

NATIONAL PARTNERSHIP AGREEMENT ON HOSPITAL AND HEALTH WORKFORCE REFORM

Council of
Australian
Governments

An agreement between

- the **Commonwealth of Australia** and
- the **States and Territories**, being:
 - ◆ the State of New South Wales;
 - ◆ the State of Victoria;
 - ◆ the State of Queensland;
 - ◆ the State of Western Australia;
 - ◆ the State of South Australia;
 - ◆ the State of Tasmania;
 - ◆ the Australian Capital Territory; and
 - ◆ the Northern Territory of Australia.

To improve health workforce, hospitals and capacity.

National Partnership Agreement on Hospital and Health Workforce Reform

PRELIMINARIES

1. This agreement is created subject to the provisions of the *Intergovernmental Agreement on Federal Financial Relations* and should be read in conjunction with that Agreement and subsidiary schedules. In particular, the schedules include direction in respect of performance reporting and payment arrangements.
2. The Parties are committed to addressing the issue of social inclusion, including responding to Indigenous disadvantage. That commitment is embodied in the objectives and outcomes of this agreement. However, the Parties have also agreed other objectives and outcomes - for example, in the National Indigenous Reform Agreement - which the Parties will pursue through the broadest possible spectrum of government action. Consequently, this agreement will be implemented consistently with the objectives and outcomes of all National Agreements and National Partnerships entered into by the Parties.
3. On 29 November 2008, the Council of Australian Governments (COAG) agreed to this National Partnership of \$3.042 billion to improve efficiency and capacity in public hospitals through the following four reform components:
 - (a) introducing a nationally consistent Activity Based Funding approach;
 - (b) improving health workforce capability and supply;
 - (c) enhancing the provision of subacute services; and
 - (d) taking the pressure off public hospitals.
4. The total funding of \$3.042 billion consist of \$1.383 billion Commonwealth transfers to states and territories, \$1.119 billion Commonwealth own purpose expenses and \$0.539 billion State/Territory contributions to the Workforce enablers component.
5. The Agreement demonstrates COAG's commitment to work in partnership to pursue reforms and improvements in the health and hospital sector —against the backdrop of increasing demand due to an ageing population, rising chronic disease, advancing technology and pressures associated with workforce shortages.

PART 1 – FORMALITIES

Parties to this Agreement

6. The Parties to this Agreement are the Commonwealth of Australia and the States and Territories.
7. In entering this Agreement, the Commonwealth and the States and Territories recognise that they have a mutual interest in reform and improving outcomes in the areas of public hospitals and health workforce and need to work together to achieve those outcomes.

Term of the Agreement

8. This agreement will commence as soon as the Parties sign the agreement and will expire on 30 June 2013, or earlier termination as agreed in writing by the Parties.

Delegations

9. The person holding the position of Commonwealth Minister for Health and Ageing is authorised to agree to any implementation arrangements on behalf of the Commonwealth. The Commonwealth will not make reward payments to the States and Territories until an independent assessment by the COAG Reform Council demonstrates that performance benchmarks have been achieved. Facilitation payments will not be paid to any State or Territory until the Minister has approved the implementation arrangements of that State or Territory.
10. The person holding the position of the Minister for Health (or their equivalent) in a relevant State or Territory is authorised to agree any implementation arrangements on behalf of their State or Territory.

Interpretation

11. Unless otherwise specified, the following terms and definitions are used throughout this Agreement:
 - (a) 'Subacute Care' means rehabilitation, palliative care, geriatric evaluation management, and psychogeriatric care as defined in the *National Health Data Dictionary* 14th ed. Australian Institute of Health and Welfare, 2008. This Agreement will use the most recent version of the *National Health Data Dictionary*.

PART 2 – OBJECTIVES, OUTCOMES AND OUTPUTS

Objectives

12. The objectives of this Agreement are to reform and improve:
 - (a) the efficiency of public hospital services;
 - (b) health workforce capability and supply;
 - (c) the volume and quality of sub-acute services;
 - (d) the functioning of emergency departments;

and thereby support an efficient and effective public hospital system that delivers high quality and safe services to patients.

Outcomes

13. The Agreement will contribute to the following outcomes:
 - (a) improved health outcomes and patient experience and satisfaction;
 - (b) a hospital system that is better integrated with other health services; will provide the right services in the right place at the right time; and smooth patients' transitions between health settings through assessment, referral and follow up at key points in patients' health journeys; and
 - (c) a basis for microeconomic reform, making the hospital system more efficient and therefore sustainable into the future, and a hospital system that is better able to adapt successfully to the pressures of rising health costs and increasing demand.

Outputs

14. The objectives and outcomes of this Agreement will be achieved by:
 - (a) application of an approach to activity based funding for public hospital services including nationally consistent classifications for admitted care, sub- acute care, non-admitted care, emergency departments, outpatients and hospital-aided community health services; and a nationally consistent costing and funding model for all care types and all nonclinical hospital services including teaching and research;
 - (b) increased supply, capacity and productivity of health professionals and multidisciplinary teams;
 - (c) increased supply, capacity and quality of subacute care services; and
 - (d) better outcomes for patients in emergency departments.

PART 3 – ROLES AND RESPONSIBILITIES OF EACH PARTY

15. To realise the objectives and commitments in this Agreement, each Party has specific roles and responsibilities in implementing the four reform components, as outlined in schedules A-D.

PART 4 – PERFORMANCE BENCHMARKS AND REPORTING

Performance benchmarks and indicators

16. The Commonwealth, the States and Territories agree to meet the performance benchmarks for the four reform components, as outlined in schedules A-D.
17. To the extent they contribute to the achievement of objectives and outcomes under the National Healthcare Agreement or contribute to the aggregate pace of activity in progressing COAG's agreed reform agenda, these performance benchmarks will be monitored for each

State and Territory by the COAG Reform Council with reference to the performance indicators for the four reform components, as outlined in schedules A-D.

Implementation plan

18. The Implementation Plans for the four reform components are as outlined in schedules A-D to achieve the objectives of this Agreement. Unless otherwise agreed by the Parties, the Plans will be reviewed by the Parties on a biannual basis, including taking account of emerging issues.

Reporting

19. The States and Territories will each provide a detailed report on an annual basis, unless otherwise specified in the schedules to the Commonwealth against the performance indicators and timelines, as detailed in Implementation Plans outlined in schedules A-D.
20. Subject to any variation agreed in schedules A-D, the reports will be provided within 30 days of the end of the relevant period, or as specified in the Implementation Plan.
21. Reporting requirements under this National Partnership should be read in conjunction with the provisions in Schedule C to the *Intergovernmental Agreement on Federal Financial Relations*.

PART 5 – FINANCIAL ARRANGEMENTS

Funding

22. The maximum amount of funding available from the Commonwealth to the States and Territories in total will be \$1,383 million. Annual funding allocation against each element is as follows:

Maximum funding from Commonwealth to States, 2008-09 to 2012-13						
Element (\$million)	2008-09	2009-10	2010-11	2011-12	2012-13	5 YR Total
Activity based funding	36.49	0.00	0.00	41.40	55.52	133.41
Workforce enabler ¹	0.00	0.00	0.00	0.00	0.00	0.00
Subacute care	500.00	0.00	0.00	0.00	0.00	500.00
Taking the pressure off Public Hospitals	750.00	0.00	0.00	0.00	0.00	750.00
Total	1,286.49	0.00	0.00	41.40	55.52	1,383.41

23. The distribution of this maximum funding between the States and Territories will be as set out in the Implementation Plans in schedules A-D.

¹ The Commonwealth's funding for clinical training has been reflected in the Agreement as a Commonwealth Own Purpose Expense and will be provided to the National Health Workforce Agency rather than directly to the States/Territories. The Agency will be responsible for the distribution of the funds. The funds to be provided by the Commonwealth are detailed in Schedule B of this Agreement.

Payment schedule

24. The Commonwealth will make payments to the States and Territories in accordance with schedules A-D.
25. States and Territories will contribute the following amounts to these initiatives:
 - (a) 2009-10 — \$71.49 million;
 - (b) 2010-11 — \$146.7 million;
 - (c) 2011-12 — \$152.86 million; and
 - (d) 2012-13 — \$168.15 million.

Contribution from States, 2008-09 to 2012-13							
Element (\$million)	2008-09	2009-10	2010-11	2011-12	2012-13	Total for each element	
Activity based funding	0.00	0.00	0.00	0.00	0.00	0.00	
Workforce enabler		71.49	146.7	152.86	168.15	539.20	
Subacute care	0.00	0.00	0.00	0.00	0.00	0.00	
Taking the pressure off Public Hospitals	0.00	0.00	0.00	0.00	0.00	0.00	
Total	0.00	71.49	146.7	152.86	168.15	539.20	

PART 6 – GOVERNANCE ARRANGEMENTS

Dispute resolution

26. Any Party may give notice to other Parties of a dispute under this Agreement.
27. The relevant delegates will attempt to resolve any dispute in the first instance.
28. If a dispute cannot be resolved between the relevant delegates, it may be escalated to the relevant Ministerial Council or COAG Working Group for consideration.
29. If a dispute cannot be resolved by the relevant Ministerial Council or COAG Working group, it may be referred by a Party to COAG for consideration.

Review of the Agreement

30. The Agreement will be reviewed in July 2011 with regard to progress made by the Parties in respect of achieving the agreed outcomes.

Variation of the Agreement

31. The Agreement may be amended at any time by agreement in writing by all the Parties and under terms and conditions as agreed by all the Parties.
32. A Party to the Agreement may terminate their participation in the Agreement at any time by notifying all the other Parties in writing.

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

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

The Honourable Kevin Rudd MP
Prime Minister of the Commonwealth of Australia
February 2009

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

The Honourable Nathan Rees MP
Premier of the State of New South Wales
December 2008

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

The Honourable Anna Bligh MP
Premier of the State of Queensland
December 2008

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

The Honourable Mike Rann MP
Premier of the State of South Australia
December 2008

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

Jon Stanhope MLA
Chief Minister of the Australian Capital Territory
December 2008

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

The Honourable John Brumby MP
Premier of the State of Victoria
December 2008

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

The Honourable Colin Barnett MP
Premier of the State of Western Australia
December 2008

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

The Honourable David Bartlett MP
Premier of the State of Tasmania
December 2008

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

The Honourable Paul Henderson MLA
Chief Minister of the Northern Territory of Australia
December 2008

Activity based funding

NATIONAL PARTNERSHIP AGREEMENT ON HOSPITAL AND HEALTH WORKFORCE REFORM

Description

- A1 This reform component will implement the 26 March 2008 COAG commitment “for jurisdictions, as appropriate, to move to a more nationally-consistent approach to activity-based funding for services provided in public hospitals – but one which also reflects the Community Service Obligations required for the maintenance of small and regional hospital services.”
- A2 Activity based funding is a management tool that has the potential to enhance public accountability and drive technical efficiency in the delivery of health services by:
- (a) capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery;
 - (b) creating an explicit relationship between funds allocated and services provided;
 - (c) strengthening management’s focus on outputs, outcomes and quality;
 - (d) encouraging clinicians and managers to identify variations in costs and practices so these can be managed at a local level in the context of improving efficiency and effectiveness; and
 - (e) providing mechanisms to reward good practice and support quality initiatives.
- A3 It will do this through the development and implementation of:
- (a) activity based funding for public hospital services;
 - (b) nationally consistent classifications and data collections for hospital provided care including admitted care, sub-acute care, emergency departments, outpatient, sub-acute and hospital-aided community health services²; and
 - (c) a nationally consistent costing model and, if COAG agrees, a nationally consistent funding model for hospital provided treatment (in admitted care, sub-acute care, non-admitted care emergency departments and hospital-aided community health services) as well as non-clinical hospital services including teaching and research.

The costing model will build on the National Hospital Cost Data Collection (NHCDC).

² This set of services refers only to community health services for which public hospitals are responsible such as palliative care, hospital in the home, early discharge support services and sub-acute community based services funded by public hospitals.

Implementation Plan

- A4 The Implementation Plan recognises the complexity of implementing activity-based funding in non-admitted service types because of the relative underdevelopment of classification and costing infrastructure in these areas. Thus, Stage 3 outputs, which are the deliverables needed for the extension of activity-based costing and hence activity-based funding to these areas, are not expected until the end of 2012-13, allowing a long lead time from the commencement of the agreement. Similarly, work on Stage 2 begins on commencement of the agreement but provides until the end of 2010-11 for delivery of the outputs.

Output	Due
Stage 1: Acute inpatient services – Complete developmental work on an agreed patient classification system and refined casemix costing methodology.	By end of 2009-10
Stage 2: Complete development of a common approach to costing of small or regional hospitals with community service obligations that will not be adequately funded using activity-based funding, in order to inform funding strategies. Implement funding strategies for training, research and development and other activities not directly related to treatment of individual patients. This work should establish a common public and private funding framework for teaching and research.	By end of 2010-11
Stage 3: Complete developmental work related to the achievement of a common casemix classification and costing methodology for emergency department services, sub-acute care and outpatient services and hospital-aided community health services, undertaken in several parallel stages.	By end of 2012-13
Stage 4: Complete development of an activity-based funding methodology, including methodology for setting price, incentives, and transition arrangements. Subject to COAG decision – Use of an activity-based funding model would begin from 2014-15, with an evaluation undertaken after the first year of operation.	By end of 2013-14

Distribution of funding to the States and Territories

- A5 The Commonwealth will provide total funding of \$153.567 million for this initiative. Total funding of \$133.410 million will be allocated to States and Territories as shown in the following table. The Commonwealth will retain the remainder to develop and implement activity based funding data management infrastructure at the national level.
- A6 The payments below are facilitation payments to develop a nationally consistent activity based funding capability and will therefore be paid in advance.

State	2008-09	2009-10	2010-11	2011-12	2012-13	Total
	\$m	\$m	\$m	\$m	\$m	\$m
NSW	10.82	0.00	0.00	12.27	16.45	39.54
Vic	9.68	0.00	0.00	10.99	14.73	35.40
Qld	6.17	0.00	0.00	7.00	9.38	22.55
WA	3.63	0.00	0.00	4.11	5.52	13.26
SA	3.15	0.00	0.00	3.58	4.80	11.53
Tas	1.09	0.00	0.00	1.24	1.66	3.99
ACT	0.86	0.00	0.00	0.98	1.32	3.16
NT	1.09	0.00	0.00	1.23	1.66	3.98
Aust	36.49	0.00	0.00	41.40	55.52	133.41

- A7 In the derivation of the above distribution, \$10 million was subtracted from the total and split equally between the States and Territories as a flag-fall. Each State's and Territory's flag-fall was distributed across the years. The remaining funds were distributed using rurality weighted admitted separations.

Roles and responsibilities

Role of the Commonwealth

- A8 The Commonwealth will have responsibility for:
- national leadership and coordination in the development of national classification systems, costing models and, if agreed by COAG, funding models required for activity based funding;
 - in collaboration with States and Territories, managing and reviewing pilot cost studies;
 - in collaboration with States and Territories, engaging with the private sector to improve comparability of performance between the public and private sectors;
 - in collaboration with States and Territories, establishing mechanisms for the supply of data to the Commonwealth; and
 - in collaboration with States and Territories, implementing national monitoring and reporting arrangements.

Role of the States and Territories

- A9 The States and Territories will have responsibility for:
- in collaboration with the Commonwealth, developing and implementing national classification systems, costing models and, if agreed by COAG, funding models required for activity based funding;
 - in collaboration with the Commonwealth, managing and reviewing pilot cost studies;

- (c) in collaboration with the Commonwealth, establishing governance arrangements, including standards and independent audit arrangements to enhance consistent application of activity based funding;
- (d) in collaboration with the Commonwealth, establish mechanisms for the supply of data to the Commonwealth; and
- (e) in collaboration with the Commonwealth, implement national monitoring and reporting arrangements.

Performance measures

A10 The States and Territories agree to report progress against the following performance indicators which are to be implemented progressively as the outputs identified in the Implementation Plan are delivered.

A11 From the beginning of 2009-10 (baseline 1 July 2010, annual reporting):

- (a) uptake of nationally consistent admitted patient costing methodology (percentage of public hospitals by state); and
- (b) uptake of agreed national admitted patient classification system (percentage of public hospitals by state).

A12 From the beginning of 2010-11 (baseline 1 July 2011, annual reporting):

- (a) uptake of a nationally consistent model for costing small or regional hospitals (percentage of small and regional public hospitals participating in new costing model, by state); and
- (b) uptake of a nationally consistent approach to funding activities not related to treatment of individual patients (percentage of relevant participating public hospitals, by state).

A13 From the beginning of 2013-14 (baseline 1 July 2014, annual reporting):

- (a) uptake of common casemix classification and costing methodology for emergency department services, sub-acute, outpatient services and hospital-aided community health services (percentage of public hospitals, by state).

A14 From the beginning of 2014-15 (baseline 1 July 2015, annual reporting):

- (a) if agreed by COAG, uptake of activity based funding methodology, including methodology for setting price and incentives (percentage of public hospitals, by state).

Performance targets

A15 By 30 June 2011, 100 per cent of admitted episodes classified and costed using the nationally consistent model.

A16 By 30 June 2015, 100 per cent of emergency department services, sub-acute, outpatient services and hospital-aided community health services classified and costed using the nationally consistent model.

A17 If agreed by COAG, by 30 June 2016, 100 per cent of admitted episodes, emergency department, sub-acute outpatient services and hospital-aided community health services funded through a nationally consistent activity based funding model, including 100 per cent

application of a nationally consistent approach to funding of small and regional hospitals with community service obligations.

Workforce enablers

NATIONAL PARTNERSHIP AGREEMENT ON HOSPITAL AND HEALTH WORKFORCE REFORM

DESCRIPTION

- B1 This reform component is aimed to improve health workforce capacity, efficiency and productivity primarily through improving clinical training; facilitating more efficient workforce utilisation; improving international recruitment efforts; and effective and accurate planning of health workforce requirements. The reforms are needed to address workforce shortages and to ensure Australia's health workforce can meet increasing demands for services resulting from factors such as an ageing population, increasing levels of chronic disease and community expectations.
- B2 The reform package consists of the following elements:
- (a) Creating a National Health Workforce Agency to establish more effective, streamlined and integrated clinical training arrangements and to support workforce reform initiatives. Its responsibilities will include funding, planning and coordinating clinical training across all health disciplines; supporting health workforce research and planning; funding simulation training; and progressing new workforce models and reforms.
 - (b) The creation of a new single body working to Health Ministers that can operate across both the health and education sectors and jurisdictional responsibilities in health is critical for devising solutions that effectively integrate workforce planning, policy and reform with the necessary and complementary reforms to education and training. Governance arrangements will be structured to ensure a national approach that supports all jurisdictions. The Agency would ensure that funding provided for clinical training is specifically used for that purpose against agreed outputs and outcomes, rather than being subsumed in global health or education budgets. It would also progress agreed reforms proposed by the NHHRC and be a key source of advice to Health Ministers on reform directions and policy, regulatory or funding barriers to implementing substantive workforce change. Over time AHMAC will explore the expansion of the Agency's responsibilities in relation to clinical training in VET, post graduate and vocational training.
 - (c) Increased funding for undergraduate clinical training in medicine, nursing, allied health and dental training). Clinical training capacity has not kept pace with the increase in tertiary training places and current funding levels limit appropriate and adequate clinical training to existing and future health trainees and the settings in which they can be trained. Student numbers and clinical training requirements will increase dramatically more than health funding and activity through to 2013.

	Commencing students			Clinical training days		
	2005	2010	Increase	2005	2010	Increase
Nursing	9,675	13,895	70%	640,705	1,273,405	50%
Medicine	1,871	3,074	61%	1,123,125	1,736,875	65%
Allied Health	17,503	19,482	10%	728,763	811,750	10%

- B3 Additional funding is needed to support these new places or the students will not be able to be provided with the required clinical training to enable them to complete their education.
- B4 The additional funding represents 30 per cent of the estimated total average annual cost of providing clinical training per student per year. The funding proposal is based on the premise that part of the cost of clinical training is a valid component of state and territory activity funding as the students contribute to service delivery. The Commonwealth is proposing to contribute a greater share of the costs now largely borne by states and territories of clinical training for undergraduates. Both levels of government will contribute to post-graduate clinical training.
- B5 The new funding would be made up of existing funding provided by States and Territories for clinical training and, for some professions, through Commonwealth HECS funding from the Department of Education, Employment and Workplace Relations. This includes funding to support commitments from the States and Territories to support the clinical training of the new undergraduate places announced previously through COAG. For the first time, however, the new funding would be attached to students in whatever service setting they train thus ensuring the training outcome and enabling an expansion into non traditional training settings including primary, community and mental health, aged care and the private sector. Funding approaches managed by the Agency could introduce competition into the market and incentives to both universities and health services to ensure clinical training is delivered in the most cost efficient manner.
- (a) Funding for clinical supervision capacity and competence for undergraduate health training. This is critical as clinical training models and the safety and quality of the workforce is dependent on the availability of competent supervisors within the health system.
- (b) Optimising clinical training through the use of technology to develop clinical skills and competencies required by health professionals, increase the capacity of the health system to provide clinical training and distribute training experiences into regional, rural and remote settings. This will include building or improving simulated learning environments (SLEs), with a focus being on accessibility to regional and rural centres. Whilst the distribution and configuration of the SLEs would be finalised following a cross jurisdictional capital planning process undertaken by the Agency, preliminary indications are this would support the construction and ongoing operation of 45 SLEs and 17 mobile SLEs for rural and remote locations.
- (c) Increased medical post graduate training places to address the future training needs of the 605 additional undergraduate medical places announced in 2006. The additional places are needed to ensure medical graduates can become fully trained medical specialists, including general practitioners. The full cost of these training places will be partly funded through hospital activity funding as the trainees will be providing services. Dedicated funding will again ensure a wider expansion of training posts and thus service delivery into new settings including primary, community and mental health, aged care and the private sector.

- (d) Consolidating jurisdictional international recruitment programs into a single program covering all professions to improve the capacity of Australia's health workforce. This will reduce infrastructure and operational costs and allow more resources to be spent on recruitment strategies. Elements of the program include facilitating employment and training opportunities, assistance to meet registration requirements and overseas recruitment campaigns. This campaign will be conducted in accordance with the Commonwealth Code Of Practice For The International Recruitment Of Health Workers.
- (e) Developing workforce redesign strategies to improve the efficiency and effectiveness of the health workforce. This will involve the Agency designing and implementing a range of strategies with and across all jurisdictions including 12 to 24 month pilot and reform projects; evaluation of workforce models to ensure quality, safety, efficiency and effectiveness; training of health workers to support new projects and enhance practice capabilities; examination of existing barriers with the focus on advising Health Ministers' on recommended changes; and promoting and facilitating roll out of successful workforce projects nationally.
- (f) Effective planning of health workforce requirements through a National Health Workforce Statistical Resource (based on data from the national registration and accreditation scheme).
- (g) Developing a national approach to employment structures to facilitate workforce reform.

Implementation Plan

Output/milestones	Due by
Workforce redesign programs funded - Phase 1	January 2009
Determine legislative basis, governance arrangements and establish National Health Workforce Agency	May 2009
National projections for undergraduate places provided to MCEETYA	April 2009
Workforce redesign programs funded - Phase 2	May 2009
National Health Workforce Agency work program agreed by AHMC with additional deliverables and milestones	June 2009
Australia wide international recruitment program in place	September 2009
Capital allocation plan for SLEs	December 2009
New clinical training subsidy in place	January 2010
National statistical database established	February 2010
National rollout of successful workforce redesign programs - Phase 1	March 2010
National rollout of successful workforce redesign programs - Phase 2	September 2010

Distribution of this maximum funding between the States and Territories

- B6 To ensure accountability and use of funds for planned purposes, it is envisaged that the majority of funding would be held by the National Health Workforce Agency in the longer term. Therefore, contributions would be to the Agency rather than payments to the States and Territories.

- B7 The National Health Workforce Agency will be responsible for funding the clinical training elements, including the SLEs, workforce redesign and workforce planning elements. It is anticipated the Commonwealth will be responsible for providing funding for the general practice and private sector postgraduate clinical training and the States and Territories for postgraduate clinical training in the public sector. A cost shared funding arrangement between the Commonwealth and States and Territories is expected for the other clinical training elements.
- B8 The Commonwealth will provide total funding of \$1099.3 million over four years for workforce and infrastructure initiatives:

(a) \$923.7m will be provided for the following workforce elements:

	2009-10	2010-11	2011-12	2012-13
	\$M	\$M	\$M	\$M
Clinical training subsidy – undergraduates (50 per cent)	67.48	140.25	143.66	145.08
Clinical training subsidy – post graduate (GPs and private sector)			32.81	53.42
Clinical training – supervision capacity	4.00	6.00	8.00	10.00
Clinical training SLEs	0.25	7.48	20.00	20.75
International recruitment program	18.00	15.00	15.00	15.00
National Health Workforce Agency	25.00	30.00	35.00	35.00
Workforce redesign funding	20.00	30.00	15.00	6.00
National workforce planning statistical database	1.50	1.55	1.10	1.35
Total	136.23	230.28	270.58	286.6

- (b) \$175.6 million non ongoing funding will be provided over four years for investment in capital infrastructure including:
- (i) \$45.6 million to contribute to the State and Territory costs for SLEs;
 - (ii) \$90 million to support innovative clinical teaching and training initiatives; and
 - (iii) \$40 million to establish or expand education and training at major regional hospitals as part of the Rural Clinical Schools Program.

- B9 The States and Territories will provide total funding of \$539.2 million³ over four years for clinical training for undergraduate training. This would be existing funding provided by States and Territories for clinical training, however, it would now be specifically attached to students and thus be provided back to health settings as clinical training activity funding.
- B10 Existing responsibilities of the Commonwealth and States and Territories to fund post-graduate training for GPs and specialists will be maintained.

³ The State and Territory contribution of \$539.2 million has already been offset by \$45.6m included in the separate workforce infrastructure package funded by the Commonwealth.

	2009-10	2010-11	2011-12	2012-13	Total
	\$M	\$M	\$M	\$M	\$M
NSW	23.34	47.89	49.90	54.89	176.02
Vic	17.72	36.36	37.89	41.68	133.65
Qld	14.29	29.32	30.55	33.61	107.77
WA	7.22	14.81	15.44	16.98	54.45
SA	5.37	11.02	11.48	12.62	40.49
Tas	1.67	3.43	3.57	3.93	12.6
ACT	1.15	2.36	2.46	2.71	8.68
NT	0.73	1.51	1.57	1.73	5.54
Total	71.49	146.7	152.86	168.15	539.2

B11 Whilst the total funding for these initiatives is shown above, some minor adjustments to funding levels per year may need in light of factors such as the scoping study to determine the location and type of SLEs to be undertaken in 2009-10, the types of reform projects funded and the actual number of post graduate trainees per year.

Role of the Commonwealth

B12 Funding the:

- (a) National Health Workforce Agency;
- (b) international recruitment program;
- (c) workforce redesign projects; and
- (d) national workforce planning statistical database.

B13 Co-funding the clinical training components.

B14 Funding investment in capital infrastructure.

Role of the States and Territories

B15 Co-funding the clinical training components.

B16 Contributing to the workforce reform agenda through the National Health Workforce Agency (which will be managed through the Australian Health Ministers' Advisory Council).

Key performance benchmarks

B17 Consistency in clinical placement hours and standardised models for clinical supervision.

B18 Establishment of the National Health Workforce Agency.

B19 Student tied funding model and activity based funding for training incorporated into service agreements.

B20 National data collections developed.

- B21 National projections for undergraduate places provided to the Ministerial Council on Education, Employment, Training and Youth Affairs.
- B22 Australia wide international recruitment program.
- B23 Rollout of successful workforce redesign programs.
- B24 Capital allocation plan for SLEs.

Performance indicators

- B25 All additional undergraduate health places provided with clinical training and additional clinical training capacity identified for further growth.
- B26 Clinical training places provided in areas and disciplines of need.
- B27 Increase in the number and types of SLEs and increased use of SLEs in clinical training.
- B28 An increase in the uptake of extended scopes or new or redesigned roles.
- B29 Increase in the capacity of Australia's health workforce.
- B30 Improved international recruitment.
- B31 Workforce redesign programs implemented.

Subacute care

NATIONAL PARTNERSHIP AGREEMENT ON HOSPITAL AND HEALTH WORKFORCE REFORM

Description

- C1 This reform component seeks to improve health outcomes, functional capacity and quality of life of patients by increasing the volume and quality of the subacute care services in both hospital and community settings.
- C2 Funding will be provided in 2008-09 for the State and Territories to expand service provision levels by 5 per cent annually over the period 2009-10 to 2012-13 in that State or Territory, and better address regional availability.
- C3 Service levels and outcomes in subacute care will be collected and publicly reported, and the capacity of the multi-disciplinary subacute workforce will be strengthened.
- C4 The setting of targets at a regional level, aggregated by State and Territory, will enable monitoring of access to subacute care services in a range of geographical areas (eg urban, rural and remote) to help inform service planning.
- C5 While the majority of the funding (around 80 per cent) is based on service level growth, components are also included for subacute care workforce (around 13 per cent), equipment (around 4 per cent) and administration to implement the measure and facilitate participation in the National Subacute Working Group (around 2 per cent).

Implementation Plan

Output	Due by
Provision by States and Territories of: (a) a satisfactory State or Territory-wide Plan to Enhance Subacute Services for the period 2009-10 to 2012-13, reflecting annual service growth targets in 'b' (below), with the Plan to be made publicly available. Agreement by States, Territories to the following for hospital and community-based subacute care services: (b) Service level annual growth targets of 5 per cent to be agreed with the Commonwealth. Note: Targets will be based at a regional level, will aim to improve the mix of services, and will take into account national benchmarks.	Completion of (a) and (b) by April 2009 as a condition of receiving 2008-09 payment.
Participation by States, Territories and Commonwealth in a National Subacute Care Working Group to be established by COAG to address: (a) enhanced provision and mix of subacute care services; (b) quality and data improvements through agreed models of care, including improved data collection and reporting	Commencing by 30 June 2009, to continue until 30 June 2013.

arrangements, and enhanced electronic communications; and (c) strengthened capacity of the multi-disciplinary subacute care workforce including improved geographical distribution, an increase in the supply of the workforce and development of new workforce models.	
Participation by States, Territories and the Commonwealth in working with national data collection agencies (such as the Australasian Rehabilitation Outcomes Centre and Palliative Care Outcomes Collaboration).	Commencing by June 2009
Agreement by States, Territories and the Commonwealth to a method for measuring growth in service provision. A provisional method will measure progress in 2009-10 of the project, with a final method to apply subsequently.	June 2009 (provisional) December 2009 (final)
Provision by States and Territories of: a) agreed data to the Commonwealth; and b) reports against annual growth targets to the Steering Committee for the Review of Government Service Provision, measured on a regional basis.	The following dates apply to both a) and b). March 2010 September 2010 September 2011 September 2012 September 2013
States and Territories to publicly report against annual growth targets, measured on a regional basis, in an agreed form. The first report will measure the first 6 months of progress (June - December 2009) while subsequent reports will measure progress over full financial years.	March 2010 (first 6 months' report) December 2010 December 2011 December 2012 December 2013
States and Territories put in place strategies to expand subacute services, including expansion of the subacute care workforce, in line with agreed targets and approach agreed by the National Subacute Care Working Group.	Ongoing throughout project

Financial arrangements

Funding

C6 The total Commonwealth funding for subacute care will be \$500.00 million in 2008-09.

C7 The maximum amount of funding available to the States and Territories in total will be as follows:

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
165.652	125.100	97.265	48.609	39.973	12.242	7.336	3.823	500.00

Note (based on age-weighted population)

Payment Schedule

C8 In 2008-09 the State or Territory will receive 100 per cent of the agreed funding for service enhancement over the period 2009-10 to 2012-13 subject to the Implementation Plan above.

Roles and responsibilities of each party

Role of the Commonwealth

- C9 Provide funding support for the enhancement of subacute care services (as specified under Funding Arrangements in this Schedule) including for: service delivery; strengthening the subacute care workforce; and quality improvement, including research into best practice models of care and improved information management to achieve nationally consistent data collections.
- C10 Fund and provide national coordination of the initiative, monitor performance, and facilitate publication of subacute care performance against annual targets.

Role of the States and Territories

- C11 Deliver enhanced provision of subacute care services in both hospital and community settings. This includes expanding the multi-disciplinary subacute care workforce (including expansion of clinical training opportunities), agreeing to subacute care service delivery benchmarks and annual growth targets of five per cent, and publishing performance against the targets annually (as outlined in the Implementation Plan).
- C12 Work towards achieving annual service growth targets, with a particular focus on the types of sub-acute care most needing expansion and on regional areas with the greatest need for enhanced services. The prospective funding arrangements (funding will be provided in 2008-09 for service enhancement over the period to 2012-13) will provide States and Territories with considerable flexibility in the way subacute care services are enhanced to best meet needs.
- C13 Actively participate in national coordination of this initiative and support governance structures.

PERFORMANCE BENCHMARKS AND REPORTING

Key performance benchmarks

- C14 Agreement to targets and benchmarks for improved service provision and publication of data.
- C15 Annual increase in provision and improved mix of subacute care services for hospital and out-of-hospital care.

Performance indicators

- C16 Access to subacute care services (measured by episodes/occasions of service for hospital and community care against agreed targets).
- C17 Increased workforce capacity in subacute care (measured by numbers of clinical training places for the following subacute care workforce categories: medicine, nursing and allied health professionals and paraprofessionals).
- C18 Patient outcomes (measured for example through the Functional Improvement Measure scores, for rehabilitation).
- C19 Quality and continuity of care (measured by evidence of agreed multidisciplinary care plans particularly at transition points between services).

- C20 Timeliness of care (measured by proportion of subacute care patients assessed within the clinically appropriate time).
- C21 Efficiency (measured for example through aggregate increases in Functional Improvement Scores per patient days/occasions of service, for rehabilitation).

Taking Pressure off Public Hospitals

NATIONAL PARTNERSHIP AGREEMENT ON HOSPITAL AND HEALTH WORKFORCE REFORM

DESCRIPTION

- D1 This National Partnership project payment aims to improve the operations of emergency departments (EDs) through a once off grant of \$750 million to States and Territories.
- D2 This payment is made in recognition that EDs are currently treating an increased number of patients including some who could otherwise be treated in a primary care setting. This is resulting in added pressure on EDs, resulting in longer waits for patients and adding avoidable costs to the public hospital system. This injection will relieve some of the pressure on public hospitals, while initiatives to improve the efficiency of public hospitals and the primary care reforms of the Commonwealth are implemented.

IMPLEMENTATION PLAN

Output	Due by
Provision by States and Territories of a satisfactory plan detailing how the funding will be spent in order to improve emergency department services	By April 2009
Payment to States and Territories by the Commonwealth of \$750 million to relieve pressure on EDs	Payment to be made by 30 June 2009
A nationally accepted definition (by States, Territories and the Commonwealth) of what a non emergency GP type presentation is based on emergency department DRGs.	June 2012
<p>Progress reports provided by States and Territories against their implementation plans, until implementation is complete.</p> <p>Expanded reporting to the non-admitted emergency department care national minimum data set collection.</p> <p>Data will be submitted to the Commonwealth every twelve months with a further three month period allowed for validation of data. This makes a total of five data submissions over the period of the agreement.</p>	Submission of reports and data to occur annually – with the first submission to occur by 30 September 2009, for the period 1 January to June 2009 and the final submission to occur by 30 September 2013.

FUNDING

- D3 The Commonwealth will provide states and territories with \$750 million in 2008-09.
- D4 The distribution of these funds between States and Territories is based on the 2008-09 distribution of the National Healthcare Agreement (in the same way as the \$500 million base injection agreed at the November 2008 COAG meeting), and is as follows:

\$ million	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUS
2008-09	248.569	181.267	146.700	75.285	61.746	16.636	9.969	9.828	750.000

ROLE OF THE COMMONWEALTH

- D5 Provide a once off injection of \$750 million to States and Territories to relieve pressure in public hospital EDs.
- D6 Facilitate national coordination of data collection and support states' efforts in using these data to improve performance.

ROLE OF THE STATES AND TERRITORIES

- D7 Improve the number of patients being treated in clinically appropriate periods of time.
- D8 Decrease the number of patients experiencing access block.
- D9 Provide data on emergency departments to the Commonwealth.

JOINT ROLES

- D10 Commonwealth and States to develop a nationally consistent DRG based definition of a non emergency primary care presentation.

KEY PERFORMANCE BENCHMARKS

- D11 By 2012-13, 80 per cent of ED presentations are seen within clinically recommended triage times as recommended by the Australian College of Emergency Medicine.
- (a) The grant in combination with the continuing increased health care funding and primary and preventative health care initiatives will reduce pressure on public hospital EDs, allowing EDs to carry out their core role of providing emergency medicine more effectively.
- D12 By 2013-14, 95 per cent of hospitals with an ED report to the non-admitted emergency department care national minimum data set collection.
- (a) Data collected will be used to determine if key performance benchmarks have been met, to inform national and state acute health policy development and to facilitate

identification of best practice in ED service delivery, especially in relation to primary care patients in EDs.

PERFORMANCE INDICATORS

- D13 Per cent of all emergency department presentations who are seen within clinically appropriate times.
- D14 Per cent of hospitals with an ED reporting to the non-admitted emergency department care national minimum data set.