The Royal Australian College of General Practitioners

# *RACGP Submission to the Senate Standing Committee on Community Affairs*

*Inquiry into the establishment of the National Health Performance Authority through amendment of the National Health and Hospitals Network Act 2011*

04 May 2011

# 1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Senate Standing Committee on Community Affairs for the opportunity to comment on the establishment of a National Health Performance Authority through amendment of the *National Health and Hospitals Network Act* 2011.

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting general practitioners in their pursuit of excellence in patient care and community service.

This submission is made in response to the Senates referral of the *National Health Reform Amendment (National Health Performance Authority) Bill* 2011 to the Committee for review on 24 March 2011, with the aim of establishing a National Health Performance Authority through amendment of the *National Health and Hospitals Network Act* 2011.

Details of the Senate Committee's inquiry can be found at:
http://www.aph.gov.au/senate/committee/clac_ctte/nhpa/info.htm

# 2. Overview of response

The RACGP welcomes and recognises the need for performance measurement in healthcare. The College believes that benchmarking should include all sectors involved in the delivery of healthcare, from healthcare providers to funding bodies.

The RACGP's concerns relate to the Performance Authority's:

1. composition
2. functions and powers
3. monitoring
4. indicators
5. reporting
6. independence
7. advisory committees
8. strategic planning
9. relationship to the Australian Commission on Safety and Quality in Healthcare.

It also recommends that there is an ongoing planned evaluation strategy to properly determine the value of performance monitoring in healthcare delivery and funding.

# 3. RACGP response to the Committee's inquiry

## 3.1 Performance Authority's composition

The Performance Authority is to consist of a Chair, Deputy Chair and five other members (Section 70), one of whom must have substantial experience, or knowledge of, and significant standing in, regional and rural health care (Section 72).

If the Performance Authority will collect, analyse, and report on performance data derived from *primary health care organisations and other bodies that provide health care services* as stated in Section 60, it seems reasonable to expect that at least one member must have substantial experience, or knowledge of, and significant standing in, the primary health care sector. The RACGP believes that general practitioners as the medical specialists in primary healthcare, combined with 20 years of experience in similar organisations, are essential for clinical input and expertise.

### 3.2 Performance Authority's functions

Section 60 states that the Performance Authority's functions include monitoring and reporting on the performance of public and private hospitals, primary healthcare organisations, and other bodies that provide health care services. It is unclear to the RACGP as to whether the reference to *primary health care organisations and other bodies that provide health care services* includes general practice.

Clarity of this issue would assist in discussion regarding the exact scope of the Performance Authority's work in relation to general practice, and would subsequently assist organisations like the RACGP facilitate discussion around the associated issues, including proposals for any new requirements for general practice.

The College also believes that benchmarking functions should include all sectors involved in the delivery of healthcare, including both healthcare providers and funding bodies.

### 3.3 Performance monitoring

If the Performance Authority is to monitor the performance of general practices, reporting must not include onerous data collection and reporting requirements.

Onerous requirements on data collection will only place additional strain on an already stretched system, and ultimately subtract from the capacity of general practice to deliver patient services to their communities.

If there are additional requirements for data collections and reporting for general practices under the new arrangements, there must be sufficient resources allocated to meet these needs.

Additionally, there is little evidence to support many of the elements of performance reporting. This is primarily due to poor planning for evaluation of these initiatives, and failure to properly define what is 'successful' when evaluating the desired outcomes of a national performance authority.

The RACGP therefore recommends that there is an ongoing planned evaluation strategy - prior to the Performance Authority's 3-year strategic plan to the Minister - to properly determine the value of performance monitoring in this area.

### 3.4 Performance indicators

When formulating performance indicators, the Performance Authority must consult with relevant clinical experts, and health service administrators. It is vital that developed indicators are relevant, useful, evidence based, and linked to quality and safety improvement. Consulting with the relevant stakeholders will also avoid 'duplication' of data collection, which is unacceptable given the current workforce shortages.

The RACGP supports the inclusion of Section 60(3) which states that the Performance Authority may make use of performance indicators and standards, other than those it has formulated itself. Engagement of other organisations, like the RACGP which has undertaken significant work in the development of professional standards and indicators for general practice, will ensure that the Performance Authority builds on and strengthens existing frameworks and standards.

For example, the RACGP has been working closely with the profession to develop:

- accreditation standards for general practices in Australia
- software that allows for internal clinical audit and performance measurement for quality and safety improvement purposes
- national quality and safety standards for primary health care services in partnership with the Australian Commission on Safety and Quality in Health Care and other key stakeholders.

### 3.5 Performance reporting

Section 62 relates to the preparation of reports which show poor performance by primary health care organisations or other bodies that provide health care services.

Overall, the RACGP is of the view that performance reporting should not identify individual practices. Performance data should only be collected, analysed, and reported, at a regional level, for quality and safety improvement purposes, particularly if performance reporting is to include patient health outcomes.

Health outcomes in general practice are often dependent on factors that are beyond general practitioners control. Key contributing factors include patient population demographics, socio-economic status, level of education, health literacy, social-connectedness, lifestyle, cultural norms and expectations. For example, due to the socio-economic status of the populations, practices in Toorak VIC are likely to experience higher patient outcomes than practices in Sunshine VIC – despite both practices being classified as Remoteness Area 1 (i.e. major city).

Ultimately, general practices in areas of patient need, or alternatively with a high proportion of a particular patient demographic (e.g. high ratios of older patients or Aboriginal and Torres Strait Islander patients), should not be penalised for poor patient outcomes.

### 3.6 Independence

Despite the Performance Authority being referred to as an ‘independent body’, the extent of Ministerial control over the Performance Authority’s composition and its activities suggests otherwise. For example, it is understood that the Minister:

- will be responsible for appointing all Board members including the Chair (Section 72)
- may appoint persons to act as Chair and Deputy Chair or member during vacancies or when appointed members are absent (Section 74)
- may terminate a member’s appointment (Section 81)
- may make legislative instruments setting out the rules for the Performance Authority in monitoring performance and preparing and publishing reports (Section 65)

- may by legislative instruments give general directions to the Performance Authority in relation to the performance of its functions and the exercise of its powers (section 125).
- may give the Performance Authority guidelines on matters to be covered in the strategic plan, and matters that should be reported as affecting achievement of the Authority's objectives. (Section 112)
- may specify additional functions to those set-out in Section 60 for the Performance Authority

Given the above, it is difficult to see how the performance authority will be an 'independent body'.

Government policy changes often, frequently in response to short term goals. Basing performance indicators and processes on ministerial policy and directions will potentially result in a diluted and confused system, which in the long term will almost certainly harm the current high standard of medical services, and consequently health services, delivered to the community.

### 3.7 Advisory Committees

According to Section 105 the Performance Authority may establish committees to provide advice or assistance to the Authority in performing its functions. The RACGP supports this measure if opportunity exists for the establishment of general practice and primary healthcare advisory committees.

### 3.8 Strategic Planning

According to Section 109, the Performance Authority is to prepare and provide the Minister with a strategic plan covering the next three years, at least once every three years.

The RACGP is of the view that the Performance Authority's must consult with the profession when developing their strategic plans, and ensure that the finalised strategic plan is made publically available along with the other reportable activities stipulated in the legislation. Involvement of the profession and other key stakeholders will facilitate the development of robust strategic planning, and ensure the inclusion of clinical input.

### 3.9 Australian Commission on Safety and Quality in Healthcare

The College notes that there is a significant overlap between the roles and functions of the Performance Authority and the Australian Commission on Safety and Quality in Healthcare (ACSQHC), including:

- Advice to the Minister on safety, quality, and performance issues
- The formulation of performance indicators
- Collecting, analysing, and interpreting performance information
- Promoting, supporting, encouraging, conducting, and evaluating research
- Monitoring of quality, safety, and performance (Section 9 of the *National Health and Hospital Network Act 2011*)

Given the overlap between these two bodies, it is important that their respective roles, functions, and interaction be clarified in the legislation.