Hamish Hansford,
Committee Secretary,
Australian Senate Community Affairs Legislation Committee.

Dear Hamish,

Thank you for the invitation to provide a submission to the Australian Senate Committee on the National Health and Hospital Network Bill 2010. Outlined below are some issues that may be of interest to the Committee.

1. Legislation

(a) Part 1, Section 5.

The Definitions could be expanded to include the following terms:

- Standards
- Indicators
- Guidelines
- Model accreditation scheme
- Lead clinical groups

Clarify whether 'Guidelines' refer to 'Clinical Practice Guidelines' and, if so, include a definition for 'Clinical Practice Guidelines'.

(b) Part 3 – Division 2 Members of the Board, Section 20: Appointment of Board members.

Consider including a category for a Board member with expertise in 'health economics' in 20(3).

Rationale: Some Principal Committees of the National Health and Medical Research Council (NHMRC) such as the former Health Advisory Committee and National Health Committee, which were involved in the development and approval of Clinical Practice Guidelines and issues on translating evidence into clinical practice, each included a Committee member with expertise in 'health economics'. Guidelines should include economic evidence in the form of Cost Effectiveness Analysis and/or Cost Benefit Analysis evidence. Economic evidence is an area that the health industry in Australia finds complex and challenging to incorporate and apply. Many reputable Australian and international Guidelines (ie 'Clinical Practice Guidelines') include economic, especially cost effectiveness evidence, in addition to clinical evidence. Australian Guidelines are not always up to date and the health industry often uses international Guidelines to implement at the point of care in hospitals and in other health sectors. The inclusion of a Board member on the Commission with expertise in health economics may greatly facilitate the work of the Commission.

Further, Schedule D of the National Health and Hospitals Network (NHHN) Agreement (2010) Clause D5 specifies that with regard to the development of performance measures, the National Standards and new national clinical and quality standards should be supported by *cost effective data* [D5a(ii)]. Further, performance measures should address, inter alia, quality of service delivery patient outcomes and *financial responsibility* [D5 a (i)].

(c) **Part 4 Division 1 Section 39 (3)**

This section could be rewritten to make the intent of this section clearer.

2. Potential for overlap of functions of NHMRC and the Commission

The NHMRC Act 1992 requires the NHMRC to pursue activities that raise the standard of individual and public health throughout Australia; foster the *development of consistent health standards between States and Territories*, support medical and public health research and training throughout Australia; and promote consideration of ethical issues related to health. The NHMRC is accountable to achieve the following outcome: Improved health and medical knowledge, including through funding research, *translating research findings into evidence based clinical practice*, administering legislation governing research, *issuing guidelines* and providing advice for ethics in health and promotion of public health. The National Institute of Clinical Studies (NICS), provides NHMRC with capacity to drive *implementation of clinical practice guidelines it develops and approves.*[1]

NHMRC legislation, the NHMRC Act 1992, covers guideline development and approval[2]. The Australian Senate Community Affairs Legislation Committee could consider the NHMRC Act 1992 (Act No 225 of 1992 as amended), Compilation prepared on

[1] NHMRC 2009 *Report on the Operations of the NHMRC Strategic Plan 2007-2009.*

[2] http://www.comlaw.gov.au/ComLaw/Legislation/ActCompilation1.nsf/0/A633FC8D6C2DC527CA25773B001EC8C5/$file/NatHeaMedResCou1992WD02.pdf

7 June 2010 taking into account amendments up to Act No 51 of 2010). Part 3 of that Act is relevant and discusses in Division 2 – Regulatory Recommendations and Guidelines. Subdivision A covers regulatory recommendations made and guidelines issues by the CEO. Consultations about guidelines are covered in Section 13 of that Subdivision. Subdivision B covers guidelines approved by the CEO for third parties in section 14A and Sub Division C concerns other provisions about consultations.

Various publications of the NHMRC define Clinical Practice Guidelines and provide excellent advice on the methodology for guideline development, implementation and evaluation[3]. The roles of the Commission and NHMRC require clarification to avoid overlap in activities. In my view, the NHMRC has well a well organised, and high impact, approach to its work on Clinical Guidelines in Australia. The NHMRC's methodologies in the area of Clinical Practice Guidelines are highly regarded internationally, especially in the area of integrating economic evidence (cost effectiveness) into guidelines.

3. Proposed new State and International Centres: National stakeholder input 2007 to 2010

The Senate Committee could consider the functions of the proposed *State Centres for Evidence Based Medicine (EBM), Health Services and Workforce Redesign* and the *International Centre for Evidence Based Medicine and Health Economics*. These were discussed in my submission to the Senate Finance and Public Administration Committee Inquiry into COAG Reforms Relating to Health and Hospitals 2010[4]. That submission was originally forwarded to State and Federal government stakeholders in the context of the April 2010 COAG Meeting.[4] The Australian Commission on safely and Quality in Health Care could be involved in the functions envisaged for the *International Centre for EBM and Health Economics*. Alternatively, the Commission could collaborate with the proposed International Centre.

Linkages between the proposed International and State Centres could be of interest to the Senate Committee given, during 2009 the Health Minister of one of Australia's largest States advised me that the State planned to implement a similar type of State Centre. Further, some other Health Ministers advised that their Departments were considering my proposals in the context of the implementation of the Agreements. Given the provisions of the NHHN Agreement (2010) the proposed International Centre and State Centres could facilitate a co-ordination function between the Local Hospital Networks and Medicare Locals.

This could be achieved by streamlining the patient journey between sectors by collaboration, with the State Centres, in the implementation of Guidelines and evidence by the development, implementation and evaluation of local quality instruments such as clinical pathways, clinical protocols and management plans. The roles of the International Centre and State Centres would enable economies of scale at the national state and regional level by facilitating the rollout and distribution of the latest evidence and guidelines from consolidated sources and avoid duplication. Some stakeholders have raised, in the press and at national forums, the need for greater co-ordination for the Local Hospital Networks and Medicare Locals. There would also be considerable scope for the proposed State and International Centres to collaborate with the NHMRC, including NICS.

4. Recommendation

That you note the above

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Member, Standing Scientific Committee, International Health Economists Association
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Dr Antioch is Principal Management Consultant Health Economics and Funding Reforms. *She held two Ministerial appointments, as the health economics member, to the Principal Committees of the National Health and Medical Research Council (NHMRC) for six years to 2009. These were the Health Advisory Committee and National Health Committee which approved Clinical Practice Guidelines and translated evidence into clinical practice. Dr Antioch worked as part of Senior Management of Bayside Health (now Alfred Health) in Melbourne until 2005 where she led the translation of evidence into clinical practice across three tertiary, community and rehabilitation hospitals. She led similar work across Western Health Network until 2007. She presented the model of EBM translation across Australia in 2007, sponsored by the Australian Health Care and Hospitals Association, in the context of the renegotiations of the Australian Health Care Agreements and, from 2008 to 2010, briefed COAG and other Federal/State stakeholders on the recommendations arising from those national consultations and recent National Forums.. She also led the risk adjustment reform of Activity Based Funding (ABF) in Victoria for the Victorian Government*

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[3] http://www.nhmrc.gov.au/guidelines/developers.htm#2

[4] Antioch KM (2010) *Submission to the Senate Finance and Public Administration Inquiry into COAG reforms Relating to Health and Hospitals.* http://www.aph.gov.au/Senate/committee/fapa_ctte/coag_health_reforms/submissions.htm *(Submission # 20)*