Toni Matulick,
Inquiry Secretary
Senate Community Affairs Legislation Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Ms Matulick,

Thank you for your invitation of 7 April 2011 requesting that I review the National Health Reform Amendment (National Health Performance Authority) Bill 2011. This Bill is for an Act to amend the National Health and Hospitals Network Act 2011 and for other purposes.

I hereby provide my submission to the Australian Senate Community Affairs Legislation Committee. My submission strongly supports the intent of the Bill and the work of the government in this very important area of health and regulatory reforms in Australia. I do however raise several issues relating to the legislation to enable greater alignment with the various commonwealth-State health agreements and the broader policy imperatives of the Government. Section 1 considers the sections of the legislation that may require revision. Section 1.4 considers the implications of my recommendations to COAG and other Senate Committees relating to risk adjustment to enable valid performance assessment. Further, translational research in Evidence Based Medicine through the establishment of State Centres is also considered in light of the Commonwealth-State Agreements in Section 2. A Cost Benefit Analysis (CBA) related to these recommendations has been undertaken indicating large national benefits.

1 National Health Reform Amendment (National Health Performance Authority) Bill 2011

1.1 Section 5: Definitions

New definitions such as performance indicators and standards could be included in the legislation. These terms are used in the legislation and should be defined. The National Health and Hospitals Reform Commission (NHHRC) provided an important framework and definitions for performance measurement in its Report on performance frameworks[1].

Recommendation

The NHHRC's framework and definitions be included in the legislation. Importantly the Reform Commission clarified the distinction between performance indicators, targets and performance benchmarks and provided examples of these terms. These terms are also used in recent Health Agreements related to the new proposed legislation. Such clarity could improve the legislation within an accountability framework.

1.2 Privacy Issues

Several sections of the proposed legislation refer to privacy issues, including disclosure to researchers at section 54J, disclosure with consent at 54K, and disclosure of publicly available information at 54L. Part 3.12 (Secrecy) includes reference to disclosure to certain agencies, bodies or personnel at section 120, disclosure to researchers including provisions mitigating identification of a particular patient at Section 121. Disclosure with consent at section 122 covers the disclosure of protected information relating to the affairs of a person if that person has consented and disclosure is in accordance with such consent. Section 123 covers disclosure of publicly available information and delegation is covered under 124.

[1] National Health and Hospitals Reform Commission (NHHRC) (2008) Beyond the Blame Game: Accountability and Performance Benchmarks for the next AHCA: A report from the National Health and Hospitals Reform Commissions. April, 2008.
http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/504AD1E61C23F15ECA2574430000E2B4/$File/BeyondTheBlameGame.pdf

Importantly, issues of the *protection of patient confidentiality* are further covered under Chapter 4, Section 128, specifying consent can take place if the patient is at least 18 years old or if the patient has died but is survived by a surviving partner who was the partner immediately before the death and was living with the partner immediately before he or she died. In addition a person can be authorized to give consent under the regulation. Section 129 specifies the concurrent operation of State and Territory laws.

The Privacy Act 1988 [2] includes all amendments until 13 April 2011 relating to education for overseas students legislation amendment Act 2011. Section 127 (personal information - reports) of the Bill makes reference to the Privacy Act 1988. That section applies to a report prepared or published by the Performance Authority where that report may include personal information and is authorized by law for the purposes of the Privacy Act 1988 if the disclosure or use is for the preparation or publication of the report. The new legislation could include more references to the Privacy Act 1988 for clarify and its linkages to the deliberations of the NHMRC.

Recommendation:

The intent of the legislation in Sections 54(J), 54(K), 54(L) and Sections 120, 121, 122, 123, 124, 127 128 and 129 and disclosure to researchers could be improved with linkage/reference in the Bill to the Privacy Act 1988. There are NHMRC's Privacy Guidelines relating to Section 95 [3] and 95A[4] of the Privacy Act 1988 which are under review for amendments to that Act. Further, there are provisions published by the NHMRC on Section 95AA (genetics only)[5]; The Australian Code for the Responsible Conduct of Research[6] and the National Statement[7] are also published by the NHMRC. Relevant aspects could be highlighted in the new legislation where appropriate. This is clarified below.

The legislation could be improved with greater clarify around the use and relevance of the Privacy Act 1988 for the privacy issues. Section 95 of the Privacy Act provides for the CEO of the NHMRC, with the approval of the Commissioner, to issue guidelines to protect privacy in the conduct of medical research. The Commissioner must be satisfied that the public interest in promotion of the research outweighs 'to a substantial degree' the public interest in maintaining adherence to Information Privacy Issues. Section 95A relates to Guidelines for National Privacy Principles (NPP) about health information. This section allows the Commissioner to approve for purposes of the NPPs, guidelines issued by the ***CEO of NHMRC or a prescribed authority***. This may relate to the use and disclosure of heath information for research or the compilation or analysis of statistics relevant to public health or public safety or the management, funding or monitoring of a health service. The 'public interest test' applies again in this instance. Section 95AA relates to guidelines for NPPs about genetic information.

The NPPs are outlined at Schedule 3 of the Privacy Act 1988. Clause 1 refers to collection provision. Clause 2 concerns use and disclosure. Clause 3 concerns data quality. Data security, openness, access and collection are covered in clauses 4, 5 and 6 respectively. Importantly, Clause 7 concerns identifiers. Anonymity, trans-border data flows and sensitive information are covered in clauses 8, 9 and 10.

The 'National Statement on Ethical Conduct of Human Research' consist of a series of Guidelines made in accordance with the NHMRC Act 1992 (NHMRC, 2007) 7. The 'Australian Code for the Responsible Conduct of Research' guides institutions and researchers in responsible research practice and promotes integrity in research for researchers (NHMRC, 2007) 6. NHMRC Guidelines approved under Section 95AA of the Privacy Act 1988 (Cth)5 are also insightful. The Privacy Legislation Amendment Act (2006) (Cth) makes changes to the Privacy Act 1988 (Cth) to allow health practitioners to disclose patient genetic information, whether or not they give consent under certain circumstances. This is reflected in additional exception to the National Privacy Principle (NPP)2 – NPP 2.1 (ea) which governs the use and disclosure of personal information in the private sector. The amendments do not oblige disclosure of information but provide the framework for this to occur under the appropriate circumstances.

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[2] Privacy Act 1988 Act No 119 of 1988 as amended. Prepared 13 April 2011 including amendments up to Act No 11 of 2011. http://www.comlaw.gov.au/Details/C2011C00179

[3] NHMRC (2000) Guidelines under section 95 of the Privacy Act 1988 http://www.nhmrc.gov.au/publications/synopses/e26syn.htm

[4] NHMRC (2001) Guidelines approved under section 95A of the Privacy Act 1988 http://www.nhmrc.gov.au/publications/synopses/e43syn.htm

[5] NHMRC, Office of the Privacy 'Commissioner (2009) Use and disclosure of genetic information to a patient's genetic relatives under section 95AA of the Privacy Act 1988 (Cth) http://www.nhmrc.gov.au/publications/synopses/e96syn.htm

[6] NHMRC (2007) Australian Code for the responsible conduct of research http://www.nhmrc.gov.au/publications/synopses/r39syn.htm

[7] NHMRC, Australian Research Council, Australian Vice Chancellors Committee (2007) National Statement on Ethical Conduct in Human Research http://www.nhmrc.gov.au/publications/synopses/e72syn.htm

The current *Senate Committee on Public Finance and Public Administration Committee Inquiry into the Exposure drafts to the Australian Privacy Amendments Legislation.* The Australian Privacy Principles – Exposure Draft aspects would be of interest[8].

Recommendation

Should there be changes impacting on health issues as a result of the abovementioned Senate Inquiry of the Public Finance and Public Administration Committee, then the results of that Inquiry should be integrated into the new Legislation. Further, the NHMRC would integrate any changes into their Guidelines on the various aspects of Privacy

1.3 Chapter 3 National Health Performance Authority

The Commonwealth and States signed the Heads of Agreement: National Health Reform[9], and the National Health Reform Agreement: National Partnership Agreement on Improving Public Hospital Services on 13 February, 2011 [9] The National Health Reform Agreement (NHRA) will be signed on 30 June 2011. References to the NHRA in the abovementioned National Partnership document is deemed to refer to the 'Heads of Agreement: National Health Reform'. These documents include provisions relevant to the Performance Authority and related legislation and they build on other Federal Financial Agreements including, *inter alia*, the National Health and Hospitals Network Agreement signed during 2010.

The Heads of Agreement: National Health Reform[9] make explicit reference to reforms in aged care, mental health and dental health at clauses 61, 62 and 63. This concerns growth funding and also federal responsibility for funding, policy, management and delivery for aged care. Further, these health sectors were discussed in the National Health and Hospitals Network Agreements 2010. It is unclear why explicit reference to these health sectors are not included in the legislation. Section 60 (1) (a) in the new proposed legislation specifies the following organizations that would be evaluated by the Performance Authority:

(i) Local hospitals networks
(ii) Public hospitals
(iii) Private hospitals
(iv) Primary health care organizations
(v) Other bodies or organizations that provide health care services

Recommendation

Amend the above part of the legislation as follows by adding new categories:

Delete the current (v) other bodies or organizations that provide health care services and replace with : (v) Aged Care, (vi) Mental health (vii) other bodies or organizations that provide health care services.

Specific reference is made to Medicare Locals in the Heads of Agreement – National Health Reforms in several clauses including inter alia, clauses 56 (a) (iii) where it states that "the National Performance Authority will transparently and publicly report on primary health services and outcomes in the local communities and regions of each Medicare Local, including on local demography, and health status, local services and health outcomes such as avoidable hospitalizations".

[8] http://www.aph.gov.au/Senate/committee/fapa_ctte/priv_exp_drafts/index.htm
[9] http://www.coag.gov.au/coag_meeting_outcomes/2011-02-13/index.cfm?CFID=94961&CFTOKEN=f9a7b665afcc1f94-BE1990AE-D1DA-6069-5FDDF8FD2F211F25

Recommendation

Whilst the legislation includes specific reference to "primary health care organizations" there may be value in referring to Medicare Locals as follows:

Insert in Section 60(1)(a) the following

(iv) primary health care organizations, including Medicare Locals.

If agreed this recommendation would serve to amend slightly the previous recommendation.

Subsection 60 (2). Hospital services in some states may also be provided in Hospital in the Home programs (eg in Victoria) and the proposed legislation capture services provided 'in a hospital'. I suggest this may be amended to include 'Hospital in the Home' or to clarify how these programs would be defined in the legislation. This program is part of the usual hospital services provided by Local Hospital Networks.

Subsection 60 (3) Makes reference to provisions of paragraph 60 (1) (c) which refers to the functions of the Performance Authority to formulate performance indicators. The legislation could provide further specification of the use of standards by the Performance Authority. *Would there by any circumstances where the Authority may have a role in the development of Standards?*

Section 61 of the proposed legislation makes provision for the Performance Authority to have regard to Intergovernmental Agreements and other instruments. The Heads of Agreements – National Health Reform makes reference to national standards at Clause 35, 36 and 37. Clause 38 links these standards to the four hour National Access Targets to reduce ED waiting times and the National Access Target and National Access Guarantee for Elective Surgery. A COAG Expert Panel will advise COAG on the implementation of the standards in the National Partnership at Clause 39. Clause 42 specifies that the NHPA will develop and produce reports on the performance of hospitals and health services. A clear framework for evaluation is referred to and further developed in the National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services. The legislation could be much more explicit about this performance framework. Part 2 of those Agreements refers to objectives, outcomes and outputs at clause 13, 14 and 15. Further, Performance benchmarks and reporting are clarified in clauses 19, 20 21 and 22 with cross reference to the schedules outlining specific performance indicators, performance benchmarks and performance reporting against national standards, performance indicators for national quality safety standards. Further, at clause 28 it makes clear that funding beyond 2013-14 and performance against the agreed outcomes and outputs will be considered in the context of the review of the Agreement in clause 48. Given this evaluation framework it would be preferable for the legislation to be more thorough in its coverage of these matters.

Recommendation: That you note the above requirement for much more explicit clarification of the evaluation framework for the NPA in the legislation given the provisions of relevant commonwealth-state agreements.

Sub-Section 72 (4) *Recommend explicit reference be made to indigenous health representation and suggest amendments as follows:* ***Amend paragraph 72 (4) (d)*** *to read as follows: "The provision of health care services in regional and rural areas* ***including indigenous health services****". (Addition is in bold) This will enable consistency with all Federal–State financing agreements which include indigenous health as an overarching top priority for Australian Governments.*

1.4 Performance evaluation: Ensuring validity and reliability

The legislation provides provision to determine 'poor performance' in Section 62 (1). National classification systems used for various sectors of the health industry should ensure adequate risk adjustment of the data. Risk adjustment enables greater precision of classifying patients according to clinical severity and will be essential in data analyses by the National Health Performance Authority to enable valid comparisons. Governments could consider use of recent USA classification systems by Ash and Ellis (2011) [10] for Primary Health Care organizations with

[10] Ash A, Ellis RP (2011) 'Risk Based Comprehensive Payment for the Patient Centred Medical Home: Building and Testing a partial capitation model' University of Massachusetts Medical School, Department of Economics Boston University, Verisk Health Inc. Boston University Working Paper.

possible application to 'Medicare Locals'. Their analyses uses the Versik Health/DxCG classification system. Australia has well developed hospital classification systems and risk adjustment mechanisms have already been considered in Victorian in the context of ABF [11] and the National Health and Hospitals Network Agreement (2010) includes an adjustment factor for risk adjustment called 'patient complexity, including aboriginality' which is excellent.

Recommendation

The legislation could make explicit reference to need for implementing valid mechanisms for ensuring risk adjustment of the data and classification systems. This can ensure validity and reliability of evaluations.

In my submission to a Senate Inquiry into the Planning Options for People Ageing with a Disability [12] I made reference to mechanisms to risk adjust analyses for aged care. Risk adjustment in Activity Based Funding and other areas in health enable funds to reflect health need[13] and has application across the continuum, including aged care services. Some variables that would be of relevance to aged care would include measures of *functional status/complexity*, such as the Barthel Index or Functional Independence Measure (FIM)[14] [15], with other key issues for consideration such as models of care, care setting, and application of clinical pathways, management plans or protocols[16]. Some classification systems include, inter alia, the Sub acute Ambulatory Classification (SACS), Casemix Rehabilitation Admitted Funding Tree (CRAFT)[17] Australian National Sub acute and Non acute patient (AN-SNAP)[18] and the Diagnostic Cost Group Hierarchical Condition Category (DCG-HCC)[19]. The *Frailty Adjuster for Program* of All-inclusive Care for the Elderly (PACE) for CMS-HCC would be of considerable interest. Some scales and indexes that could be useful to consider for the service needs, planning and also funding for the elderly with a disability could include the Charlson Index (Romano Adaptation), Charlson and Elixhauser co-morbidities, SF 36V Physical Component Score, SF 36V Mental Component Score, Diabetes Severity Index (DSI), Burden of Illness Score for Elderly Persons (BISEP) and the High Risk Diagnoses for Elderly Scale. The development of adequate risk adjustment could enable transparent financing to enable high quality standards and would be important in addressing information and market asymmetries through developing more accurate price signals. It would also assist in service planning and *evaluating performance*.

1.5 Interaction with other governance bodies

There is a lack of information about how the governance agencies will interact. There could be merit in an explicit mention in the legislation of the nature of the interaction to enable consistency in approaches to data collection, classification systems, risk adjustment mechanisms, and data sharing. This would involve the National Health Performance Authority, Australian Commission on Safety and Quality in Health Care and the Independent Hospital Pricing Authority. The legislation does not specify the data sharing pooling and analysis of the global data. This could be done by one of the governance bodies or independently by the Australian Institute of Health and Welfare. Resolution of the 'efficient price' of hospital services and the need to achieve quality standards should be addressed. This could be assisted by the proposed functions of the *State Centres of EBM, Health Services and Workforce Redesign*, and *International Centre for EBM and Health Economics* discussed in more detail below. The NHHRC raised the possibility of using score cards and/or league tables for analyzing and comparing performance. These

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[11] Antioch KM & Ellis RP et al (2007) "Risk adjustment Policy Options for Casemix Funding: International Lessons in Financing Reforms" *European Journal of Health Economics*. September. http://people.bu.edu/ellisrp/EllisPapers/2007_AntiochEllisGillett_EJHE_RiskAdj.pdf

[12] http://www.aph.gov.au/Senate/committee/clac_ctte/planning_options_people_ageing_with_disability_43/submissions/index.htm (Antioch KM submission 71).

[13] Antioch KM & Ellis RP et al (2007) "Risk adjustment Policy Options for Casemix Funding: International Lessons in Financing Reforms" *European Journal of Health Economics*. September. http://people.bu.edu/ellisrp/EllisPapers/2007_AntiochEllisGillett_EJHE_RiskAdj.pdf

[14] Granger, C et al (2007) "Modifications of the FIM instrument under the inpatient rehabilitation facility prospective payment system" *American Journal of Physical Medicine and Rehabilitation* 86 (11);883-82.Nov

[15] Mackintosh S (2009) "Functional Independence Measure" *Australian Journal of Physiotherapy* Vol 55 pg 65.

[16] Antioch KM, Jennings, G & Botti M et al (2002) "Integrating cost-effectiveness evidence into clinical practice guidelines in Australia for Acute Myocardial Infarction" *European Journal of Health Economics* 3:26-39

[17] Brook K et al (2007) "The effect of the introduction of a casemix based funding model of rehabilitation for severe stroke: an Australian experience. *Archives of Physical Medicine and Rehabilitation* 96(7):827-32, July

[18] Gordon R, Eager K and Currow D et al (2009) "Current funding and financing issues in the Australian hospice and palliative care sector" *Journal of Pain and Symptom Management* 38 (1): 66-74 July

[19] Pope G et al (2004) "Risk Adjustment of Medicare Capitation Payments using the CMS-HCC". *Health Care Financing Review* 25(4): 119-141.

instruments could be considered within the broader performance framework and could be reflected in the proposed legislation.

The relationship between the NHPA and the service providers to affect changes requires attention in the legislation. The proposed *State Centres of EBM, Health Services and Workforce Redesign* could assist by synthesizing data at the level of the health services, and also regionally and at State level. This could facilitate changes in performance at the local level.

1.6 Private hospitals

The legislation in section 62 refers to poor performance to private hospitals in 62 (1) (c). It is unclear how this will be managed. Currently private hospitals are accredited by the ACHS. Will the information compiled by the Performance Authority be shared with the ACHS? Will the Council share its information with the Performance Authority? Likewise the extent of data sharing with the State governments on private hospitals with the Performance Authority has not been specified in the legislation.

2. State Centres of EBM, Health Services and Workforce Redesign: Cost Benefit Analysis (CBA)

Work was undertaken at Bayside Health (now Alfred Health) over seven years to 2005 and, then at Western Health to 2007 on implementing EBM economic and clinical evidence and Clinical Practice Guidelines (CPGs) through clinical protocols, pathways and management plans. The approach was led by Dr Kathryn Antioch, using NHMRC and international methodologies, including The Netherlands [20] [21] Given evidence of improvements in quality and efficiency, the Australian Health Care and Hospitals Association sponsored presentations by Dr Antioch in all Australian States and Territories and New Zealand in the context of the renegotiations of the Australian Health Care Agreements (2008).[22] The key recommendation from stakeholders participating in the national presentations was to implement the EBM methodology nationally. In subsequent briefs to Council of Australian Governments (COAG) and other Federal and State stakeholders from 2008 to 2010, Dr Antioch recommended that the methodology could be implemented, with economies of scale, by establishing *State Centres of Evidence Based Medicine (EBM), Health Services and Workforce Redesign* and, for the 2010 COAG briefing, also by creating an *International Centre of EBM and Health Economics* [23] [24]

These recommendations, along with associated cost savings, were included in her submissions to four Federal Senate Committees undertaking parliamentary inquiries during 2010, which were published. [25] [26] [27] The Senate Community Affairs Legislation Committee inquiry into the National Health and Hospital Network (NHHN) Bill (2010) and the Senate Economics Legislation Committee inquiry into the Federal Financial Relations Amendments (NHHN) Bill 2010 published her submissions, showing estimated cost savings nationally and by State and Territory. They also cited some of her views on aspects of the government's reforms in their final reports [28] [29] The Senate Committee inquiring into the new NHHN (2010) Bill had invited Dr Antioch to review the legislation. ***The national annual cost savings associated with the reforms are $273.5m or $1,367.6m over five years***.

Recent work in Victoria has involved a Cost Benefit Analysis (CBA) and found that the costs of establishing a State-wide Centre within an existing hospital network[30] would result in **net** cost savings of $76.6m per annum or $383m over five years in Victoria. This is extremely cost effective. In addition to the functions of such Centres relating to EBM, health services and workforce redesign functions for the new national health reforms, they could also assist with updating stakeholders with evidence regarding emerging health issues of State and national public health significance. This could assist with the work of the NHMRC and the Australian Commission on Safety and Quality

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20 http://www.aph.gov.au/Senate/committee/economics_ctte/health_finance_10/submissions.htm (Antioch KM: submission 1)
21 http://www.aph.gov.au/Senate/committee/clac_ctte/Nat_hlth_hospital_network_43/submissions.htm (Antioch KM: submission 10)
22 http://www.aushealthcare.com.au/news/news_details.asp?nid=8754
23 http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/297-interim
24 http://www.aph.gov.au/senate/committee/fapa_ctte/coag_health_reforms/submissions.htm (Antioch KM: submission 20)
25 http://www.aph.gov.au/Senate/committee/clac_ctte/Nat_hlth_hospital_network_43/submissions.htm (Antioch KM: submission 10)
26 http://www.aph.gov.au/Senate/committee/clac_ctte/planning_options_people_ageing_with_disability_43/submissions/index.htm (Antioch KM submission 71).
27 http://www.aph.gov.au/Senate/committee/economics_ctte/health_finance_10/submissions.htm (Antioch KM: submission 1
28 http://www.aph.gov.au/Senate/committee/economics_ctte/health_finance_10/report/index.htm
29 http://www.aph.gov.au/senate/committee/clac_ctte/Nat_hlth_hospital_network_43/report/report.pdf
30 costs includes staffing costs, office equipment and other operating costs, with the use of existing office space,

in Health Care. Discussions with private hospital stakeholders have emphasized that the Centres could assist in this way, especially with regard to evidence relating to new health technologies available internationally and under consideration in Australia. Some health insurance funds have also called for the rapid dissemination of EBM material in the media.

In my recent work with some sectors of the health industry in Victoria, I have emphasized that the State Centre could be located at a Victorian Local Hospital Network (LHN), providing information to other LHNs, Medicare Locals, Aged care, community care, and Lead Clinical Groups across Victoria. Centre staff would have expertise in health economics, clinical evaluation, Evidence Based Medicine implementation, Information Technology, health administration and health services research. The creation of local quality instruments by organizations would facilitate the 'patient journey' across sectors. The organizations could collaborate with Centre staff to develop the localized quality instruments if required. Local ownership is central to the success of such initiatives. Victorian Centre staff could develop templates for clinical pathways, and management plans, with finalization by each organization given local conditions eg discharge planning opportunities and clinical staff availability. Centre staff could identify clinical Protocols from the best published CPGs and related evidence. The pathway and management plan template development and the protocol selection would be undertaken in consultation with specialty/'State wide referral' clinical staff from various LHN e.g. Cystic Fibrosis with Alfred Health and also the 'Lead Clinical Groups'. A 'bottom up' approach would be used to identify the key medical and surgical areas in each LHN, Medicare Local etc that require priority in the EBM process through identifying access, quality and efficiency issues. There will likely be similarities in priority medical and surgical areas between LHNs thereby achieving economies of scale in the EBM process Statewide.

The State Centre staff could assist LHNs, and other organizations to establish quality and efficiency performance evaluation systems relating to the use of the quality instruments to facilitate meeting the national health care performance reforms associated with the ACSQHC and the National Health Performance Authority on the outcome data. It could provide input into the deliberations of the Independent Pricing Authority about the 'quality and efficiency implications' of the 'efficient price by public hospital services'. The extent of linkage between the National Health Performance Authority, ACSQHC and Independent Hospital Pricing Authority would be subject to further consideration once the legislation is passed in the Parliament and details specified. The State Centre could facilitate the Victorian quality initiatives[31] in clinical risk management, incident management systems, clinical governance, infection control, accreditation, Victorian Quality Council, Consultation Councils, the transforming practice in Victorian hospitals program and the Cross Program initiatives. The cost associated with establishing the State-wide Centre at a Local Hospital Network is approx. $491,000 per annum. This includes $480,000 for four staff ($120,000 per staff); $8000 for office equipment (four computers and software), $3,000 stationary and photocopying and with use of existing office space. Given State-wide cost savings of $77,119,721, then the costs of $491,000 would result in net cost savings of $76,628,721. ***The proposed Centre is extremely cost effective. The net savings per annum is $76,628,721 or $383,143,605 over five years*** Applying these costs to the benefits calculated for other States and Territories then the Cost Benefit Analysis results showing net benefits across Australia are as follows:

Table 1: COST BENEFIT ANALYSIS

Hospital Savings by State/Territory (Annual and 5 years)[32]

Implementation of State/Territory Centres of Evidence Based Medicine, Health Services and Workforce Re-design

State	Annual Savings ($m)	5 Year Savings ($m)
NSW	85.3	426.5
Victoria	76.6	383.0
Qld	45.6	228.0
WA	26.0	130.0
SA	22.4	112.0
Tas	5.2	26.0
ACT	4.0	20.0
NT	4.5	22.5
National	269.6	1,348.0

31 Victorian Government Department of Health Victorian Health Services Policy and Funding Guidelines 2010-2011. http://www.health.vic.gov.au/pfg/statewide.htm

32 Net benefits shown in 2006 prices. The benefits are net of the per annum establishment and operational costs

This type of initiative could be funded under the provisions of the National Health Reform agreement – National Partnership Agreement on Improving Public Hospitals Services under Clause E13 (c) of Schedule E entitled "New Sub-acute Beds Guarantee Funding" which makes provision for project eligibility criteria purposes:

'co-ordination across relevant Australian Government and States and Territory programs and activities to ensure seamless and high quality patient care, including development and application of agreed nationally consistent performance measures, uptake and dissemination of relevant evidence based guidelines and Information Technology systems to improve the management of patient flows across the health care system'.

Recommendation

That you note the above issues and recommendations in the document. In my view the overall direction of the government in these reforms represents excellent Evidence Based Policy.

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Health Economics and Funding Reforms
Deputy Chair, Guidelines and Economists Network International (GENI)
Adjunct Senior Lecturer, Department of Epidemiology and Preventive Medicine Monash University
Board Member and Associate Editor, Cost Effectiveness and Resource Allocation Journal
9 May 2011.

Dr Antioch currently holds appointments to Government Expert Panels (Federal and State) relating to Activity Based Funding and Casemix Reforms. She led the risk adjustment reform of Activity Based Funding (ABF) in Victoria for the Victorian Government, applying performance and clinical evaluation data and worked in the Senior Management of Hospital Networks. She previously held two ministerial appointments, as the health economics member of 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. She was also an appointed member of the NHMRC's Privacy Working Committee and Lead Committee. She was previously appointed by the Victorian Governor in Council to a Victorian Health Practitioners Registration Board and worked on a Canadian Royal Commission on Health Care and Costs on hospital and aged care reforms. She has worked in Australian Federal and State Governments