAO, Audit Report, p 47.

15 Kalisch D, transcript, p 3.

16 Schedule D of the AHCAs requires the states to maintain independent complaints bodies to resolve complaints about the provision of public hospital services.

Recommendation 1

3.17 **That in negotiating the 2008-2013 Australian Health Care Agreements (AHCAs), the Australian Government require a reporting framework that provides the Commonwealth with regular and compatible data from the states and territories on the number and nature of complaints and allegations they receive about non compliance with the AHCAs.**

Hospital services as of 1 July 1998

3.18 As mentioned, clause 7(a) of the AHCAs requires the states to provide no less than the range of services available to public patients on 1 July 1998. Health had difficulty confirming exactly what were the full range of services available to public patients on 1 July 1998. This, in turn, made it difficult to test compliance by the states with clause 6(a) – the public's entitlement to services that 'are currently, or were historically, provided by hospitals'.[17]

3.19 Health told the committee that the problem was compounded because in 1998 there was a lack of consistency in the range of services offered within states, let alone between states:

> …it is important to recognise here that this is not a blanket statewide approach that we are often talking about here. Often what the pre-1998 services referred to are the practices in an individual hospital that took place before 1998 and the services that were offered at that time. It is not as if there is a standard statewide coverage that everyone is aware of, that this hospital might offer this service, another hospital may have offered it in a different way that is now consistent and does not breach that principle.[18]

3.20 According to the ANAO, this required Health to accept the states' assertions about when they had implemented particular services, with little, if any, supporting evidence.[19]

3.21 The difficulty facing Health in defining the services available in the states on 1 July 1998 is parallelled by the difficulty Health faced in determining the states' base levels of expenditure on health services at

17 See ANAO, Audit Report, p 46.

18 Kalisch D, transcript, p 8. See also ANAO, Audit Report, p 46.

19 ANAO, Audit Report, p 46.

the commencement of the AHCAs – an issue explored in greater detail in the next chapter.

3.22 Clearly, Health has not been in a position to be too pedantic about the states' compliance with clause 6(a) given the uncertainty inherent in Health's baseline data. The lesson drawn by the committee is that the 2008-2013 AHCAs will need to be drafted with the limitations of the current agreements in mind and define far more clearly and precisely the baseline public hospital services that the states are to provide.

Treatment in a clinically appropriate time

3.23 Clause 6(b) of the AHCAs requires that public patients receive access to services 'on the basis of clinical need and within a clinically appropriate time'. Schedule C of the Agreements specifies three of the performance measures to measure compliance with clause 6(b). They are: waiting times for elective surgery, waiting times for emergency departments by triage category and admission from waiting lists by clinical category.

Elective surgery waiting times

3.24 Public patients requiring elective surgery are assigned to one of three categories of urgency. The categories set admission to hospital as being desirable within 30 days, 90 days and 12 months respectively.

3.25 Nationally, in 2005-06, 83 per cent of category one patients were admitted within 30 days, 74 per cent of category two patients within 90 days and 88 per cent of category three patients within one year. Overall national performance has decreased steadily from 1998-99 when 90 per cent of patients were admitted within the recommended times for their elective surgery category.[20] These figures also hide significant variations between states. Nationally, 81 per cent of elective surgery admissions in all categories were seen within the recommended time in 2005-06. Queensland recorded the highest percentage (86%) while Tasmania recorded the lowest (68%).

Emergency department waiting times

3.26 On presentation to hospital emergency departments, patients are assigned to one of five triage categories. A maximum time in which patients should be seen is set for each category. Category one patients

20 Health, *The state of our public hospitals, June 2007 report*, p 40.

are critically ill and require immediate attention. Patients in categories two to four should be seen within 10, 30, 60 and 120 minutes respectively.

3.27 Nationally, in 2005-06, 69 per cent of all patients were seen within the time recommended for their triage category. Victoria performed the best with 77 per cent of all patients seen within the recommend times. The Australian Capital Territory (ACT) at 52 per cent was the poorest performer. Fortunately, very nearly all patients in category one were seen immediately with little variation in performance between the states. Nationally, 64 per cent of patients in triage category three were seen within the recommended time of 30 minutes, although this dropped to 44 per cent in the ACT. Nationally 65 per cent of patients in category four were seen within the recommended 60 minutes. Again the ACT was the worst performer with only 47 per cent of patients being seen within the recommended time. [21]

Committee assessment of waiting times

3.28 The figures for 2004-05 on which the ANAO reported are broadly consistent with the more recent data reported above.[22] It is clear to the committee that not all patients are being seen within clinically appropriate periods – a requirement of clause 6(b) – and that some states are performing worse than others.

3.29 Health was reported to state in its annual advice to the Minister that it believed it would be difficult to propose sanctioning any state for its performance against clause 6(b). The reasons being that the AHCAs did not set benchmarks for waiting times and because there were difficulties with the consistency and accuracy of state waiting time data. [23]

3.30 On the latter issue, Health told the committee:

> We have a minimum data set that we use to measure waiting times, but underneath that there are different processes that occur within hospitals, within emergency departments and in primary care. An example is when the clock starts ticking on your waiting time at the moment we do not have an agreed business rule on when the clock starts.[24]

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21 Health, *The state of our public hospitals, June 2007 report*, pp 49-51.

22 See Health, *The state of our public hospitals, June 2006, report*.

23 ANAO, Audit Report, p 47.

24 Gibson B, transcript, p 15.

3.31 The ANAO recommended that Health work with the states to improve the consistency and accuracy of emergency department performance data and inpatient waiting times.[25] While agreeing with the ANAO recommendation, Health noted that the states managed waiting lists in different ways as described above. Health told the committee that it was working with the states to improve the consistency of the data collected on elective surgery waiting lists and emergency department performance.[26]

3.32 The committee accepts the difficulty Health faces in collecting consistent and meaningful data across the states on elective surgery and emergency department waiting times. The committee also acknowledges that the priority function of state public hospitals is to treat patients rather than collect statistics for the Commonwealth.

3.33 However, in its 2006 health funding inquiry the committee received considerable evidence that the community places a high priority on receiving timely health care, particularly for elective surgery and emergency department care.[27] The complaints to the committee, while anecdotal, back up the official statistics that many patients face lengthy waits on elective public surgery lists or in emergency departments.

3.34 The committee fully endorses the ANAO recommendation that the data on emergency department performance be improved. Even on the presently available data, it seems clear that not all public patients are receiving clinical care 'within a clinically appropriate period' and that this is significantly worse in some states than others. To the committee, this seems a breach of the AHCAs in principle, even if not the lack of performance benchmarks makes it difficult to sanction the worst performing states. Importantly, the data is also necessary in order to hold state governments accountable for the performance of their hospitals. The need for performance benchmarks in the AHCAs and greater public accountability are returned to later.

Equitable access

3.35 Clause 6(c) of the AHCAs imposes on the states a requirement to provide 'equitable access to [public hospital services] for all eligible persons, regardless of their geographic location'.

25 ANAO, Audit Report, recommendation 2, p 40.

26 Gibson B, transcript, p 15.

27 HAA, *The Blame Game*, pp 206-09.

3.36 The ANAO assessed that Health had insufficient information to evaluate or measure whether access to services based on geographic location was indeed equitable:

> In particular, Health requires measures and data to enable it to assess whether States and Territories were providing equitable public hospital access to people in rural and remote areas, as well as in the fast-growing areas on the edges of major cities.[28]

3.37 In *The Blame Game* the committee also noted that the AHCAs provide no guidance to the states on the standard of access necessary to qualify as 'equitable access'. Evidence indicated that public hospital services were less accessible to those living in regional and remote areas, particularly if specialist treatment is required.[29] While it is unrealistic to expect every town to have the full range of public hospital services, it is currently left to the states to determine what is an appropriate level of service.

3.38 In *The Blame Game* the committee recommended that in negotiations for future AHCAs, the Commonwealth define the standards that the states must meet to satisfy the principle of equitable access regardless of geographic location.[30] The committee can only reiterate this recommendation here and urge Health and the states to develop the necessary performance data sets.

Benchmarks

3.39 Clause 6 of the AHCAs sets only the broadest of performance standards with which the states need to comply. The Commonwealth can use *The state of our public hospitals* series to highlight variations in the periods patients are forced to wait for various services but the AHCAs themselves do not articulate acceptable waiting times for compliance purposes. Health also struggles to confirm whether people have 'equitable access' to services regardless of location, but again there are no standards for what is acceptable.

3.40 The AHCAs allow Health to determine performance relativities between states and over time in some detail but it is not underpinned by detailed benchmarks or performance expectations. This allows all

28 ANAO, Audit Report, p 48.

29 HAA, *The Blame Game*, pp 154-55. See also: chapter 5.

30 HAA, *The Blame Game*, recommendations 11 and 15, pp 130, 155.

the states to 'comply' with Clause 6 of the AHCAs even while some clearly offer lower standards of performance in their hospitals.

3.41 In evidence to the committee Health noted the variation between the states:

> What is apparent from some of the data collected… is that some state health systems are less well funded than others. Some we would argue are underfunded and others are funded to a more acceptable level. You see that in terms of the services they are providing and the way in which the general public are able to access those services in those states.[31]

3.42 Furthermore:

> …it is clear that some states do much better than others. Whether that is because of extra funding or because they are more efficient and effective, probably both.[32]

3.43 The committee takes a national perspective on health care and does not believe that people should suffer a lesser standard of public hospital care simply because they live in one state and not another. AHCAs are the vehicles to pull up those states providing a lesser service to public patients. The mechanism is to set performance benchmarks that need to be met as part of the AHCA compliance assessment.

3.44 The committee is aware that Health sees the setting of benchmarks for performance as a policy matter and that the current AHCAs do not give the department a mandate to define, negotiate or apply performance benchmarks.[33] The Commonwealth and states are also still grappling with the development of nationally consistent performance indicators – necessary to measure whether the benchmarks have been met.

3.45 However, the committee has already recommended that the Commonwealth define standards associated with the principle of equitable access. Furthermore, the ANAO has also suggested the development of performance benchmarks and noted that 'the absence of such benchmarks causes difficulties in assessing whether the States and Territories are complying with the AHCAs'.[34]

3.46 The committee can only urge the Government to adopt the relevant recommendations in *The Blame Game* and heed the advice of the Audit

31 Kalisch D, transcript, p 11.

32 Yapp G, transcript, p 12.

33 ANAO, Audit Report, p 48.

34 ANAO, Audit Report, p 48.

Office and develop performance benchmarks for application in future AHCAs.

Rewarding good practice

3.47 The ANAO noted that state health authorities were keen to avoid breaching the AHCAs and thus risk receipt of the annual compliance payment of four percent of the Base Health Care Grant.[35] The threat of this sanction seems, at least, a partially effective tool for ensuring compliance with the Agreements. The committee, however, also sees the potential for a system of incentives to be built into the AHCAs to encourage compliance and reward good performance.

3.48 As was noted in *The Blame Game,* the committee is generally reluctant to see the AHCAs as a vehicle for large scale health system changes.[36] The AHCAs are interconnected with broader Commonwealth-state financial transfers and, as currently structured, are too blunt a tool to be a successful mechanism for negotiating broad reform.

3.49 However, in *The Blame Game* the committee recommended dividing future AHCAs into separate streams: one stream to provide general revenue assistance; and the other to allow specific purpose payments to be made to the states to support policy objectives in relation to public hospitals and health system reform.[37] These latter payments were to be linked to outcomes and performance standards.

3.50 As indicated, the committee does not know whether the Government will adopt this and other recommendations to restructure the AHCAs. Given this uncertainty, the committee has chosen to make a conservative assumption that the 2008 to 2013 AHCAs will be similar to their 2003 to 2008 predecessors.

3.51 In this more limited context, the 2008-2013 AHCAs could reward states that significantly exceed performance benchmarks associated with the clause 6 (or equivalent) principles and the associated financial and reporting requirements. Potentially the AHCAs could offer additional Commonwealth funds to states that significantly exceed benchmarks set for emergency department or elective surgery waiting times (Clause 6(b)) or for providing better access to services in regional and remote areas (Clause 6(c)). Similarly, incentives could be offered for the early adoption of particular national performance

35 ANAO, Audit Report, p 49.

36 HAA, *The Blame Game,* p 155.

37 HAA, *The Blame Game,* recommendation 16, p 156.

indicators by all states (see chapter 5). Accordingly, the committee makes the following recommendation.

Recommendation 2

3.52 **That in negotiating the 2008-2013 Australian Health Care Agreements (AHCAs), the Australian Government offer a structure of financial incentives to allow it to reward those states and territories that significantly exceed benchmarks associated with meeting AHCA objectives.**

3.53 More ambitiously, financial incentives could be offered by the Commonwealth if the states meet or exceed benchmarks associated with the cooperative reforms outlined in Part 4 of the Agreements. Part 4 commits the Commonwealth and states to work together to, among other things: improve the interface between hospitals and primary and aged care services; explore setting up a single national system for pharmaceuticals across all settings; and support ongoing work in areas of information management and workforce. These are the types of broader reform that the committee thought in *The Blame Game* were best facilitated through significantly restructured AHCAs.

Dispute resolution

3.54 As already indicated, Health is responsible for assuring the Minister that the states are meeting their obligations under the AHCAs in a given grant year. Only after such an assurance will the Minister approve release of the base health care grant, other grants and the four percent compliance payment.[38]

3.55 The compliance payments have been paid to all states in each grant year to date, even though Health recognised that minor breaches of the principles had occurred and been addressed.[39] Mention has already been made of the difficulty of withholding payments due to the lack of performance benchmarks. The ANAO noted that Health was also reluctant to withhold the compliance payments when in doubt because withholding the funds would be a disproportionate penalty and impact adversely on patient care.

38 AHCAs, clause 31.

39 ANAO, Audit Report, p 13.

3.56 State government representatives, on the other hand, told the ANAO that they were concerned that Health's assessment process could result in the full compliance payment being withheld for a one-off breach by a single hospital. States also considered that they had no recourse if they disagreed with an assessment of non compliance by Health that subsequently led the Minister to withhold the compliance payment.[40]

3.57 Clause 29 of the AHCAs does require the Commonwealth to allow a state 28 days to respond to any potential finding that it has not met the AHCA compliance requirements before a final assessment is made by the Minister. However, the AHCAs do not include any formalised dispute resolution procedures to allow such a state to disagree with a potential or final finding of non compliance.

3.58 While they have not been needed to date, good practice suggests that dispute resolution procedures should be included in any form of intergovernmental agreement.[41] The committee recommends accordingly.

Recommendation 3

3.59 **That in negotiating the 2008-2013 Australian Health Care Agreements, the Australian Government include dispute resolution procedures.**

40 ANAO, Audit Report, p 49.

41 See Council of Australian Governments, *Guide to Intergovernmental Agreements*, COAG, December 2005, www.coag.gov.au/guide_agreements.htm, viewed on 16 July 2007.

4

Financial reporting by the states and territories

…each of the state and territory governments do not necessarily work in a perfectly consistent and comparable financial framework. That is one of the complications that we are also working with.[1]

Measuring expenditure

4.1 Clauses 11 and 25(b) of the AHCAs require each state to increase their own funding for public hospital services such that the cumulative funding growth rate will at least match the cumulative rate of growth of Commonwealth funding to that state. Under Clause 33 each state agrees, that for the purpose of measuring their rate of funding increase in any grant year, the Commonwealth will consider each state's recurrent expenditure. The definition of recurrent expenditure was to be agreed between the Commonwealth and states before the AHCAs were signed.

4.2 The first challenge for Health was to determine the base level of expenditure in each state before the AHCAs were signed. Health then had to be able to confirm that the states were increasing their expenditure on public hospitals at a rate that matches any funding increase by the Commonwealth.

4.3 The states have structured their health programmes and accounts in different ways. Thus, in 2003 when the AHCAs commenced, the states were using different approaches to collecting and reporting their

1 Kalisch D, transcript, p 8.

public hospital related recurrent expenditure.[2] As a result, Health did not have a clear or consistent definition of what public hospital expenditure encompassed in the states nor how it might be compared between the states.

4.4 This problem was anticipated in the AHCAs. Clause 36 of the Agreements, committed the parties to 'develop a comprehensive, standardised system for determining recurrent health expenditure' by June 2005. In the interim, Health developed its own definitions of 'AHCA related services' to overlay state financial data and calculate each state's recurrent expenditure in a consistent manner – even though none of the states used the Health devised definitions for their own public hospital accounting and budgeting.[3]

4.5 The ANAO reported that a standardised system was developed by June 2005 and that all parties agreed to report under the new as well as the interim Health derived system for the remainder of the 2003-08 agreements.[4] Health informed the committee:

> There was significant work over the first two years of the agreement in order to set out more clearly how [the states and territories] should be reporting their financial circumstances.[5]

4.6 The new standardised system, which allows more reliable comparisons of expenditure across states and over time, will apply exclusively in the 2008-2013 Agreements. As Health commented:

> Certainly the position that we are going to be in at the start of the next health care agreements will be a superior position regarding monitoring and consistent information reporting than the one we were in at the start of 2003.[6]

Independent verification

4.7 Clause 35 of the AHCAs requires the states to provide independent verification of the financial information they are required to provide Health. Health advised the states in August 2003 that the external auditing could be done by state Auditors-General or private sector

2 For example, one state reported on a cash rather than accrual basis; some excluded depreciation in their statements and some included ambulatory services while others did not. ANAO, Audit Report, p. 53

3 ANAO, Audit Report, p 53.

4 ANAO, Audit Report, pp 53, 57.

5 Yapp G, transcript, p 7.

6 Kalisch D, transcript, p 7.

accountancy firms but not by their health department's internal auditor.[7] In this context, the ANAO advised of finding an instance of the same firm undertaking the internal auditing as well as the external audit for the AHCAs.[8]

4.8 While it gave guidance to the states on who could undertake the financial statement audits, Health had not clarified the levels of assurance to be applied by the external auditors in preparing their reports. As a result, the scope and assurances of the external audits differed between states.[9] As the ANAO noted, the benefits to be gained from having the external audits were diminished further as Health did not assess the scope of the audits nor whether the auditors had qualified their options. Health advised the ANAO that it accepted the signed verifications from the external auditors and considered that compliance was satisfied if the states provided these reports on time.[10]

4.9 The ANAO recommended that Health clarify with the states the level and nature of the assurance it requires from independent audits of state recurrent expenditure on public hospital services. The ANAO also recommended that Health review future auditors' statements on state recurrent expenditure on public hospitals to ascertain any adverse findings on its assessment of compliance with the AHCAs.[11]

4.10 Health accepted the ANAO's recommendation and advised the committee that Health and the states had agreed to a uniform financial audit methodology and guidelines and that the new protocols would give greater consistency and surety.[12] As Health conceded:

> …if the states and territories could provide [financial information] in a more consistent fashion and use more consistency in terms of their internal and external verification that would make it easier for the Commonwealth to be able to assess whether each of the states are playing ball.[13]

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7 ANAO, Audit Report, p 55.
8 ANAO, Audit Report, p 55.
9 ANAO, Audit Report, p 55.
10 ANAO, Audit Report, p 55.
11 ANAO, Audit Report, recommendation 3, p 57.
12 Yapp G, transcript, p 7. See also ANAO, Audit Report, p 57.
13 Kalisch D, transcript, p 7.

4.11 Health also committed to reviewing future auditors' statements for state public hospital expenditure and to fully investigate any limitations or adverse findings raised by the auditors.[14]

4.12 The committee was alarmed that Health was asking for auditors' statements and then not reviewing them. Possibly Health had difficulty defining what assurance it expected from the external auditors' statements. Maybe Health assumed that receipt of the audit statements, in themselves, demonstrated that states' financial records were true and accurate records of public hospital recurrent expenditure for the purposes of AHCA compliance. In any event, the committee urges Health to make it clear to the states the level of assurance it will expect from external auditors for the next round of AHCAs before they commence. The committee also expects Health to review future auditors' statements and act on any qualifications or adverse findings made by those auditors.

14 ANAO, Audit Report, p 19.

5

Performance reporting by the states and territories

The Commonwealth [and the states] agree that the publication of performance information against agreed indicators should occur to improve the transparency of the performance of the public hospital system.[1]

Compliance assessment requirements

5.1 In order to qualify for the full level of funding under the AHCAs, the states are obliged by clause 25 to meet three compliance assessment requirements. As discussed in earlier chapters, the first two are that the states adhere to the principles set out in clause 6 and that they match the Commonwealth's funding growth rate. The third compliance assessment requirement is that the states meet the performance reporting requirements as set out in the AHCAs.

5.2 Schedule C of the AHCAs specifies what performance related data items the states are to provide the Commonwealth and when. Performance data is required on, among other things, the national minimum data sets (NMDS) for elective surgery waiting times, emergency department waiting times and community mental health care outcomes.[2] Schedule C also commits the states to work with the

1 AHCAs, Schedule C, clause 1.

2 A national minimum data set (NMDS) is a minimum set of data elements agreed for mandatory collection and reporting at a national level. It may include data elements that are also included in other NMDS. An NMDS is contingent upon a national agreement to collect uniform data and to supply it as part of the national collection, but does not

Commonwealth to develop and refine additional nominated performance indicators – such as measures of rural and remote access to public hospital services; indicators of effort in medical training and medical research; and indicators of access to and quality of palliative care services.[3] As a result of that work, the states now provide data to Health on 18 new performance indicators in addition to those originally specified.[4]

5.3 Health developed a *Compliance Monitoring and Assessment Framework* ('the Framework') to advise the states on the required format for the NMDS and when it would be expected.[5] From Health's perspective:

> …one of the challenges is really that we are monitoring eight different health care systems.[6]

5.4 However, state representatives reported to the ANAO that they were not being provided with sufficient detail from Health about all the performance data that it wanted from them.[7] Indeed, the ANAO recommended that Health provide the states with more detailed guidance of its procedures and assessment principles in order to assist them clearly understand Health's processes and expectations for assessing AHCA compliance by the states.[8] Health agreed to this recommendation and undertook to prepare a high level principles document based on the Framework and distribute it to the states.

5.5 Health advised the committee in March 2007 that the high levels principles document would be distributed to the states 'certainly before the end of June [2007]'.[9] The committee understands that this timetable has been met.[10] Certainly, such comprehensive information on Health's compliance assessment processes should be available for the states at the commencement of the 2008-2013 AHCAs.

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preclude agencies and service providers from collecting additional data to meet their own specific needs.

3 AHCAs, Schedule C, clause 12.

4 Gibson B, transcript, p 9.

5 AHCAs, Schedule C, clause 11.

6 Kalisch D, transcript, p 2.

7 ANAO, Audit Report, pp 34-35.

8 ANAO, Audit Report, recommendation 1, p 20.

9 Yapp G, transcript , p 14.

10 Telephone advice, 2 July 2007.

Public accountability

5.6 The parties to the AHCAs agree 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.[11]

5.7 To meet this goal for its part, the Commonwealth has committed to publish an annual report *The state of our public hospitals* which is a compilation of the performance data provided by the states.[12] The report aims to 'demonstrate that all governments are accountable for expenditure on public hospitals' and provide each year a state by state analysis by the Commonwealth of public hospital performance.[13] These reports have been published every year since 2004 and analyse performance in the previous financial year.

5.8 When the June 2007 report was released, the Minister advised that several states were reporting beyond that required by the AHCAs:

> …Victoria's *Your Hospitals* report and Queensland's *Public Hospitals Performance Report* publish similar performance measures to those used in this report, but at an individual hospital level.[14]

5.9 Thus, other states are to be encouraged to follow this lead by providing reports on individual performance of their public hospitals.

5.10 The committee strongly supports the publication of public hospital performance information and urges the Government to include a similar publication requirement in the 2008-2013 AHCAs, and to encourage states to go further, as shown by Victoria and Queensland, by publishing additional information on the performance of individual hospitals.

5.11 In its report *The Blame Game*, the committee made two relevant recommendations to improve the quality of public information on public hospital performance. The first was that future AHCAs (or substitute arrangements) include a requirement that all public hospitals gain accreditation by the Australian Council on Healthcare

11 AHCAs, Schedule C, clause 3.

12 AHCAs, Part 3, clause 9(c); See also: www.health.gov.au/internet/wcms/publishing.nsf/content/health-ahca-sooph-index06.htm, viewed on 26 June 2007.

13 Health, *The state of our public hospitals, June 2007 report*, pp 5-7.

14 Hon Tony Abbott MP, Minister for Health and Ageing, Media Release ABB80/07, *State of our public hospitals*, 29 June 2007.

Standards (or equivalent accreditation agency) and that the accreditation reports be published within three months of completion.[15] The second relevant recommendation was that all state and territory governments regularly publish reports on sentinel events occurring in their public hospitals.[16] Sentinel events are adverse events that occur because hospital failures result in death or serious injury.

5.12 The committee is pleased that *The state of our public hospitals* reports at least the number and proportion of hospitals that are accredited in each state, even if not which hospitals, and hopes that future editions can also include statistics on sentinel events.

Burden of data collection on the states

5.13 State governments complained to the ANAO that the Australian Institute of Health and Welfare (AIHW), the Productivity Commission and Health all report on public hospital performance and that each agency requires slightly different data sets despite them being based largely on the NMDS specified in the National Health Data Dictionary.[17] This places an unnecessary administrative burden on the states, but has also led to differences in the data provided in the different Commonwealth publication series.[18]

5.14 The committee appreciates that the reports of the different agencies serve different purposes and have different audiences. The AIHW and Productivity Commission are collecting data for reporting purposes while Health is seeking fiscal and performance accountability. However, the committee urges the various Commonwealth agencies to agree on consolidated data sets which each agency could then use for its own purposes.

15 HAA, *The Blame Game*, pp 213-16.

16 HAA, *The Blame Game*, pp 216-19.

17 ANAO, Audit Report, p 67. The National Health Data Dictionary contains the Australian National standard of data definitions recommended for use in Australian health data collections and the NMDS.

18 Health, *The state of our public hospitals*; Productivity Commission, *Report on Government Services*; Australian Institute of Health and Welfare, *Australian Hospital Statistics*.

6

Conclusion

> *…states are carrying out some performance audits of their own internal audit processes and their own external audit arrangements within those states. That (brings) greater transparency and understanding…*
>
> *(States) main purpose is actually to deliver the health services.*[1]

6.1 During the committee's health funding inquiry[2], significant problems came to light in the Queensland public health system in particular. Issues of poor administration and / or medical malpractice arose in public hospitals in Bundaberg, Mackay and Caboolture. More recently, Cairns Base Hospital has been at the centre of claims of inappropriate medical practice. While the magnitude of the problems may have been greater in Queensland, the committee received enough evidence to suggest there are significant problems in other jurisdictions too.

6.2 During both this and its previous inquiry, Members debated whether the Commonwealth should play a more active role in oversighting public hospitals – particularly given the magnitude of the funds provided through the AHCAs. Members have long felt that the current agreements do not allow the Commonwealth sufficient information to determine whether its money is being spent efficiently and effectively to operate public hospitals. Furthermore, the financial arrangements underpinned by the AHCAs make it difficult for Australians to determine which level of government is responsible for meeting the AHCA objectives. This is not just a matter of whether the

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1 Kalisch D, transcript, p 2.

2 HAA, *The Blame Game.*

states comply with their obligations under the AHCAs but whether the best possible services are being provided to the public.

6.3 The ANAO's report only reinforces the committee's view that the current intergovernmental roles and responsibilities, as expressed through the AHCAs, need rethinking.

Performance audits in the states and territories

6.4 The ANAO noted that several state auditors-general have conducted performance audits on aspects of the public health system funded directly or indirectly through their state's AHCA. Such audits compliment the Commonwealth's assessment of compliance with the AHCAs and assist the Commonwealth Auditor-General to gain a greater appreciation of state activities. The conduct of performance audits by all states would further enhance the Commonwealth and states' accountability to the public for the health system.[3]

6.5 The committee acknowledged that not all state auditors-general can conduct performance audits and that some only conduct performance audits with a limited scope.[4] Moreover, the Commonwealth Auditor-General cannot extend his audits to review the expenditure of the Commonwealth's funds within the state health systems. Thus, in some jurisdictions Commonwealth expenditure under the AHCAs is not subject to any independent performance audits – either directly by the Commonwealth Auditor-General or by state auditors-general.

6.6 The committee thinks it fundamentally important that the totality of public hospital expenditure under the AHCAs should be potentially subject to performance audit reviews. The state auditors-general should be empowered by their legislatures to conduct full performance audits of AHCA related expenditure.

Recommendation 4

6.7 **That in negotiating the 2008-2013 Australian Health Care Agreements (AHCA), the Australian Government require the parties to the AHCAs to agree that state and territory auditors-general be empowered to conduct full performance audits of AHCA expenditure within the public hospital systems of their respective states.**

3 Kalisch D, transcript 7.

4 Appendix C lists the powers of the auditors-general to conduct performance audits, p 41.

6.8 If the state and territory auditors-general do not have the expertise to undertake their own full performance audits of AHCA-funded expenditure, they should be able to contract the Commonwealth Auditor-General to act on their behalf, on a fee for service basis. Such audits should be conducted to comply with the Auditing Standards issued by the Australian Auditing and Assurance Standards Board.[5]

Final comments

6.9 In *The Blame Game*, the committee urged the Commonwealth and states to develop a national health agenda. The agenda should identify funding principles and initiatives to, among other things, rationalise the roles and responsibilities of governments, including their funding responsibilities. The agenda should also provide a reporting framework on the performance of health service providers and governments. The committee also made recommendations to restructure the AHCAs.

6.10 The final form of the 2008-2013 AHCAs may well have been largely determined as this report is tabled. However, the committee hopes that these and future AHCAs, in whatever form they ultimately take, make both levels of government more accountable for public hospital services and avoid creating barriers to more fundamental reform.

Hon Alex Somlyay MP

Chair

5 ANAO report, *Planned Audit Work Programme 2007-2008*, p 5: www.anao.gov.au/uploads/documents/Audit_Work_Programme.pdf, viewed on 8 August 2007.

A

Appendix A - Witnesses at public hearing

Wednesday 28 March 2007

Australian Government Department of Health and Ageing

Ms Kerry Flanagan, First Assistant Secretary, Acute Care Division

Dr Brendan Gibson, Acting Assistant Secretary, Health Care Services and Financing Branch, Acute Care Division

Mr David Kalisch, Deputy Secretary

Ms Lana Racic, Director, Acute Care Access and Financing Section

Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch

Australian National Audit Office

Ms Sheila Bird, Group Executive Director

Ms Judi Robinson, Senior Director, Performance Audit Service Group

B

Appendix B – Relevant recommendations in *The Blame Game*[1] report

Recommendation 1

The Australian, state and territory governments develop and adopt a national health agenda. The national agenda should identify policy and funding principles and initiatives to:

- rationalise the roles and responsibilities of governments, including their funding responsibilities, based on the most cost-effective service delivery arrangements irrespective of governments' historical roles and responsibilities;
- improve the long term sustainability of the health system as a whole;
- support the best and most appropriate clinical care in the most cost effective setting;
- support affordable access to best practice care;
- rectify structural and allocative inefficiencies of the whole health system, as it currently operates;
- give a clear articulation of the standards of service that the community can expect;
- redress inequities in service quality and access; and

1 House of Representatives Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding,* Parliament of the Commonwealth of Australia, Canberra, 2006.

- provide a reporting framework on the performance of health service providers and governments. *(para 3.52)*

Recommendation 7

The Australian Government develop explicit purchasing agreements for clinical training with public health care providers. The purchasing agreement would cover:

- funding levels — adequate to support existing and planned levels of training in both metropolitan and regional locations;
- specified outcomes — including the quantity and quality of training conducted; and
- performance measures — allowing timely assessment of progress in meeting obligations. *(para 4.82)*

Recommendation 11

The Minister for Health and Ageing, in consultation with state and territory health ministers and as part of the national health agenda (see recommendation no. 1), develop standards for the delivery of health services in regional, rural and remote areas. *(para 5.41)*

Recommendation 13

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government either:

- vary its funding arrangements so that the 'utilisation growth factor' can rise or fall in response to the actual level of services provided on the basis of clinical need; or
- define the number of services that it will fund, in a way that is consistent with its funding and indexation formulae. *(para 7.33)*

Recommendation 14

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government ensure that indexation arrangements reflect actual cost increases discounted by an appropriate efficiency dividend. *(para 7.34)*

Recommendation 15

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government should define the standards that states must meet to satisfy the principle of

equitable access to public hospital services, particularly in relation to people living in rural and regional areas. *(para 7.43)*

Recommendation 16

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government consider dividing funds into separate streams through which it can:

- provide general revenue assistance to the states as a supplement to the Goods and Services Tax (GST) pool; and
- make specific purpose payments to the states to support its policy objectives in relation to public hospital services and health system reform. These payments:
  - ⇒ should be linked to outcomes and performance standards; and
  - ⇒ should not be absorbed into the GST pool. *(para 7.49)*

Recommendation 17

The Australian Government should make specific purpose payments to the states and territories for the provision of public hospital services subject to horizontal fiscal equalisation using the Commonwealth Grants Commission's 'inclusion' method rather than by being absorbed into the Goods and Services Tax (GST) pool. This would require amendments to the *A New Tax System (Commonwealth –State Financial Arrangements) Act 1999. (para 7.53)*

Recommendation 18

The Australian Government should ensure that the terms and conditions associated with future public hospital arrangements do not lock-in historical Commonwealth-state service provision models. Future arrangements should:

- support the movement of services between Commonwealth and state funded programs where this leads to better quality or more cost effective care; and
- allow post hoc adjustments to Commonwealth-state funding arrangements if necessary. *(para 7.59)*

Recommendation 19

The Australian Government consider extension of Medicare Benefits Schedule funding, or substitute grant funding, to public outpatient and emergency department services. *(para 7.65)*

Recommendation 24

The Australian Government, in conjunction with the states and territories, give priority to undertaking research to develop mechanisms to make waiting lists for public hospital elective surgery fairer. *(para 9.15)*

Recommendation 25

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government provide incentives for the states and territories to report in a consistent manner on patient waiting times for access to specialists in outpatient clinics. *(para 9.20)*

Recommendation 26

In negotiating future Australian Health Care Agreements, or substitute arrangements, the Australian Government require all public hospitals to:

- be accredited by the Australian Council on Healthcare Standards (or an equivalent accreditation agency); and
- publish their accreditation reports within three months of being completed. *(para 9.38)*

Recommendation 28

The Australian Government require all state and territory governments to regularly publish reports on sentinel events occurring in their public hospitals. *(para 9.47)*

Recommendation 29

The Australian Government support the development of hospital and clinician-based performance information systems to better inform patients about the competence of health care providers and strengthen accountability of health professionals and health service providers. Reporting systems should allow, where appropriate, for performance information to be qualified to reflect differences in the type of patients being treated. *(para 9.54)*

C

Appendix C - State and Territory Auditors-General

Performance audit reporting

1.1 Most states undertake audit reporting. Only a few conduct full performance audits. For example, the Auditor-General in Queensland is not empowered to do performance audits.[1]

1.2 States have their own legislation, which may or may not allow for performance audits by the relevant State Auditor-General:

- Australian Capital Territory – *Auditor-General's Act 1996* (financial and performance audits) www.audit.act.gov.au
- New South Wales – *Public Finance and Audit Act 1983* – (financial and performance audits) www.audit.nsw.gov.au
- Northern Territory – *Audit Act 2002* (financial and performance audits) www.nt.gov.au
- Queensland – *Financial Administration and Audit 1995* (audits of performance management systems[2]) www.qao.qld.gov.au

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1 Private briefing.

2 Queensland Audit Office, private memo, 10 May 07: Auditor-General of Queensland does not undertake performance audits, but audits of performance management systems. There is however a close but subtle difference… In summary, the Queensland Auditor-General can provide an opinion on whether an agency's performance management system allows it to assess whether its objectives are being achieved economically, efficiently and effectively, and whether the performance measures associated with these systems are relevant and appropriate and fairly represent the entity's performance. A performance audit mandate is different as it would require the Auditor-General to

- South Australia – *Public Finance and Audit Act 1987* (financial and compliance audits; efficiency and economy audits; examinations of publicly funded bodies) – www.audit.sa.gov.au
- Tasmania – *Financial Management and Audit Act 1990* (financial and compliance; efficiency and economy audits[3]; examinations of publicly funded bodies) – www.audit.tas.gov.au
- Victoria – *Audit Act 1994* (financial and performance audits) – www.audit.vic.gov.au
- Western Australia – *Auditor General Act 2006* (financial and key performance indicator audits) – www.audit.wa.gov.au

Audit reports on services funded under AHCAs

1.3 Some recent reports related to the services funded under the AHCAs included[4]:

New South Wales:

- *Emergency Mental health Services, NSW Department of Health*, May 2005;
- *NSW Department of Health and Ambulance Service of NSW: Transporting and Treating Emergency Patients*, July 2004;
- *Department of Health, NSW Ambulance Service: Code Red: Hospital Emergency Departments*, December 2003; and
- *NSW Department of Health: Waiting times for elective surgery in public hospitals*, September 2003;

at <www.audit.nsw.gov.au/publications/reports/performance/performance_reports.htm>.

Victoria:

- *Access to specialist medical outpatient care*, June 2006; and
- *Managing emergency demand in public hospitals*, May 2004;

at <www.audit.vic.gov.au/reports_par/performance_audit_reports.html>.

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provide an opinion on the performance of a public sector entity in terms of meeting its objectives economically, efficiently and effectively.

3 Such audits are also known as 'value for money (or performance) audits'. Methodology encompass: Planning; Fact Gathering; Quality Control; Forming Provisional Conclusions; Natural Justice/Procedural Fairness; Processes Reporting – refer http://www.audit.sa.gov.au/rolehtm

4 ANAO Audit Report, Appendix 1, p 71.

Western Australia:

- *Early Diagnosis: Management of the health Reform Program*, Report 5, June 2006; and
- *Patients Waiting: Access to Elective Surgery in Western Australia*, Report No 11, December 2003;

at www.audit.wa.gov.au/reports/index.html.

Tasmania:

- *Elective surgery in public hospitals*, Special Report No 61, August 2006, at www.audit.tas.gov.au/publications/reports/specialreport/index.html.

Australian Capital Territory:

- *Waiting Lists for Elective Surgery and Medical Treatment*, Report No 8, December 2004, at www.audit.act.gov.au/reports.shtm1#2004.

D

Appendix D – Sample Australian Health Care Agreement[1]

Australian Health Care Agreement
between
the Commonwealth of Australia
and
the State of New South Wales
2003-2008

The committee is grateful to the Department of Health and Ageing for making this document available in this format.

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1 The funding formula is essentially the same for each state and territory. Formula is at Schedule G of each of the eight AHCAs. The exceptions are South Australia (SA) and Queensland (QLD). SA gets a payment related to Woomera and QLD gets a payment relating to the Torres Strait. Application of the formula results in different funding amounts flowing to the states and territories – indexation factors in the formula vary according to variables like population and age of population. [DHA information provided 26 July 07.]

Australian Health Care Agreement

between

the Commonwealth of Australia

and

the State of New South Wales

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 New South Wales in relation to health services provided before the date of termination.

3. This Agreement constitutes the entire agreement between the Commonwealth and New South Wales 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 New South Wales 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 New South Wales 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 New South Wales'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 New South Wales 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 New South Wales

10. New South Wales 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 New South Wales'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. New South Wales 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 New South Wales under this Agreement.

12. New South Wales accepts responsibility for maintaining patient entitlement to services relating to broadbanded programs.

13. New South Wales 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 New South Wales

14. The Commonwealth and New South Wales 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 New South Wales 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 New South Wales 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 New South Wales 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. New South Wales 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. Subject to signing an agreement between the Commonwealth and New South Wales 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 (PBS) to admitted public and private patients on separation, to non-admitted patients and to day admitted patients for a range of cancer chemotherapy drugs made available by specific delivery arrangements provided under section 100 of the *National Health Act 1953*.

PART 5 – FINANCIAL ASSISTANCE AND ASSOCIATED TERMS AND CONDITIONS

22. New South Wales 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, New South Wales 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. New South Wales 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 New South Wales 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 New South Wales'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. New South Wales'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 New South Wales and received by the Commonwealth by 31 August 2003, provided that New South Wales 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. New South Wales 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 New South Wales 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 New South Wales 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. New South Wales 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 New South Wales 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 New South Wales 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. New South Wales 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 New South Wales before this Agreement is signed.

34. The Commonwealth considers that New South Wales 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. New South Wales agrees that all financial information relating to clauses 33 and 34 will be independently verified.

36. New South Wales 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 New South Wales 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. New South Wales 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 New South Wales 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 New South Wales 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. New South Wales 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 New South Wales, 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. New South Wales 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 New South Wales.

47. New South Wales 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 New South Wales.

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 New South Wales 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. New South Wales 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. New South Wales 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 New South Wales 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. New South Wales 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. New South Wales agrees to provide financial and performance information in accordance with Schedule C.

57. The Commonwealth and New South Wales 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 New South Wales 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 New South Wales 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.

SCHEDULE A

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: - 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 *Health Insurance Act 1973*, dated 11 January 1984 remains in force, or a replacement order remains in force. *Note: The order referred to above excludes compensable patients from eligibility for Medicare in relation to public hospital services related to the compensable injury, illness or disease.*
Complaints body	Means an independent entity established or commissioned to investigate complaints and/or grievances against providers of New South Wales'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 *Health Insurance Act 1973*.

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 *Veterans' Entitlements Act 1986.*
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 New South Wales 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 *Health*

	Insurance Act 1973 provided, that the order was made 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 *National Health Act 1953* (the Act) together with the National Health (Pharmaceutical Benefits) Regulation 1960 made under the Act.
Private patient	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. *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*.
Public hospital services	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). *Note: This relates to the minimum level of public hospital services and does not preclude States from establishing or re-establishing public hospital services.*
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

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 New South Wales 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 New South Wales and agreed to by the Commonwealth, outlining how funds will be spent by New South Wales.

Terms and conditions for accessing funds

4. One-off funding of $86,000,000 will be available to New South Wales 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, New South Wales 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 New South Wales.
6. Any funding in 2005-06, 2006-07 and 2007-08 grant years will be conditional on New South Wales 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;

(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, New South Wales 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 New South Wales to develop proposals in line with state specific needs and infrastructure. For example New South Wales 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. New South Wales would also be able to develop local partnerships to support the Pathways Home program.

10. New South Wales 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 New South Wales.

11. New South Wales 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. New South Wales agrees to repay to the Commonwealth any funding for projects or programs not conducted during the period of this Agreement.

12. New South Wales 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. New South Wales will also be required to commit to meet the performance reporting requirements of the program in order to receive the maximum funding available for New South Wales. 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;

(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 New South Wales 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. New South Wales 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. New South Wales 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 New South Wales 28 days prior to the Commonwealth submitting it for publication.

Scope of Performance Measures for Compliance Assessment

5. New South Wales 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 New South Wales 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. New South Wales 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;

(e) all financial information required to measure New South Wales'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. New South Wales 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. New South Wales 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 New South Wales, 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. New South Wales 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. New South Wales 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: New South Wales 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. New South Wales 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 New South Wales agree to the use of the latest version of the National Health Data Dictionary throughout the life of this Agreement. However, the Commonwealth and New South Wales 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. New South Wales 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. New South Wales 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. New South Wales 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 New South Wales;
      (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 New South Wales 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 New South Wales's public hospitals, regardless of their private health insurance status.

Independent Complaints Body

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

5. New South Wales agrees to the following minimum standards:

(a) the complaints body must be independent of bodies providing public hospital services and New South Wales'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 New South Wales agree that the powers of the complaints body will not interfere with or override the operation of registration boards or disciplinary bodies in New South Wales 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, New South Wales 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 a 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 unforseen 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

Age	*Weight*
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

Age	*Weight*
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 NEW SOUTH WALES

1. The Commonwealth will make a financial contribution to New South Wales 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:

   $$(G\text{-}_1)*[(0.75 * 1.017 * \frac{WPOP}{WPOP\text{-}_1} * WCI\text{-}1) + (0.25 * \frac{WPOP}{WPOP\text{-}_1} * WCI\text{-}1)]$$

   where:

   $G\text{-}_1$ is the final grant entitlement for the general component for the previous year, and in respect of the 2002-03 grant year is $2,337,720,246;

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

   $WPOP\text{-}_1$ 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:

   $$G\text{-}_1 * \frac{WPOP}{WPOP\text{-}_1} * WCI\text{-}1$$

   where:

   $G\text{-}_1$ 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 $11,226,488; and

   WPOP, $WPOP\text{-}_1$, and WCI-1 are as defined in clause 1(a) of this schedule.

   (c) A safety and quality component of $50,118,251 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 New South Wales in the form of a non-base Health Care Grant comprising:
   (a) Mental health funding calculated in accordance with the following formula;

   $$G\text{-}_1 * \frac{WPOP}{WPOP\text{-}_1} * WCI\text{-}1$$

   where:

   $G\text{-}_1$ 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 $19,449,908; and

   WPOP, $WPOP\text{-}_1$, 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) New South Wales's share of this pool of funds will be determined by the following formula:

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

where:

S is New South Wales'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 New South Wales'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 New South Wales 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 $86,000,000 over 5 years to New South Wales to increase investment in service delivery infrastructure under the Pathways Home program. This funding will be available to New South Wales on the basis of the terms and conditions set out in Schedule B.

6. New South Wales'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 New South Wales 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 New South Wales 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 New South Wales'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 entitlement to the funding available under clause 3(b) of this schedule. At this time the Commonwealth Minister will review New South Wales'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, New South Wales will be considered to have met its matching obligation if the cumulative rate of growth in New South Wales's own source funding is at least equal to the Commonwealth funding growth level defined as:

    (a) 4.7% 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 New South Wales 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 New South Wales 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 New South Wales 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 New South Wales 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. New South Wales 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 New South Wales'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 New South Wales has failed over consecutive years to meet the requirements in relation to the clause 9 of this schedule, New South Wales'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. New South Wales 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 New South Wales'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 New South Wales'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. New South Wales'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 New South Wales'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 New South Wales'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. New South Wales 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) 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;
  (b) 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
  (c) separate acquittance statements in respect of funds provided for the Pathways Home program and Mental Health Reform program.

22. New South Wales 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 New South Wales they will be subject to specific conditions and reporting arrangements negotiated on a bilateral basis.

24. The Commonwealth may make funds available to New South Wales in respect of the following national programs:
  (a) Hospital Information and Performance Information Program (formerly casemix);
  (b) Mental health reform; and
  (c) 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:

$$FUNDS_{-1} * \frac{AWPOP}{AWPOP_{-1}} * WCI\text{-}1$$

where:

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

(a) $4,871,802 in respect of the Hospital Information and Performance Information Program;
(b) $11,715,593 in respect of Mental health reform; and
(c) $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;

$AWPOP\text{-}_1$ 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 New South Wales 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 New South Wales'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

Commonwealth Department of Health and Ageing

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

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

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)
NEW SOUTH WALES BY)
THE HONOURABLE MORRIS IEMMA MP)
MINISTER FOR HEALTH)
)
)
)

IN THE PRESENCE OF

)
)
)
)
)
)
)

ON THE _____ DAY OF _____ 2003.