GUIDE TO COMMONWEALTH PUBLIC HOSPITAL FUNDING

INTRODUCTION **2**

THE NATIONAL HEALTH REFORM AGREEMENT **2**

Roles and Responsibilities 3

Local Hospital Networks 3

COMMONWEALTH PUBLIC HOSPITAL FINANCING ARRANGEMENTS **4**

Activity Based Funding 4

Block Funding 4

What is a public hospital service? 5

The Commonwealth funding contribution 5

Efficient Growth Funding 5

THE INDEPENDENT HOSPITAL PRICING AUTHORITY **6**

Annual Determinations 6

National Efficient Price 6

National Weighted Activity Unit 6

Calculation of Commonwealth funding under ABF 6

Adjustments to the National Efficient Price 7

National Efficient Cost 7

ADMINISTRATOR OF THE NATIONAL HEALTH FUNDING POOL AND THE NATIONAL HEALTH FUNDING BODY **8**

National Health Reform Funding Flows 8

CROSS-BORDER ARRANGEMENTS **9**

Principles of Cross-border Activity 9

Access to Services 10

Application of Cross-border Arrangements 10

Pricing of Cross-border Activity 11

Funding Flow Arrangements 11

Cross-border Disputes 11

Reporting of Cross-border Funding 12

ATTACHMENT A - GUIDELINES FOR NON-ADMITTED SERVICES **13**

3.1 Overall scope 13

3.2 Non-admitted services 13

Interpretive Guidelines for Use 14

Out of scope services 14

Introduction

Australian public hospitals and Local Hospital Networks (LHNs) are established and managed under state and territory (state) legislation. States provide the majority of public hospital funding (approximately 52 per cent nationally). The Commonwealth contributes approximately 37.0 per cent of public hospital expenditure through payments to LHNs and state governments. Approximately a further 2 per cent is provided through the Department of Veterans' Affairs (DVA). The remaining 9 per cent of public hospital funding is derived from sources including rebates of health insurance premiums, health insurance funds, individuals, and compensation payments.

This user guide provides an overview of the arrangements by which Commonwealth funding is provided for public hospital services under the National Health Reform Agreement (the Agreement), with particular reference to the:

- role of the Independent Hospital Pricing Authority (IHPA) in determining a national system for classification, costing and pricing of public hospital services;
- role of the Administrator of the National Health Funding Pool (Funding Pool) in overseeing payments to public hospitals; and
- operation of current cross-border arrangements.

Additional Australian Government funding provided for public hospitals through National Partnership Agreements, and other programs, such as the Health and Hospitals Fund (HHF), Medicare Benefits Scheme, Pharmaceutical Benefits Scheme, Private Health Insurance Rebate, and DVA are not specifically discussed within this guide.

The National Health Reform Agreement

The National Health Reform Agreement (the Agreement), agreed by COAG in August 2011, changed the funding and governance arrangements for Australian public hospitals. The new arrangements commenced on 1 July 2012 and included:

- Establishment of LHNs by states. States devolved public hospital management to the local level where LHNs are directly responsible for managing their hospital budgets and working with local communities to shape local health delivery and to meet local needs.
- Introduction of a nationally consistent system of Activity Based Funding (ABF) for public hospitals services. Under the national ABF arrangements the Commonwealth's contribution to public hospital services is now made on the basis of a National Efficient Price (NEP) as determined by the IHPA.
- Establishment of the Funding Pool. All governments have jointly established a Funding Pool through which Commonwealth and state funding for public hospitals services flow directly to LHNs and is reported in a consistent and transparent manner by the Administrator of the Funding Pool.

Roles and Responsibilities

Under the Agreement, the Commonwealth and the states are jointly responsible for:

- funding public hospital services, using ABF where practicable and block funding in other cases; and
- funding growth in public hospital services and the increasing cost of public hospital services.

The Agreement recognises that the states are the system managers of the public hospital system. As system managers, states are responsible for deciding which services are provided where, and for funding the cost of the delivery of public hospital services over and above the Commonwealth contribution. In this role states have autonomy to determine the level of funding they allocate to public hospital services. The Agreement specifies that the state system management role includes responsibility for:

- the establishment of the legislative basis and governance arrangements of public hospital services, including the establishment of LHNs;
- system-wide public hospital service planning and performance; and
- purchasing of public hospital services and monitoring of delivery of services purchased. States undertake this purchasing role through the negotiation of Service Agreements with each LHN which specify the number and broad mix of services to be provided.

States are also responsible for providing capital funding for public hospitals.[1]

The Agreement reaffirms that states will continue to provide health and emergency services through the public hospital system, based on the following Medicare principles:

- 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 their geographic location.

Local Hospital Networks

Each LHN consists of small groups of local hospitals, or an individual hospital, linking services within a region or through specialist networks across a state. Localised governance arrangements for LHNs provide for decentralised hospital management and increased local accountability. LHNs work with Medicare Locals (established to coordinate primary health care) to deliver better integrated care to patients.

The responsibilities of LHNs include:

- receiving Commonwealth and state funding contributions for delivery of services as agreed under the Service Agreement entered into with the state government;

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[1] The Commonwealth presently provides some funding to states for capital projects through the HHF.

- managing their own budget, in accordance with state financial and audit requirements;
- managing performance of functions and activities specified in Service Agreements; and
- local clinical governance arrangements.

A total of 136 Local Hospital Networks have been established across all states. Of these, 123 are geographically based networks and 13 are state-wide networks that deliver specialised hospital services across some jurisdictions.

Commonwealth Public Hospital Financing Arrangements

Under the former National Healthcare Specific Purpose Payment (SPP) arrangements (prior to 2012-13), Australian Government funding for public hospital services was provided to the states as block grants. From 2012-13, the Agreement introduced ABF as the primary mechanism for the Commonwealth's funding of public hospital services. In cases where ABF is not practicable, the Agreement provides for Commonwealth funding to be provided through block grant arrangements. Presently, approximately 85 per cent of Commonwealth public hospital funding is provided as ABF payments to LHNs, with the remaining funding (approximately 15 per cent) paid as block funding to the states.

Activity Based Funding

Under ABF, hospitals are paid for each public hospital service they provide, with the payment dependant on the type and complexity of the service. ABF links funding to the volume and kinds of services provided in a public hospital and the efficient cost of delivering those services. Funding on the basis of activity provides a uniform way to drive efficiency in public hospitals, providing incentives for hospitals to treat patients more efficiently and in the most appropriate setting.

Block Funding

Block funding involves paying a fixed sum based on the cost of maintaining a particular public hospital service. The IHPA is responsible for specifying the types of public hospitals, or public hospital services which are appropriately funded through block funding. Under the Agreement, the IHPA has specified that public hospitals, or public hospital services, will be eligible for block grant funding if the technical requirements for applying ABF are not able to be satisfied and/or if there is an absence of economies of scale that means some services would not be viable under ABF.

The IHPA has determined that there are two main types of services which require block funding:

- Small hospitals, primarily in rural areas, where there is a lack of economies of scale; and
- Teaching, training and research functions undertaken in public hospitals.

Additionally, due to the current limitations of data and classifications for some non-admitted services (including non-admitted specialist mental health services), the IHPA has also decided that these services will be block funded in 2013-14 and 2014-15. It is expected that these services will transition to ABF in future years.

What is a public hospital service?

At the time of the negotiation of the Agreement, there was no national listing of public hospital services, nor an agreed definition of what constitutes a public hospital service. Through the Agreement, Governments gave the IHPA the task of deciding which services will be ruled 'in-scope' as public hospital services, and so eligible for Commonwealth funding. The IHPA performs this through the development and maintenance of the 'General list of in-scope public hospital services eligible for Commonwealth funding' (the General List). The IHPA's General List defines public hospital services eligible for Commonwealth funding to be:

- all admitted programs, including hospital in the home programs;
- all emergency department (ED) services; and
- non-admitted services as specified in the annual National Efficient Price (NEP) Determination (NEP guidelines for non-admitted services at Attachment A).

The way in which public hospital services are delivered is evolving with many services now delivered 'off-campus'. For example, dialysis is now frequently provided in a person's home or in satellite clinics located outside public hospitals. Hospital-in-the-home programs allow people to receive chemotherapy, intravenous antibiotics and antiviral therapy in their homes under the supervision of hospital outreach staff. For the purposes of attracting Commonwealth funding, such services are considered to be public hospital services.

The Commonwealth funding contribution

The latest published estimates (MYEFO 2013-14) of Commonwealth funding for public hospitals through the Agreement are shown in Table 1.

Table 1: Commonwealth National Health Reform funding (public hospital services and public health).

$million	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
2013-14	4,457	3,459	2,816	1,529	1,005	308	232	144	**13,949**
2014-15	4,873	3,794	3,102	1,730	1,115	333	267	168	**15,383**
2015-16	5,351	4,159	3,429	1,962	1,242	361	308	196	**17,009**
2016-17	5,871	4,551	3,787	2,218	1,380	392	352	226	**18,778**

Source: 2013-14 MYEFO.

Efficient Growth Funding

The Commonwealth has committed through the Agreement to increase its contribution to the growth in public hospital costs through the payment of efficient growth funding to LHNs. From 2014-15, the Commonwealth will fund 45 per cent of efficient growth in public hospital services, increasing to 50 per cent from 2017-18. The Agreement specifies that efficient growth consists of the:

- national efficient price for any changes in the volume of services provided (see section on IHPA for the role of the NEP and how it is determined); and
- growth in the national efficient price of providing the existing volume of services.

The Independent Hospital Pricing Authority

The IHPA was established as an independent statutory body under the *National Health Reform Act (2011)* and is responsible for determining a national system for classification, costing and pricing of public hospital services. This includes the introduction of a nationally consistent system of ABF and the annual determination of the NEP and National Efficient Cost (NEC) for services which are block funded.

Annual Determinations

In undertaking the annual determinations of the NEP and NEC the IHPA is required to publish supporting documentation. The Pricing Framework for Australian Public Hospital Services (Pricing Framework) is updated annually and outlines the principles, scope and methodology adopted by the IHPA to determine the NEP and NEC for the specific financial year. The IHPA also produces the National Pricing Model Technical Specifications outlining the methodology the IHPA has used to develop the ABF models and the measure of public hospital activity, the National Weighted Activity Unit (NWAU).

National Efficient Price

The IHPA develops the NEP annually in close consultation with all Australian governments (Commonwealth, states and territories). The NEP reflects the price that will be used for the calculation of Commonwealth payments for each episode of care under ABF. The IHPA determines the NEP for public hospital services through the analysis of data on actual activity and costs in public hospitals. Costing information used to determine the NEP is drawn from the National Hospital Cost Data Collection. Costing data is submitted to IHPA by states on an annual basis.

The IHPA's current pricing position is to set the NEP at the average cost of a hospital separation. In adopting this position the IHPA has specified that the NEP is not the price at which public hospital services can be provided most cheaply or at the lowest price. Rather, the NEP reflects the price that allows for the provision of public hospital services at a quality level consistent with national standards. The NEP will move in response to changes in how care is delivered and in response to changes in the costs of delivering public hospital services.

National Weighted Activity Unit

A NWAU is a measure of health service activity expressed as a common unit, specified in the NEP Determination and Pricing Framework and associated National Pricing Model Technical Specification documents. It provides a way of comparing and valuing each public hospital service (whether it is an admission, emergency department presentation or outpatient episode), by weighting it for its clinical complexity. The average hospital service is worth one NWAU – the most intensive and expensive activities are worth multiple NWAUs, the simplest and least expensive are worth fractions of a NWAU.

Calculation of Commonwealth funding under ABF

In very simple terms, the NWAU multiplied by the NEP provides the total cost of a hospital service. This figure is then used to calculate total Commonwealth payments to LHNs based on services delivered. Table 2 gives examples of the funding a hospital would receive for various dialysis services if funded at the 2013-14 NEP ($4993).

Table 2: Sample ABF payments

Service	NWAU	Price per episode
Renal Dialysis (day patient)	0.1118	$558.22
Haemodialysis (home delivered)	0.1118	$558.22
Peritoneal Dialysis (home delivered)	0.1118	$558.22
Haemodialysis (inpatient)	0.1196	$597.16
Peritoneal Dialysis (inpatient)	0.2201	$1098.96

Commonwealth funding for ABF services is provided on the basis of the Commonwealth paying a share based on the NEP. If a hospital is operating at the efficient price, on average the Commonwealth will contribute approximately 35 per cent of the NEP (although the percentage will differ slightly between states). There is no requirement for states to fund their hospitals at the NEP. States can provide their LHNs with the level of funding they consider appropriate to meet their costs. Under the national ABF arrangements, states are provided with an incentive to use the NEP as a benchmark to drive improvements in efficiency in their public hospitals.

Adjustments to the National Efficient Price

Under the Agreement, the IHPA is responsible for determining adjustments or loadings to the NEP required to take account of legitimate and unavoidable variations in the costs of service delivery, including those driven by hospital size, type and location. The purpose of loadings is to ensure that all hospitals are appropriately resourced and there are no disincentives for the provision of services.

The IHPA has determined four levels of loadings to the NWAU in recognition of patients with higher than usual costs:

- Intensive care units;
- Specialist paediatric hospitals;
- Aboriginal and Torres Strait Islander patients; and
- Remoteness.

National Efficient Cost

The IHPA develops a NEC Determination on an annual basis which sets out the arrangements to be applied for block funding payments. The NEC contains the IHPA's determination of the NEC (or funding) required to operate small rural hospitals according to size and geographic location. The NEC determination also sets out the efficient costs of delivering Teaching, Training and Research functions and a limited number of non-admitted services for each jurisdiction. Similar to the NEP, the Commonwealth pays a share of block funded services based on the NEC. However, unlike ABF payments, block funding is paid to the State rather than directly to LHNs.

Administrator of the National Health Funding Pool and the National Health Funding Body

The Funding Pool is the combined State Pool Accounts with the Reserve Bank of Australia for each of the eight states. The Administrator of the Funding Pool administers the Funding Pool and is responsible for:

- overseeing payments into and out of the state pool account for each state;
- calculating the Commonwealth public health funding contribution to states;
- ensuring funds are deposited into pool accounts in line with the Agreement;
- reconciling estimated and actual service volumes;
- authorising payment instructions; and
- reporting on all activities for the Funding Pool and on various funding and service delivery matters.

The function of the National Health Funding Body (NHFB) is to assist the Administrator in the performance of the Administrator's functions.

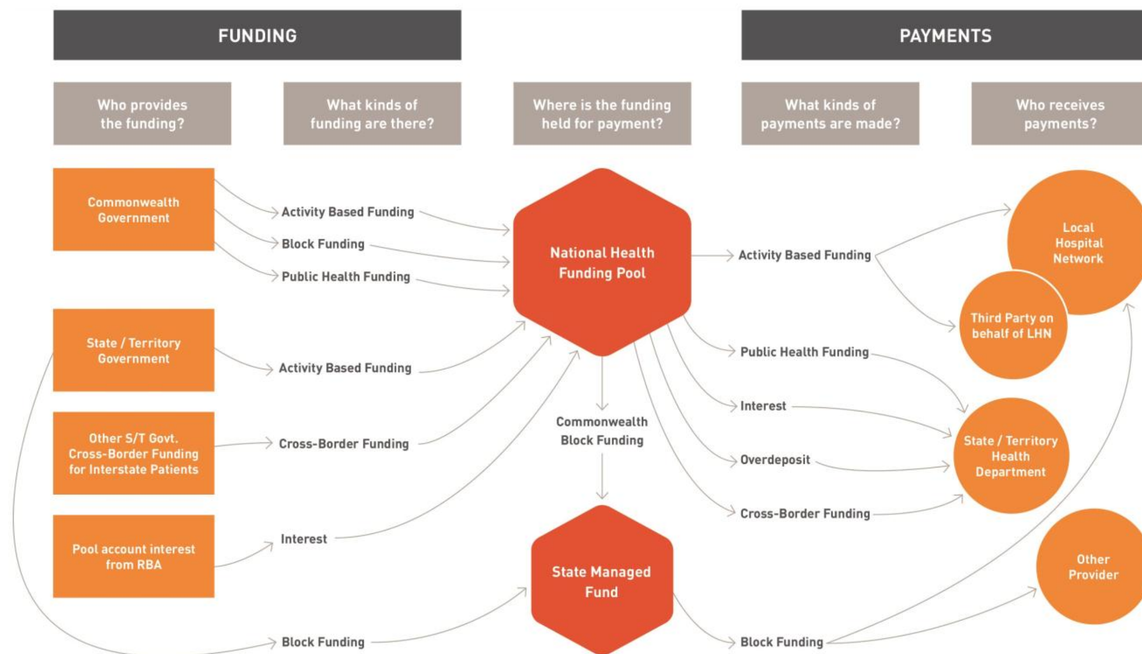
National Health Reform Funding Flows

Under the Agreement, ABF funding from Commonwealth and state governments is provided to each LHN on the basis of the number and type of services delivered by each hospital (for example acute admitted patients, non-admitted patients, and emergency department patients).

Commonwealth funding for public hospital services is paid monthly into the Funding Pool. Each state also has a separate fund (known as its state managed fund) for receiving Commonwealth block funding via the Funding Pool, receiving block funding directly from the state itself, and for making payments of block funding by the state to LHNs.

Payments occur when the funding deposited into a state pool account or state managed fund is paid out of the state pool account by the Administrator, or is paid out of the state managed fund by the state. Figure 1 illustrates how this funding flows.

Figure 1: National Health Reform funding flows



Source: Administrator of the National Health Funding Pool, http://www.publichospitalfunding.gov.au/national-health-reform/funding-flows

Cross-border Arrangements

The Agreement introduced new cross-border arrangements for the reimbursement of costs between jurisdictions where residents of one jurisdiction receive patient services in another jurisdiction. Under the new arrangements, the Commonwealth has an increased interest in cross-border agreements because Commonwealth funding will flow directly to provider states for cross-border activity (as illustrated in Figure 1).

Principles of Cross-border Activity

Under the Agreement, cross-border agreements are to be developed between jurisdictions which experience significant cross-border flows, where one of the parties requests such an agreement. Cross-border agreements set out estimated activity levels providing the capacity for both parties to contribute to planning of cross-border activity.

States have agreed a template cross-border agreement with the IHPA, to standardise arrangements between states as much as possible, enabling states and territories to negotiate and develop bilateral agreements from the same position. The template is intended to form the basis of bilateral agreements for 2012-13 and 2013-14. From 2014-15, states and territories are proposing to develop ongoing arrangements.

The Agreement specifies that the following principles will apply to cross-border funding arrangements:

- the state where a patient would normally reside should meet the cost of services (exclusive of the Commonwealth contribution discussed below) where its resident receives hospital treatment in another jurisdiction;
- payment flows (both Commonwealth and state) associated with cross-border services should be administratively simple, and where possible consistent with the broader arrangements of the Agreement;
- the cross-border payment arrangements should not result in any adverse GST distribution effects;
- states recognise their commitment under the Medicare principles which require medical treatment to be prioritised on the basis of clinical need;
- both states should have the opportunity to engage in the setting of cross-border activity estimates and variations, in the context that this would not involve shifting of risk; and
- there should be transparency of cross-border flows.

Access to Services

Under the Agreement, states have agreed that Australian residents will have access to public hospital services on the basis of clinical need and within a clinically appropriate period, and patients will have equitable access to services regardless of their geographic location.

Service Agreements between state health departments and LHNs set the number and type of services which will be provided at particular public hospitals, and the level of funding which will be provided. Decisions regarding the prioritisation of individual patients are clinical decisions made by medical practitioners.

Not every hospital is required to provide every service. States can and do consolidate their service provision in particular hospitals. Also, states may choose not to provide particular services themselves, but to send their patients to hospitals in other states under cross-border arrangements.

Application of Cross-border Arrangements

In practice for routine and standard treatment, there is no prior negotiation between states for individual patients. For example, patients travelling in another state may attend the local emergency department for urgent treatment. Some geographic areas closer to state borders have relatively large cross-border flows, where patients routinely seek treatment at the nearest or most appropriate public hospital which happens to be across the border (such as Queanbeyan residents seeking treatment in the ACT).

For complex, very high cost and non-standard treatment, LHNs or state health departments would generally liaise with the other jurisdiction regarding access, clinical prioritisation, and to negotiate costs, for example, a patient requiring complicated surgery such as a heart-lung transplant.

Pricing of Cross-border Activity

Prices for inter-jurisdictional services are set at the NEP, as determined by the IHPA including adjustments for any loadings for the provider Local Hospital Network, unless otherwise agreed by the parties to a cross-border agreement. As the base price is set at the NEP, there is little incentive for a jurisdiction to agree to a higher price with the possible exception of very rare, high cost procedures which do not fit neatly in a particular Diagnosis Related Group.

Where a jurisdiction cannot provide a service at or below the NEP, there is arguably a small incentive for the state to seek to have that service provided in another state. However, there are a range of factors, such as the expectations of residents, transportation costs, and the need to maintain their public hospital workforce, that preclude states from transferring interstate all services which operate above the NEP.

Funding Flow Arrangements

Commonwealth funding contributions for cross-border services flow to the provider jurisdiction through the Funding Pool. Commonwealth payments are made in advance, based on estimates of cross-border activity and are reconciled on a six-monthly basis. The Agreement requires that the Commonwealth take steps to prevent Commonwealth payments made in accordance with cross-border arrangements being subject to equalisation by the Commonwealth Grants Commission to avoid financially disadvantaging one state.

The funding contributions by the resident state will be made to the provider state through the Funding Pool, either:

- on a regular basis throughout the year, reflecting activity estimates between the parties as scheduled through a Cross-border Agreement with subsequent reconciliation for activity; or
- on an ad-hoc basis reflecting actual activity.

Cross-border Disputes

The IHPA has the role of considering cross-border disputes as part of its dispute resolution process. The IHPA has established the Cross-Border Dispute Resolution Framework in consultation with jurisdictions to guide its consideration. The Commonwealth and states have agreed that they will accept and implement any recommendations made by the IHPA in relation to cross-border disputes, where the parties have been unable to reach bilateral agreement and either party sees a determination from the IHPA. Additional funding will be provided to the other party in a dispute if this is required.

The Agreement provides that three months after the IHPA has made such a recommendation, if a state has not complied with any element of the recommendation requiring it to make payments to another state, the IHPA may at the request of the second state, advise the Commonwealth Treasurer of any adjustments to Commonwealth payments to the Funding Pool required to give effect to the recommendation. States have agreed to fund from their own resources any reduction in Commonwealth payments to LHNs.

Reporting of Cross-border Funding

The Administrator of the Funding Pool publishes monthly reports detailing funding provided to LHNs throughout Australia by the Commonwealth and state governments, which may include cross-border flows where relevant.

Attachment A - Guidelines for non-admitted services

3.1 Overall scope

In accordance with section 131(f) of the Act and clauses A9–A17 of the Agreement, the scope of public hospital services eligible for Commonwealth funding under the Agreement is as follows:

a. all admitted programs, including hospital in the home programs. Forensic mental health inpatient services are included as recorded in the 2010 Public Hospital Establishments Collection;
b. all Emergency Department Services provided by an Emergency Department; and
c. non-admitted services as defined below.

3.2 Non-admitted services

The listing of in-scope non-admitted services is independent of the service setting in which they are provided (e.g. at a hospital, in the community, in a person's home). This means that in-scope services can be provided on an outreach basis.

To be included as an in-scope non-admitted service, the service must meet the definition of a *Service Event* which is:

> "an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record."

Consistent with clause A25 of the Agreement, the Pricing Authority will conduct analysis to determine if services are transferred from the community to public hospitals for the dominant purpose of making services eligible for Commonwealth funding.

There are two broad categories of in-scope, public hospital non-admitted services:
(a) Specialist Outpatient Clinic Services; and
(b) Other Non-admitted Patient Services.

Category A: Specialist outpatient clinic services – Tier 2 Non-admitted Services Classification – Classes 10, 20 and 30

This comprises all clinics in the Tier 2 Non-Admitted Services classification, classes 10, 20 and 30 that were reported as a public hospital service in the 2010 Public Hospital Establishments Collection in terms of their activity, expenditure or staffing, with the exception of the General Practice and Primary Care (20.06) clinic, which is considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service.

Category B: Other non-admitted patient services and non-medical specialist outpatient clinics (Tier 2 Non-Admitted Services Class 40)

To be eligible for Commonwealth funding as an Other Non-admitted Patient Service or a Class 40 Tier 2 Non-Admitted Service, a service must be:

a. directly related to an inpatient admission or an emergency department attendance; or
b. intended to substitute directly for an inpatient admission or emergency department attendance; or
c. expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission; or

d. reported as a public hospital service in the 2010 Public Hospital Establishments Collection.

Jurisdictions have been invited to propose services that will be included or excluded from Category B "Other Non-Admitted Patient Services". Jurisdictions will be required to provide evidence to support the case for the inclusion or exclusion of services based on the four criteria above.

The following clinics are considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service under this category:

- Commonwealth funded Aged Care Assessment (40.02);
- Family Planning (40.27);
- General Counselling (40.33);
- Primary Health Care (40.08).

Jurisdictions that consider that there are exceptions where the above services should be included as eligible for Commonwealth funding as a public hospital service have been asked to provide evidence to support their inclusion based on whether the clinic was reported as a public hospital service in the 2010 Public Hospital Establishments Collection.

Interpretive Guidelines for Use

In line with the criteria for Category B, community mental health, physical chronic disease management and community based allied health programs considered in-scope will have all or most of the following attributes:

- Be closely linked to the clinical services and clinical governance structures of a public hospital (for example integrated area mental health services, step-up/step-down mental health services and crisis assessment teams);
- Target patients with severe disease profiles;
- Demonstrate regular and intensive contact with the target group (an average of 8 or more service events per patient per annum);
- Demonstrate the operation of formal discharge protocols within the program;
- Demonstrate either regular enrolled patient admission to hospital or regular active interventions which have the primary purpose to prevent hospital admission.

Out of scope services

The Pricing Authority has determined that the following non-admitted services are not in-scope for Commonwealth funding, on the basis that they do not align with interpretive guidelines for inclusion listed above:

Mental Health:

- Psychosocial rehabilitation programs (including long term supported accommodation, vocational training programs) where the primary purpose is to meet the social needs of consumers living in the community rather that hospital avoidance.
- Prevention and early intervention services.

Chronic Disease management:

- Community based diabetes programs where the primary focus is on the ongoing management of stable diabetes patients.

Home Ventilation

A number of jurisdictions have submitted home ventilations programs for inclusion on the general list. The Pricing Authority has included these services on the general list in recognition that they meet the criteria for inclusion, but will review this decision in the future once the full scope of the National Disability Insurance Scheme is known.