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The National Primary Health Care Partnership (NPHCP) response to the Standing Committee on Health and Ageing Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011

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Introduction and Background

The National Primary Health Care Partnership (NPHCP) welcomes this opportunity to provide comment against the National Health Reform Amendment (National Health Performance Authority) Bill 2011 (The Bill).

The NPHCP is a unique collaboration of twenty peak health organisations, which collectively represent over 100,000 health professionals working in primary health care as well as health consumers. The partnership was established in 2006 to provide a single national voice promoting the importance of primary health care in Australia[1]. The NPHCP operates as a collaborative forum to discuss common issues impacting on primary health care in Australia and ways of strengthening the primary health care sector with a consumer focus. It has a strong track record in acting as a consultative body with government, advising on primary health care related service delivery, primary health care provider matters and consumer needs through consumer body representation.

The NPHCP has been fully engaged and largely supportive of the health reform agenda and the establishment of the National Health and Hospitals Network (NHHN), comprising Local Hospital Networks (LHNs) and primary health care organisations (PHCOs) - also known as "Medicare Locals" (MLs). The NPHCP has been particularly engaged with the evolution of Medicare Locals by collaborating and advising on multi-disciplinary considerations in the development and functionality of these incoming organisations.

The NPHCP is, in principle, supportive of the proposed *National Health Reform Amendment (National Health Performance Authority) Act 2011*. In particular, the NPHCP is broadly supportive of the establishment of the National Health Performance Authority (NHPA) as a means by which to continually improve and advance delivery of health care through the new NHHN including through LHNs and MLs. We do however provide comments in relation to the NHPA, especially in regard to

[1] Further information on the NPHCP and a list of its members can be found below in Appendix 1 & 2.

primary health care organisations/bodies (PHCOs)[2] MLs and more broadly, against the specific areas identified below. Of particular note, the NPHCP strongly recommends the inclusion of a broader definition of health (not limited to medical, dental and pharmaceutical services) in the NHPA's constitution and the assurance that the expertise of Members appointed to the NHPA includes comprehensive, multi-disciplinary primary health care knowledge.

Part 3.2 - Performance Authority's establishment, functions, powers and liabilities
60. Functions of the performance Authority
60. (1) (a) (iv) and (v): The NPHCP notes that a prime responsibility of the NHPA is the monitoring and reporting on the performance of a number of health agencies, including primary health care organisations (iv) and other bodies or organisations that provide health care services (v). Key activities in relation to this function are that the NPHA will:
(60 1 c): formulate, in writing, performance indicators to be used by the Performance Authority in connection with the performance of the function conferred by paragraph (a);
(60 1 d): collect, analyse and interpret information for purposes in connection with the performance of the function conferred by paragraph (a);

The NPHCP raises the several points here:
In relation to clause 60 (1) (a) (v): monitoring / reporting on the performance of other bodies or organisations that provide health care services, the NPHCP seeks clarification and examples as to what "other bodies" this would include, for example general practices or allied health services. The NPHCP represents a number of diverse primary health care providers (PHCPs), and any proposed performance monitoring/reporting for these providers - performed by the NPHA - must be clearly articulated to keep these providers informed and to assist them with compliance.

In relation to clause 60 (1) (c), and not withstanding points 60 (3) (a) and (b)[3] in the Bill, the NPHCP strongly recommends that if performance indicators were developed for individual PHCPs, that they are developed in conjunction and consultation with providers and consumers so that they are realistic, meaningful and achievable. In general however, the NPHCP suggests that broad based monitoring and reporting of primary health care performance occurs through performance indicators (PIs) developed for ML PHCOs although the NPHCP believes it is critical that there is opportunity for input into those PIs by relevant stakeholders including MLPHCOs and PHCPs. The NPHCP also suggests that agencies such as the Australian Commission on Safety and Quality in

[2] Government announcements have made it clear that these will be known as Medicare Locals, however PHCOs is used as a generic term To avoid confusion in this submission the acronym ML PHCOs is used,
[3] Paragraph (1)(c) does not, by implication, prevent the Performance Authority from using either of both of the following in connection with the performance of the function conferred by paragraph (1)(a): (a) performance indicators formulated by a person or body other than the Performance Authority; (b) standards formulated by a person or body other than the Performance Authority.

Health Care (the Commission), who will play a key role in setting Standards for health care across Australia, work collaboratively with providers and the NHPA in this regard.

The NPHCP also recommends that any comparative reporting against performance indicators for ML PHCOs as well as for individual PHCPs, should the latter be developed, is:

- not restricted to national benchmarks but includes like with like provider and region reporting, in order to overcome some of the inherent demographic differences that exist between certain providers in different regions
- takes into account the performance of other parts of the health system and the NHHN that may influence performance within ML PHCOs and/or PHCPs but is beyond their immediate and direct control.

In relation to clause 60 (1) (d), the NPHCP considers it important that in collecting data to fulfil the NHPA's requirements to report on primary health care performance, overlap and duplication of effort regarding information collected by ML PHCOs and potentially by PHCPs themselves is avoided.

In relation to clause 60 (1) (e): to promote, support, encourage, conduct and evaluate research for purposes in connection with the performance of any of the functions of the Performance Authority. The NPHCP believes the promotion, support and evaluation of such research is important and supports this goal. However, the NPHCP believes that the NHPA should commission, rather than conduct its own research, to ensure independence in any studies undertaken and to access existing expertise in health research and evaluation available in the academic sector.

The NPHCP also considers it important that research undertaken is done in consultation with the relevant bodies whose performance the NHPA is monitoring and reporting on, and that the findings of any research are available publicly after relevant bodes have also had opportunity to contribute to their interpretation of these findings.

62. Additional Provisions about reports 62 (1) (e) refers specifically to any other body or organisation that provides health care services, which may include PHCPs
This section details provisions for reports that indicate poor performance from PHCPs. In particular the NPHCP highlights points 2a and b whereby:
Before completing the preparation of the report, the Performance Authority must:
(a) give a copy of a draft of the report to the manager of the entity or facility; and

(b) invite the manager of the entity or facility to give the Performance Authority written comments about the draft report within 30 days after receiving the draft report.

The NPHCP supports this clause and considers 30 days a reasonable time period in which to provide comments in normal circumstances. The NPHCP recommends however that this point is expanded to include allowance for a longer time period where there are extenuating circumstances and/or where additional data or information is required from the PHCP in order to comment more fully on the poor performance described in the draft report. The NPHCP also suggests that explanatory comments provided by PHCP managers are included in the final report where relevant, especially where they legitimately explain what can be considered poor performance based on intrinsic elements. On this note, the NPHCP also considers it vital that exactly what constitutes "poor performance" is well defined and clearly explained in public reports. This in turn is related to comments made above regarding clause 60 (1) (c) and the need for any comparative reporting for PHCPs not to be restricted to national benchmarks, but to include performance against like providers and regions.

65. Rules to be complied with by the Performance Authority in its monitoring and reporting functions

(1) The Minister may, by legislative instrument, make rules to be complied with by the Performance Authority in performing the functions conferred by paragraphs 60 (1) (a) and (b).
14 (2) The Performance Authority must comply with rules in force under subsection (1).

The NPHCP considers it important that any such rules developed for PHCPs relevant to the NHPA's monitoring and reporting functions are developed in consultation with PHCPs and with representatives from the associated professions, consumers and service providers potentially impacted by these rules.

66. Minister may direct the Performance Authority to formulate performance indicators

(1) The Minister may, by legislative instrument, direct the Performance Authority to formulate performance indicators in relation to a specified matter.
(2) The Performance Authority must comply with a direction under subsection (1).

The NPHCP reiterates its recommendations from Part 3.2, section 1 (a) (iv) (c) that any performance indicators directed to be developed for PHCPs by the Minister are developed in conjunction and close consultation with PHCPs in order that they are realistic, meaningful and achievable, that new Indicators are "road tested" prior to their incorporation into PHCP reporting requirements and that adequate provision is allowed between the collection of

baseline data on the new indicator and the time in which improvement may realistically first be expected to be achieved.

72. Appointment of members of the Performance Authority

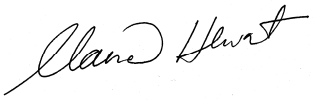
(4) The Minister must ensure that at least one member of the Performance Authority has:
substantial experience or knowledge; and
significant standing;
in the following fields:
(a) the health care needs of people living in regional or rural areas;
(b) the provision of health care services in regional or rural areas.

The NPHCP strongly recommends that at least one member of the NHPA has significant understanding and expertise in primary health care (PHC) systems and services within a multi-disciplinary framework, as well as an understanding of the interface between PHC and the hospital setting. The NPHCP considers this knowledge crucial to members of the NHPA if they are to make recommendations regarding monitoring and performance of PHCPs and of PHC more broadly.

In summary, the NPHCP supports the overall intent of the NHHN and the establishment of the NPHA however believes it essential that: clarity is provided as to whether "other bodies or organisations that provide health care services" [60 (1) (a) (v)] includes individual PHCPs, if so, that the development of performance indicators against which PHCPs will be asked to report to the NHPA are developed in close consultation with PHCPs and do not unnecessarily duplicate PIs developed for ML PHCOs; and that expertise of members of the NHPA includes sounds knowledge of primary health care systems and services within a multi-disciplinary framework.

I would welcome the opportunity to provide you with further information about the NPHCP, as well as further discuss any of the positions taken in this response. I can be contacted via Scott Brown at the Secretariat, whose contact details are provided above.

Yours sincerely



Claire Hewat
Chair, National Primary Health Care Partnership

Appendix 1: National Primary Health Care Partnership organisations

Allied Health Professions Australia	Consumers Health Forum
Audiology Australia	Dietitians Association of Australia
Australian Association of Social Workers	Optometrists Association Australia
Australian Association for Exercise Physiologists	Occupational Therapy Australia
Australian Dental Association	Pharmaceutical Society of Australia
Australian General Practice Network	Royal College of Nursing Australia
Australian Podiatry Council	Society of Hospital Pharmacists of Australia
Australian Physiotherapy Association	Services for Australian Rural and Remote Allied Health
Australian Psychological Society	Speech Pathology Australia
Australian Practice Nurse Association	The Pharmacy Guild of Australia

Appendix 2: NPHCP Terms of Reference

Aim and Purpose of the NPHCP
The aim of the NPHCP is to achieve to achieve a primary health care system that works for the people who need, use and work within it.

The purpose of the NPHCP is to provide:
- A successful advocacy mechanism to Governments for primary health care reform;
- Expert advice on primary health care to government.
- A collaborative forum to discuss common issues impacting on primary health care in Australia and ways of strengthening the primary care sector with a consumer focus.

Vision for the NPHCP:
To facilitate the development of a national primary care system which:
- Engages the consumer as an essential member of the team;
- Provides an integrated and team-based approach to care across primary health care disciplines;
- Supports its workforce by providing ongoing timely access to appropriate training and education, resources, support and infrastructure;
- Allows for flexible and innovative service models to meet local health needs;
- Provides quality, safe, measurable patient care based on best-practice and clinical evidence; and,
- Includes a focus on prevention and early intervention.

- In achieving the vision, the role of the NPHCP will be:
- To develop strategies aimed at strengthening the primary health care sector and improving patient outcomes, such as increasing the prevalence and effectiveness of team-based care
- To identify key issues impacting on the primary health care sector and discuss best-practice solutions
- To promote the effectiveness of the primary health care sector and increase links with secondary and tertiary health systems
- To develop strategies for integrated services between primary, secondary and tertiary care if needed to overcome identified service gaps for consumers
- To develop appropriate evidence-based population health strategies and endorse health promotion campaigns; and,
- To maintain effective communication channels and strong relationships with the Australian Government and State and Territory governments and between primary health care disciplines.

Options for working towards the NPHCP vision include:
- Ensuring regular meetings and communication between members to progress work plans and the group's agenda

- Establishing delegations to visit the Minister and advocate for Government response to key primary health care issues
- Establishing working groups to investigate and develop responses to specific issues identified by the NPHCP
- Developing a comprehensive communications plan for the NPHCP, including communications with members, development of a joint publication, establishment of a web presence and agreed protocols for issuing joint media releases or statements.
- Liaising as appropriate with other stakeholders; and
- Develop joint submissions, for example responses to Senate inquiries.

Terms of Reference

The agreed terms of reference for the NPHCP are:

- To collaborate on areas of mutual interest in primary health care
- To provide a forum for exchange and consultation to Government and other relevant national organisations with a view to influencing policy
- To facilitate discussion on national approaches to primary health care policy and practical strategies to create a better primary health care system that works for the people who use it and work within it
- To provide collective representation where a mutually agreed position has been established.