Australian Institute for Primary Care & Ageing
Faculty of Health Sciences
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Committee Secretary
Senate Standing Committee on Finance and Public Administration
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Sir/Madam

Inquiry into the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011

Please accept the following submission to the Inquiry into the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011 ("the Bill"),[1] which will amend the *National Health Reform Act 2011* and establish the Independent Hospital Pricing Authority ("the Pricing Authority").

This submission will discuss the:

- Eligibility requirements for members (and acting members) of the Clinical Advisory Committee (Part 4.10); and
- Interaction of the Pricing Authority with the National Health Performance Authority ("the Performance Authority") and the Australian Commission on Safety and Quality in Health Care ("the Commission").

1. Clinical Advisory Committee: eligibility requirement for members and acting members

1.1. The Pricing Authority's Clinical Advisory Committee (CAC), established under Part 4.10, will provide specialist advice to the Pricing Authority on various matters.[2] To be eligible for appointment to the CAC, a person must be a clinician;[3] the same eligibility restriction applies to acting appointments.[4] The Explanatory Memorandum states that clinician input will be central to the development of the classification systems that the Pricing Authority will use.[5] Clinician input will be important in "ensuring that casemix classifications are clinically meaningful and will be accepted by the clinical community."[6]

1.2. The definition of "clinician" is found within the *National Health and Hospitals Network Act 2011* (Cth), which states that clinician "means an individual who provides diagnosis, or treatment, as a professional:

[1] For reasons of clarity, this submission will use the section numbers for the proposed amended version of *National Health Reform Act 2011*.
[2] *National Health Reform Act 2011* s 177
[3] *National Health Reform Act 2011* s 179(3).
[4] *National Health Reform Act 2011* s 181(3)
[5] National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011 Explanatory Memorandum, p 12.
[6] Ibid.

(a) medical practitioner; or (b) nurse; or (c) allied health practitioner; or (d) health practitioner not covered by paragraph (a), (b) or (c)."[7]

1.3. The Inquiry should consider whether the Bill will support the stated function of the CAC to advise on the classification of "services provided by public hospitals."[8] The rationale for narrowing eligibility to clinicians is obvious: to ensure that the CAC has the required clinical expertise to advise the Pricing Authority. However, the use of "clinician" in ss 179(3) and 181(3) does not sufficiently narrow eligibility in accordance with this rationale. As it currently stands, CAC membership would potentially be open to general practitioners and other community based health professionals, who would also meet the definition of "clinician." While these groups would have a contribution to make, they would not necessarily provide the level of expertise required of the CAC to execute its functions, particularly as they relate to advising on "services provided by public hospitals".[9]

1.4. This submission proposes that the Inquiry should recommend narrowing ss 179(3) and 181(3) in a way that ensures the expertise of the CAC. This would be achieved by redrafting these sections to incorporate requirements for:

a. *Registration*: CAC membership is open only to health professionals registered under the National Law.

b. *Practice*: irrespective of health professional type, a CAC member must have practice experience in public hospitals. Such a provision could be modelled on the existing legislative language in s 144(4), and specify that "substantial experience or knowledge" and "significant standing" in public hospital practice is required.

1.5. Arguably, the registration requirement is superfluous; in order to be a practitioner of "significant standing", the practitioner would (presumably) be registered. However, the Inquiry should consider including the registration requirement and using it to improve the legislation further by using to ensure that different types of health professionals with experience in public hospital practice are represented on the CAC. The registration requirement could be used to specify, for example, that there must be a minimum of one medical practitioner, one nurse, one pharmacist and one other allied health professional (e.g. podiatrist, psychologist). Inclusion of a "minimum core" of health professionals would ensure that the CAC possess the broad range of expertise necessary to support the Pricing Authority.

2. Integration with the Performance Authority and the Commission

2.1. As with the previous health reform amendments, there is very little integration between the statutory bodies. The only real legislative connection between the Pricing Authority, the Performance Authority and the Commission is found in the secrecy provisions of the Bill, enabling disclosure of protected information by the Pricing Authority to assist the other two statutory bodies.[10]

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[7] *National Health and Hospitals Network Act 2011* (Cth) s 5.
[8] *National Health Reform Act 2011* s 177(a).
[9] *National Health Reform Act 2011* s 177(a).
[10] *National Health Reform Act 2011* s 220(1).

2.2. The Bill would benefit from some requirement for the Pricing Authority to have regard for the work and output of both the Performance Authority and the Commission. As per clause B12(a) of the COAG agreement,[11] the determination of efficient prices must have regard for issues of access, clinical safety and quality efficiency and effectiveness and financial sustainability. The Performance Authority and Commission also have regard for these issues, and will be collecting substantial amounts of data (as appropriate to their remit).

2.3. As such, there is risk of duplication (or, in the case of quality and safety, even triplication) between the activities of the Pricing Authority, the Performance Authority and the Commission, and create a significant burden for health services who will be required to supply the three statutory bodies with data.

2.4. The current/proposed legislative scheme contains no real obligation for the three statutory bodies to work together towards the joint aim of improving the Australian health care system. While independence of these three statutory bodies is necessary, their isolation from each other is counter-productive. The Inquiry may wish to consider recommending an amendment to the Bill to establish a duty of cooperation between the three bodies.

2.5. Such an amendment would not be without precedent. The UK *Health and Social Care Act 2008* imposes a duty of cooperation in certain matters between the UK Care Quality Commission (CQC) and the Independent Regulator of NHS Foundation Trusts (known as "Monitor").[12] The Inquiry should consider the inclusion of a duty of cooperation to improve the coherence of the legislation and support the general aim of improving the Australian health care system.

Summary

The Inquiry should recommend amendments to the Bill to ensure that the CAC is appropriately constituted, and should consider imposing a positive duty of cooperation on the three statutory bodies to improve their integration.

Yours sincerely,

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[11] COAG National Health Reform Agreement (2011).
[12] *Health and Social Care Act 2008* (UK) s 70.