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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Reference: National Health and Hospitals Network Bill 2010

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Tuesday, 9 November 2010

Members: Senator Moore (Chair), Senator Siewert (Deputy Chair) and Senators Adams, Boyce, Carol Brown and Furner

Participating members: Senators Abetz, Back, Barnett, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Brandis, Bob Brown, Bushby, Cameron, Cash, Colbeck, Coonan, Cormann, Crossin, Eggleston, Faulkner, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Ian Macdonald, McEwen, McGauran, Marshall, Mason, Milne, Minchin, Nash, O'Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Stephens, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Boyce, Carol Brown, Feirravanti-Wells, Moore and Siewert

Terms of reference for the inquiry:

To inquire into and report on: National Health and Hospitals Network Bill 2010

WITNESSES

Committee met at 2.43 pm

WATSON, Dr Darryl, Treasurer, Royal Australian and New Zealand College of Psychiatrists

CHAIR (Senator Moore)—I declare open this public hearing of the Senate Community Affairs Legislation Committee, which is commencing its inquiry into the National Health and Hospitals Network Bill 2010. I welcome Dr Watson from the Royal Australian and New Zealand College of Psychiatrists. I understand that you have information on parliamentary privilege and the protection of witnesses. If you have any questions, the secretariat is here to help you. We have your submission; thank you very much. As always, the college provides information. I invite you to make an opening statement, and then we will go to questions.

Dr Watson—The Royal Australian and New Zealand College of Psychiatrists welcomes the opportunity to comment on the National Health and Hospitals Network Bill 2010. The college is a professional body that represents over 4,000 psychiatrists in Australia and New Zealand. The college sets the standards for psychiatry and trains and assesses against those standards. The college also advocates and works with other organisations for fair, equitable and assessable mental health services for all.

Mental health and wellbeing is central to all aspects of physical health care. The college has outlined its views on the National Health and Hospitals Network Agreement through previous submissions. Whilst the college recognises the interest and emphasis the agreement has placed on mental health, it remains concerned that implementation of health and hospital reform continues to neglect the needs of those with mental illness. Mental health funding and services must be integral to planning and reforming the health system. The college is committed to the delivery of quality mental health services that seek to improve safe practice and promote optimal outcomes for those receiving care. Commitment and leadership to changing practices and continued investment are essential to delivering high-quality care.

The college values the work of the commission with regard to patient safety and quality improvement of health care and looks forward to further engagement around standards and accreditation. The college believes there is a need for specific focus on the special needs of the safety and quality issues in the mental health sector. Closer engagement between the commission and mental health consumers and carers would improve the influence of the commission on practice in this sector. The provision of this focus is not covered by this bill.

Our submission to this inquiry focuses on the bill itself rather than on safety and quality in mental health services more generally. Comments have been limited to the content of the bill and how this can best be introduced to promote improved safety and quality in health care.

The college supports the establishment of the Australian Commission on Safety and Quality in Health Care as a statutory, permanent and independent authority as proposed through this bill. It is, however, suggested that the title and the object of the bill be revised to better reflect what is being considered under the bill and to distinguish it from the establishment of other bills that will be introduced under the National Health and Hospitals Network Agreement. The bill mentions consultation with the public in a number of clauses. We suggest that this is retained but that express mention of consumers and carers is also included. It is recommended that the bill make specific provision for the expertise of health consumers and carers and mental health professionals as part of the board of the commission. Such provision would be a significant step in ensuring that the activities of the commission reflect the needs of mental health consumers and carers. It would further assist the commission to better address the safety and quality needs in the mental health system. The bill must further ensure that the commission is working with other health practitioners. Collaborative provision of health care is very important in the mental health system. Specific inclusion of allied health and nursing in section 12(a) would avoid the risk of a narrow focus on medical and dental practitioners.

The college is encouraged to note that the second reading speech of this bill mentions mental health several times. We are hopeful that this bill will go some way towards addressing safety and quality care within the mental health services. Finally, I would like to express the appreciation of the college for the opportunity to address this hearing on what is an important issue in delivering quality and safeguarding high standards of care for all Australians.

Senator FIERRAVANTI-WELLS—You made the point that the title of the bill is not descriptive. I must say that, given the amount of legislation that is likely to be introduced as a consequence of this package of reforms, we will probably end up having more bills with that nomenclature, but I think it is a valid point. Regarding the establishment of the other bodies—the hospital pricing authority and the national performance

authority—are you basically saying that they should really be introduced as a package given the interaction between them?

Dr Watson—One of the inherent problems when you are talking about safety and quality is that there is a benefit in having separate independent authorities but in actual fact they need to mesh throughout the whole process. So there is a risk, when considering these things separately, that you reinforce the idea that safety and quality are addressed as a checklist or a tick box rather than being an integral part of services or, in this case, an integral part of reform and future planning. Obviously, that can be addressed in more than one way. By making that point in our submission we wanted to emphasise the idea of safety and quality being involved at all levels in what we are doing or what we are planning to do.

Senator FIERRAVANTI-WELLS—I do not know whether you are aware of the provisions. I think you have seen the agreement pursuant to which a lot of this has been established. Given the nature of that agreement—and I will not traverse on the various pros or cons of it—very much integrated into it is effectively the state control of the local hospital networks. I do not know what your understanding is but it is very clear from this agreement that the local hospital networks are supposed to be local but are not going to have local clinicians on them. Is that your understanding?

Dr Watson—My understanding is that there will be local governance and decision making through that process. As that pertains to safety and quality that is as it should be with central direction and agreement around standards with local input and implementation.

Senator FIERRAVANTI-WELLS—The difficulty is of course that pursuant to this agreement at page 14 it says that the clinical expertise on the local hospital networks will come from outside the network. In light of what you have said to me particular areas have particular needs. One would assume that in the question of quality, quality assessment and ensuring that quality services are delivered, surely, a local focus is better. What is your view in relation to that?

Dr Watson—A local focus is essential and clinical expertise is essential. We think that fellows of our college should be actively involved at those local levels. But it is perfectly reasonable to have national standards and national qualities.

Senator FIERRAVANTI-WELLS—I was going to come to that. I am not coming at it from that angle. With the national standards that are going to form part of this commission's purview, the issue that I have is that, given the entrenchment of the states' role in the health system through this agreement, what if the states do not want to accept those standards or in the day-to-day practice those standards are not adhered to? We have a problem and that problem is how you enforce those quality standards and ensure that those quality standards are met. Do you see the point that I am getting at? Because of the fact that the states are still in control, if they do not want to play ball, then how do we deal with that?

Dr Watson—The college's perspective is that we would continue our advocacy role both nationally and locally should a situation like that arise. We are well-placed to speak out on those issues should they arise. We think that part of the reason for having mental health professionals and fellows of the college actively involved is that we are very good at identifying where there is a breakdown in those systems and generally very good at speaking out and advocating about that. So whether a problem arises and how you monitor or penalise it is an issue for others. The college's perspective is that we, both as a group and as individuals, will be speaking out on instances such as the example you gave should they occur in the future.

Senator FIERRAVANTI-WELLS—The difficulty I have is that the parameters for enforcement at that local level do not appear to have been written into the agreement. You just used the example of allied mental health experts. Unless you have become aware of it in some other way, it is not clear to me how they are going to interact in this process, most especially at the local level.

Dr Watson—In delivering modern mental health services, an interdisciplinary model is the norm and needs to move ahead. We have taken the opportunity to emphasise in this single piece of legislation both that issue you are reflecting on and the larger reforms, so I am pleased that that point is being picked up in our discussion today. There needs to be that broader focus. There is an argument in any standards setting that by raising the bar and publishing those things—having a strong independent authority—it discourages people from creating a larger gap below that, as you are implying. But we agree with you that how that is enforced in a complicated health system is worthy of concern.

Senator FIERRAVANTI-WELLS—One of the concerns—and this has been raised by the mental health council—is that the bill does not refer to the sustained method for better accountability based on consumer

outcomes, and I think that ultimately accountability and consumer outcomes go hand in hand. What is your view in relation to that? I ask that because you argue that consumer groups—and not just the consumers but also their carers—should be more specified in the bill as having a greater role.

Dr Watson—In any reform aiming at improvement in health you are looking at improved outcomes. I agree with you that that should be a focus. Having consumers and carers at the table focuses the mind around those issues. Some of the measurable outcomes can be quite difficult in mental health compared to other specialties, but we do not see that we should be looking to be second best from that point of view; there should be outcomes. I think that the Commonwealth over a decade or two has been able to measure certain outcomes among jurisdictions and see evidence of differences arising there. Some of those differences are unhelpful and help to shine a light on those problems. Another way of emphasising that would be to have those people at the table and involved in the process, whether locally or—as we have argued—within the central authority.

Senator FIERRAVANTI-WELLS—Thank you. I have other questions, but other senators may have some too.

Senator BOYCE—You have made the point that your organisation and a number of others have suggested that the three bodies in this area should all proceed into legislation together. Why is that?

Dr Watson—I think there is a concern that when you look at the safety and quality in a narrow focus it is easy to tick the boxes, go through the checklist and conform with whatever the standard is, but it is much more complicated than that. If you were looking at safety and quality as part of the effectiveness of health care, you could look at performance and pricing as efficiency, and you need to balance those things. The other concern is that you could end up at a local level with an imbalance around some of those efficiency and effectiveness issues that need to be tied together. There are different ways of doing that, but I think that the discussion we are having today helps to shine a light on tying these things together and to create a bit of a focus around it and that it encourages people that it is an important thing to do. Safety and quality need to be embedded across that whole spectrum of reform.

Senator BOYCE—Health Minister Roxon, in the House of Representatives on 27 October, said that the bills for the independent hospital pricing authority and the national performance authority would come into the House of Reps early next year. Is there any reason why this bill should not also be delayed so that the three can be dealt with together? Is there urgency about the formalising of this commission?

Dr Watson—We are very comfortable with the work of the commission to date. We are very supportive of what they have done in the past and what they are doing currently. We want that to be permanent. But in answer to your question, will being permanent make any difference to the good work they are doing today in that time frame, I do not see any evidence for that. So as long as the commission continues, as long as there is a commitment for its permanence and its retained independence, we are very supportive of that. We think there is also some benefit in tying the legislation together.

Senator BOYCE—Apart from the reasons you put about the different pressures and the different priorities that could emerge if they are not together, I presume there is also the potential for gaps in supervisory areas. The legislation does not require that hospitals take up the safety in care standards as mandatory. It is voluntary as I understand it.

Dr Watson—I am not sure.

Senator BOYCE—I believe that is the case from the legislation. Would you have any concerns about that?

Dr Watson—I think one needs to be careful in what is mandated. In terms of setting standards there is an argument for raising the bar or being aspirational around that. If you say every standard has to be met every day immediately it is brought in, that goes against the idea of an improving pathway within health care so there is a balance. I think what you are talking about are minimum standards, and within that I think accreditation processes at local levels cover the concept of minimum standards. So if you have an accredited health service, they have met the minimum standards for that. There is an argument that a central commission is about, in part—

Senator BOYCE—It would be an improvement, one would think.

Dr Watson—extending those things over time. I think there is a good argument in our sector that the minimum standards have increased over time, which we support, and the further increase in those things over time we support as well. So where you draw the line on mandated at any point in time, it is probably best left

for the accreditation process recognising that that is working hand in hand with this strengthening and improving pathway against these standard improvements.

Senator BOYCE—The minister also makes the point that one in 30 Australian adults contracted infection in hospital, 12,000 have a severe hospital-acquired bloodstream infection and a quarter of those patients will die. Approximately double the number of patients die from hospital acquired infections than from deaths on our roads. Is making the commission permanent in the next month or two going to affect those statistics in any way?

Dr Watson—Not that I am aware, and that reflects the point that I have already made—that is, we think the commission is doing excellent work at present. So as long as there is the continuity of the provision of that excellent work, I do not see there is a compelling argument for it being implemented today versus next month or the month after.

Senator SIEWERT—I want to go to the issue that you raised about community and consumer engagement and flesh that out a bit more, because a number of submissions have raised it. How would you see that it could be better addressed?

Dr Watson—In many ways mental health services are leaders in terms of engagement and participation with consumers and carers. Within my own organisation, all of our committees now have input from the consumer and carer movement, which we embrace. The bill mentions the term 'the public'; we would expand that so that there is some mandated presence of consumers and carers. There are a number of reasons for that. All aspects of the health system seem to work better when they are sitting at the table with consumers and carers. There is something about that that focuses the mind; there is something that those people bring which is novel, creative and helpful around that path. It maybe that specifically noting the representation of that group is something that could be added to the bill, in addition to the notion of 'public'.

Senator SIEWERT—If I understood correctly your last comment to Senator Boyce, although you are saying that the authorities in the bill should be aligned you do not see why this one should not go ahead now. Do I understand that correctly?

Dr Watson—Our submission had a number of elements. First, in terms of the naming, there is some confusion—safety and quality are too important to be confused—and, secondly, having those key bills aligned would seem to give more benefit than having them apart. I think my answer was that as long as the good work of the commission is able to continue and we are not talking about years of delay, our preference would be that those things be aligned and we try to reduce the chance of there being cracks in the system or parts that are missed across those bills.

Senator BOYCE—Given that the minister said early next year, one assumes that is what she means.

CHAIR—Your opening statement raised one more point additional to your written submission, and that was about the engagement of people from the mental health industry in the actual process. I think that is a great idea. You have raised issues about ensuring that consumers and carers are identified, and I think other senators have mentioned that, but the one point that was not in your written submission was about people from your own particular area, with the knowledge you have of mental health in particular, being involved somewhere in the formal process. Have you given any thought to in what way?

Dr Watson—One of the problems of mental health is that you want to push that forward and then there are quite practical arguments about why it should not be treated specially—the number of members of a commission, who are already representative of a large range of things. The problem with that is that mental health never actually gets a seat on where it is going; it never becomes a focus from that point of view. Everyone says that this is important and we would like to do it, but we still do not achieve appropriate funding parity; we still do not necessarily get clear representation of interest within the commission. We think there are a number of ways that could be done. At the central level, the minister going to some pains to make sure that somebody on the commission would clearly satisfy the needs of the mental health community would be one step, but there are probably other ways it can happen between the central and the local to emphasise that. We have not given specific examples around that in our submission, but if it is something of interest in moving this bill forward we would be happy to provide further advice.

CHAIR—I think that would be very useful, Dr Watson, in terms of putting forward the concept. As you say, it is one of those things where you cannot ever find a body that truly picks up all the different groups. You have got to have people who can effectively represent. But your point about mental health is well made. So if your college has given thought to where—in the proliferation of structure that is going to occur as this whole

process evolves, well beyond this bill—and how that would be best done, I think that would be very useful for everybody.

Dr Watson—We will be happy to provide some further advice on options around that issue.

CHAIR—Thank you very much, and thank you to the college for presenting their submission, as always. Again, I apologise for the delay you had.

Dr Watson—Thank you.

CHAIR—We will now move to a revisit from the Consumers Health Forum of Australia.

[3.10 pm]

BENNETT, Ms Carol, Executive Director, Consumers Health Forum of Australia

WISE, Ms Anna, Senior Policy Manager, Consumers Health Forum of Australia

CHAIR—Welcome back. I know you have all the necessary documentation and information. We have your submission, thank you very much. If either of you would like to make an opening statement you may do so, and then we will go to questions.

Ms Bennett—Thank you. We appreciate the opportunity to be here this afternoon to talk to you about the National Health and Hospitals Network Bill. Consumers place a very high value on the safety and quality of their health care—that is a fundamental given. Access to safe, high-quality healthcare services is a priority for consumers, who are all too aware of the consequences when things go wrong in health care.

The National Health and Hospitals Network Bill, which provides for the establishment of the Australian Commission on Safety and Quality in Health Care as a permanent body, is a bill which has been welcomed by us. The passage of this bill through the House of Representatives we think was a very good thing. We believe that the commission's work has the potential to enhance safety and quality in the healthcare system, and consumers have welcomed—the people in our networks we have consulted with have welcomed—the recommendation by the National Health and Hospitals Reform Commission that the Australian Commission on Safety and Quality in Health Care should be made a permanent body.

However, our support is very conditional on that body delivering genuine improvements in the safety and quality of health care in Australia. That requires it to consult widely with those who use and pay for the system, and to ensure that they are drawing on their advice as a touchstone for any changes. We also require that it is enabled to take strong and necessary action on providers who do not comply with their standards and guidelines put into place.

As outlined in our submission, we have some serious concerns about the wording of the bill in its current form. In the interests of time, I will not outline all of these in detail because they are in our submission. Broadly speaking, our main concerns relate to, in particular, the need for specific reference to consumer engagement and identification of health consumers as a group that must be consulted as the commission undertakes its functions. We are concerned that the bill enables specific consultation with clinicians but not consumers. To simply state that the public must be involved in consultation is not good enough. We note that many other stakeholders have made this point in their submissions. Every study around the world has supported the involvement of consumers in health decision-making as a way of ensuring that you get health system improvements. Secondly, there is a need to clarify the commission's functions and whether they extend to include allied health professionals and allied health services. Finally, there is a need for greater clarity around how consumers will be represented and supported on the commission's board.

We have noted the argument in several submissions that legislation to establish the commission should be considered in conjunction with consideration of legislation to establish the National Performance Authority and the Independent Hospital Pricing Authority. Given the likely interrelationships between these three bodies, that is an approach that makes sense to us. CHF would not be opposed to this, particularly as the government's 'gold book', *A national health and hospitals network for Australia's future: delivering the reforms*—have we got a copy of that?

Ms Wise—No, I did not bring it.

Ms Bennett—Well, I am sure everyone knows it.

Senator FIERRAVANTI-WELLS—We were calling it something else!

Ms Bennett—That identified that legislation to establish the National Performance Authority and the Independent Hospital Pricing Authority will be introduced in the first quarter of 2011. It is already November, so we do not see any reason for that not to be taken into account and considered in conjunction.

I would like to make some general comments about the commission and its role. The commission, particularly with its new permanent status, will have the capacity to be a leader in driving safety and quality in health care. However, it appears to us from this bill that compliance with the standards and guidelines developed by the commission will remain voluntary. If we are to aim for the highest standards of safety and quality in health care, and if the commission is to drive this, some kind of incentive or sanction needs to be in place to encourage or enforce some kind of compliance. Otherwise, we run the risk of seeing a commission

developing high-quality standards and guidelines which have no value because they are not adopted by our health services. In that instance, it becomes an expensive and irrelevant body.

It is also essential for the commission to continue to work effectively with other standards bodies and to draw on what is already existing good practice. Consistency across healthcare standards and between different bodies will benefit all parties and strong working relationships need to be in place between different standards and accreditation bodies if this is to be achieved. The importance of consistency and coordination is also highlighted in the submission by AMSANT, the Aboriginal Medical Services Alliance Northern Territory, who have outlined some of the challenges faced by some healthcare organisations in needing to meet multiple sets of standards. We would not want a situation in which healthcare organisations are taking time and resources away from patient care to manage the complexities of proving compliance with multiple standards. As AMSANT have argued, national standards set by the safety and quality commission should not add to the complexity.

CHF welcome the introduction of this legislation to establish the commission but, as discussed in our submission, we have some serious concerns about the wording of the bill. As outlined today, we want to ensure that the work of the commission adds real value to improving safety and quality in health care. We accept that there may need to be a delay so that the legislation can be considered in conjunction with legislation for the establishment of other bodies. We look forward to working with the commission on an ongoing basis. Consumers will be the major beneficiaries of health services that are safer and/or higher quality, and they will suffer the most if the commission fails to deliver on its promise of improving the safety and quality of health care in Australia. We are confident that the newly formed permanent commission will recognise the centrality of consumers to its work.

CHAIR—Thank you. Ms Wise, do you wish to add anything?

Ms Wise—I have nothing to add.

CHAIR—Senator Siewert.

Senator SIEWERT—I know you were in the room when I asked the previous witness about how to fix the bill to include consumers and carers. Do you see that carers should be included? The recommendation made was that the public does not do it and we need to fix it there. Would you agree that if that was fixed that would ensure that consumers were adequately included?

Ms Wise—Our submission suggested three specific changes around consumer engagement: section 9 should include specific references to consumer engagement in the list of the commission's functions and sections 10 and 11 should specifically identify consumers as groups to be consulted.

Senator SIEWERT—Are you happy that those three changes would fix it?

Ms Wise—We would be much more comfortable with that.

Senator SIEWERT—Would you also include carers?

Ms Wise—We tend to include carers in our definition of consumers. For clarity, including carers would be quite appropriate.

Senator SIEWERT—I want to talk about enforcement versus voluntary. Have you raised these concerns with the government?

Ms Bennett—Yes.

Senator SIEWERT—And what was the feedback?

Ms Bennett—I suppose we have not yet been in a situation where the bill has been passed through the House of Representatives. Until now it has been a relatively temporary situation. We have certainly put forward the fact that we consider the compliance factor to be absolutely critical to the function and the robustness of the commission's work. I am not sure that we have necessarily heard in response how that will translate. There are a number of layers to all of this. There are the state governments and their role, there is the accreditation system and the different standards bodies, and they are all involved in this equation. I guess it remains to be seen—and the proof is in the pudding—in terms of ensuring that the commission is given some powers to provide that level of compliance or act on that level of compliance.

Senator SIEWERT—So you would see it as the role of the commission to then act on compliance, or would you see some sort of a mechanism under the health reform process to ensure compliance?

Ms Bennett—Ideally, if the commission is being charged with having national oversight for improving quality and safety in health care, then we would want it to have some teeth in terms of its powers in enforcing compliance with its guidelines and standards. Otherwise it is a guidelines and standards setting body that is not empowered to actually ensure that those changes occur.

Senator SIEWERT—I agree with you. I think there should be some ability to ensure compliance and I am just wondering whether there is another mechanism within the health and hospital reform process, maybe, that is envisaged could be used to do compliance and the standards setting body and some other process is linked into it. Have you looked at that or are you aware whether that is being considered?

Ms Wise—It will be interesting to see the national performance authority legislation and whether there is any provision in that.

Senator SIEWERT—As you have already raised and we discussed earlier, there are the other bodies as well and perhaps there is some link or some expectation that that is where compliance will be brought in.

Ms Bennett—I guess we want some clarification about exactly how that will work, and are urging that that happens.

Senator SIEWERT—Okay, I take your point.

Senator FIERRAVANTI-WELLS—I had a look at the agreement. I will not traverse the comments that you have made—and I have not seen subsection (3); we are just getting a copy of that—but the basically you are saying that you think clause 20(3) should be amended to make the clarification of consumers and carers a lot clearer in terms of not just participation on the board, but also the various other clauses amended to reflect that similar intention. Is that so?

Ms Bennett—Absolutely. Representation is one thing, as we have discussed before, but it is also about the way in which that translates to genuine engagement with the consumer.

Senator FIERRAVANTI-WELLS—In the time available I would like to take another aspect. Your point about mandatory and the set of standards is certainly well picked up given in particular that you are aware of the agreement and the terms of the agreement. What concerns me, and I would like your views on this, is that it is very clear from this agreement that the role of the states is well and truly entrenched even further here. The local hospital networks are established by the states and, indeed, when you look at the wording it actually says:

State governments, as system managers, will agree and adopt the Performance and Accountability Framework as outlined in Schedule D.

Then of course you go into schedule D and it sets up the new standards. My question is: if the states do not want to play ball, how are you going to improve care and quality at the coalface? That is really the crux of this.

Ms Bennett—That would be a disappointing outcome from our perspective. We would want to see that there is some kind of agreement struck between the Commonwealth and the states about how this will actually transpire and how it will work in practice.

Senator FIERRAVANTI-WELLS—Many of the issues that we see day to day in our state hospital systems are supposedly the basis on which we are now hearing a lot of talk about national standards, but if those standards are not enforceable in those states then what is the point of having the standards? We are back to square one. It is just hollow rhetoric.

Ms Wise—I think that comes back to our point about wanting some sort of mechanism that the commission has to enforce its standards or at least encourage compliance with its standards.

Senator FIERRAVANTI-WELLS—Yes. Otherwise we are just back to square one. When you see the development of these standards, obviously you would like to be involved as part of that.

Ms Bennett—Yes, absolutely. We would like to know that the commission considers consumers as its genuine client, because at the end of the day—

Senator FIERRAVANTI-WELLS—There are lots of people in hospital today. They are consumers of hospital services.

Ms Bennett—Absolutely, yes. The client is not just health providers and health professionals; the client is actually, at the end point, the consumer. Unless the commission sees the consumer as its client, it is hard to see how at the end of the day you will see a genuine improvement in the kind of safety and quality care that people receive.

Senator FIERRAVANTI-WELLS—If I understood your evidence earlier, you have raised these concerns with the government. What has been the response of the government?

Ms Bennett—We have always held the same position: that we believe that consumers must be involved and that at all levels of standard setting and guideline setting there needs to be some kind of assurance of compliance with those mechanisms. We are pleased that there is on the current body a consumer commissioner; I think that is a really welcome measure in terms of ensuring consumer representation. However, as we have discussed before, a single person is not the answer to ensuring that you are covering off all consumers, and it is limited. That is why we say there must be engagement at all levels of the commission's work.

Senator FIERRAVANTI-WELLS—I am conscious of the time. I have one last question. The Australian Council on Healthcare Standards in their submission—if you have had a look at that—basically say in a nutshell, if I understand their submission, 'We've got a set of standards and are suggesting that those standards be used as a base to build upon.' What sort of changes to those standards do you think should be effected to come up to the sort of level that you want? Also, I note that the Australian Institute for Primary Care has argued that the bill is not in keeping with international standards. How do you see the bill coming up to your standard and then the international standard?

Ms Bennett—In answer to your first question, there are a number of bodies—the ACHS is obviously one of the key bodies—who have already been working in this space and have already spent many years developing standards and guidelines and have also looked at engaging consumers, particularly in the mental health area, in assessing how those standards are applied. So it will be important, I think, to ensure that there is not duplication of effort between the ACHS and the commission in their work. There is certainly some value in the commission working closely with the ACHS around the work that it has already done in that area. We would like to think that they are drawing on the good elements of that work. So certainly I think there is scope to do that. On the second part of your question, around international standards and how this bill is not up to that level, I am not sure that I have enough expertise to be able to comment on that. I am not sure.

Senator BOYCE—I want to ask you about the voluntary aspects of the standards that the commission will have. Are you concerned by that?

Ms Bennett—Yes.

Senator BOYCE—What would your preference be?

Ms Bennett—At the point that you are setting standards and guidelines there must be some kind of measure that ensures that those standards and guidelines are not only being taken up but actually being used to improve quality and safety. I think there needs to be some kind of test applied to whatever standards and guidelines are developed, at the point that they are developed, to ensure that that happens. If they are voluntary then there is no assurance. Essentially, people can say, 'Tick, we've done that.' They can apply whatever criteria they feel are necessary rather than the criteria being independently set, including engagement with all stakeholders, and that includes consumers.

Senator BOYCE—My next question follows on from that and moves into the area of governance. The minister has said that this will be an independent and permanent body. Some members of this committee will know my concerns about some organisations, such as the National E-Health Transition Authority and the fact this parliament cannot query it in any way. This organisation is being set up in exactly the same way. It could, in effect, end up with the state directors and the federal director of health being the board of directors and their being required to issue an annual report and, obviously, in terms of corporate character to behave, but there is virtually no way of questioning their activity outside their annual report. What would your views be if that were how it transpired?

Ms Bennett—That would be a very disappointing outcome for Australia's health consumers because, at the end of the day, there is a huge amount of work to be done in the area of quality and safety. We are very optimistic that this body may be the one that could actually achieve some of those changes that are absolutely fundamental and necessary. That is why we are here and that is why we have put our submission to the committee. We see this as an opportunity to get this bill right in order to ensure that the commission is empowered to deliver on the potential that it has to improve quality and safety.

Senator BOYCE—Would it be useful if the bill required the minister to appoint, after consulting with the state ministers, a certain number of independent directors? At the moment, the only criterion is their expertise.

I am sure, if you wished to, you could argue that the secretaries of state health departments had that sort of expertise.

Ms Bennett—From our perspective, the level of expertise or the independence of the directors is less of an issue than ensuring that we specifically have some consumer representation at that governance level. One thing that concerned us about the wording of the bill is that, if you do not specify that there must be consumer expertise on the board, the chances are that you may get a doctor, a lawyer or some other member of the community who is there and who can technically represent consumer expertise but they actually do not engage with their community and do not have a good network at the ground level in terms of understanding consumer issues and, therefore, do not genuinely engage with or represent consumer issues.

Senator FIERRAVANTI-WELLS—What would be your suggestion? At the moment, I think you are referring to proposed section 20(2)(k). How would you reword that proposed section?

Ms Bennett—Have we suggested something?

Ms Wise—We have not suggested a rewording with regard to—

Senator FIERRAVANTI-WELLS—I am sorry, I missed that.

Senator BOYCE—It is further back, isn't it?

Ms Wise—Yes. It is proposed section 20. With regard to the board members, our concern is that there are 13 fields of expertise identified for inclusion on that board—and I note that many of the submissions said that we need other types of expertise on the board—but the board will include not more than nine members, plus the chair. Our concern is that a health professional, for example, which is one of the identified areas of expertise, may also say, 'I'm coming with consumer expertise.' In many cases, they are conflicting viewpoints.

Senator BOYCE—The retired doctor syndrome.

Ms Bennett—Yes. I guess we are specifically seeking consumer expertise on the board as a separate category of representation.

Senator BOYCE—A number of submitters have suggested that, before this becomes permanent and set in stone, the other standards and quality organisations, such as the pricing authority, should all come in together. The minister has said that the legislation for those will be introduced early next year. Do you see any problems in waiting to introduce this legislation with the other legislation?

Ms Bennett—No. In fact, given that it is already November and those bodies will be considered early in 2011, it makes good sense that some of those arrangements be clarified and those roles and responsibilities considered in conjunction.

CHAIR—Thank you very much.

[3.36 pm]

O'CONNOR, Ms Linda, Executive Director, Australian Council on Healthcare Standards

WOODRUFF, Associate Professor Peter, President, Australian Council on Healthcare Standards

CHAIR—Welcome. Would you like to comment on the capacity in which you have come to talk to us today?

Prof. Woodruff—I am also a member of the Queensland board of the Medical Board of Australia, which gives me a lot of interest in safety and quality issues as well.

CHAIR—Thank you very much for your submission. You have been given information on parliamentary and the protection of witnesses and evidence. I now invite you to make an opening statement before we go to questions.

Prof. Woodruff—Thank you. We are very supportive of a permanent commission and we seek to work collaboratively with such an entity. We have a strong record of achievement, which is well encapsulated in our submission, in relation to safety and quality issues. We seek reassurance that the wording of section 9(1) (e), (f) and (g) on page 6 does not in any way preclude our continued collaborative involvement. But perhaps of more critical importance is the structure and function of the Independent Hospital Pricing Authority and the National Performance Authority. We know that this is to be included in the bill, but we believe it is so important that it should be available for public scrutiny and debate prior to the passage of the bill. We have heard reference made this afternoon to what mechanisms there might be to lend teeth to compliance and observation of national standards. Of course, these are the two bodies that are going to do it and there are many ways in which it can be done. We have had experience in going about it in a fashion that produced considerable disquiet. I was an investigator in Bundaberg. When Dr Patel arrived there, the hospital was 92 weighted separations behind target. He worked prodigiously, achieved his targets and achieved a bonus of $750,000 in performance pay. But the downside to all this is well known. So I think that, with such an important bill—and we are all supportive of the commission as a durable entity—we must work out how the commission is going to have teeth, how performance is going to be measured and how compliance is going to be assured.

We are concerned that the current proposal as to the commission is that accreditation will have just 'met' or 'not met'. In our own accrediting process we have in addition 'partially met'. We believe that induces people who have had a deficiency identified to lift their game and try and work out what they have to do to improve their performance. We think this is lacking in the current binary system that the commission is proposing, which is more a 'tick box' certification exercise than a continuous quality improvement exercise. If I may, I will continue along these lines. When I was a director of vascular surgery at the Princess Alexandra Hospital, Minister Wendy Edmond was embarrassed by the number of long-wait category 1 cases appearing on the Gold Coast waiting list featuring on the front page of the *Courier-Mail* and she offered me $500,000 if I could remove 50 of those in six months. We managed to achieve that. But that exercise revealed to me the problems of double booking on waiting lists and also hidden waiting lists. All these issues and how they are going to tie into the pricing authority and the performance authority must be included with this major revamping of safety and quality. For instance, I am a renal transplant surgeon at the Princess Alexandra Hospital, one of the four hospitals with a 95 per cent or greater primary graft function at 12 months in the country. We were asked to establish a satellite transplant unit in Cairns. None of us would go there because we knew it would be professional suicide. We would go from being the top performers in the country to unfathomable depths.

CHAIR—Why?

Prof. Woodruff—Because (a) we would not have the full network and (b) we would be dealing with a very high risk group of Indigenous people and a transplant service would be predominantly directed towards caring for those people. Currently they are filtered and brought down to PA and get mixed with people from northern New South Wales and greater Queensland. How do you factor that into a performance model or a pricing model? There are a lot of these sorts of issues that are going to have to be considered in how we determine what teeth the commission will have—and it has got to have teeth—and they cannot be added as an afterthought. That is really the front end of the bill, I think, not the formation of the commission, which is a given.

If I could go on a league table of performance of the Australian Council on Healthcare Standards, which was inappropriately published, I believe, a few years ago, and alienated a significant tranche of the private

hospital society and we were not on speaking terms for some months. We have finally got that sorted out. This is a very vexed and difficult situation and the most important issues of this whole bill are: what teeth it is going to have—and it must have them—and how this is going to be administered and defined. So I think it would be inappropriate not to consider all that as part of this very important bill.

CHAIR—So why wouldn't it be able to be considered in a sequential way, which is obviously the process that the government is really putting up? There is no doubt about the need for it to be considered. You have made your point that it needs to be considered. What I am speaking about—and I am sorry to jump in from the chair and I do apologise—is that it needs to be considered, and there is no doubt about that, but why would it not be appropriate to actually go in a stepped way?

Prof. Woodruff—I think there are so many really critical issues there that I would not expect it necessarily to get simple passage. I think this issue could precipitate major debate. Just to take part of it without the teeth that is going to allow it to perform as an entity that is any improvement—in fact, without those teeth it will not be comparable in its capability to the ACHS. So it seems inappropriate to me to put it in place without actually having the very poignant debate about what teeth it is going to have, how they are going to be administered and—

CHAIR—I think it is about the timing of the debate, Professor.

Prof. Woodruff—I think that could be significant in this circumstance too.

CHAIR—Ms O'Connor, do you have anything to add?

Ms O'Connor—I have a brief comment. The Australian Council on Healthcare Standards was established in 1974 with the support of the federal government, which provided seed funding to ACHS at that time. In 1989, the federal government once again supported and provided funding for the establishment of the ACHS Clinical Indicator Program. Over the last 36 years, ACHS has extensively developed and implemented the areas outlined in part 2, clauses 9, 10 and 11 of the National Health and Hospitals Network Bill 2010. The commission function as outlined in the bill could be strongly supported by ACHS resources, which could form the foundation for many of the areas still needing to be developed by the commission.

ACHS seeks to ensure that the wording of the bill does not exclude the commission adopting ACHS standards, guidelines, clinical indicators, accreditation systems and processes. In addition, ACHS has well-developed IT infrastructure that could support the commission with data collection, analysis and reporting. Great benefit can be derived from minimising duplicated processes, building upon existing systems and working together to achieve higher levels of safety and quality in the provision of healthcare services.

CHAIR—Thank you, Ms O'Connor. That was establishing where your organisation comes from and your focus.

Ms O'Connor—That is right.

CHAIR—Professor Woodruff, the reason I was just checking then with the Secretary is that none of the issues you raised in your opening comments were in your written submission, such as issues to do with teeth, when things should be discussed and the debating process. It is really important to be there, but that is why I was a bit taken aback, because your written submission was entirely about how standards should be—

Prof. Woodruff—I do apologise for that. I was caught up in France with airline problems.

CHAIR—That is fine. It is just that we had your submission and I had studied it, then you raised new issues. I just wanted to see whether there was any reason for that.

Prof. Woodruff—I thought the written submission spoke for itself and I thought that this was an opportunity—

CHAIR—You enhanced it.

Prof. Woodruff—to enhance it.

Senator FIERRAVANTI-WELLS—Just looking at the ACHS's current role, is there any reason you could not undertake the functions that are required under the proposed bill?

Prof. Woodruff—The difficulty that is answered by the formation of the commission through this bill is that in the past we had the dilemma of being both the teacher and the policeman. Although we are a not-for-profit organisation, we relied on the voluntary participation of our members. We do have 1,400 members and we do fail a significant moiety, but the safety and quality agenda requires more teeth, and this proposal with the pricing authority and the performance authority is going to give it that. Therefore I think we are moving

on. But I also think it is a shame if the commission wastes too much of its time and effort on re-inventing the wheel, as it were.

We have been very effective. In fact, we are one of only four organisations that meet international accreditation from the International Society for Quality in Health Care. They are in Canada, the Netherlands, Jordan and Australia. So we have one of the four systems that are accredited internationally. Linda, did you elaborate on our exposure into Asia? We have a huge and expanding accreditation network extending through Hong Kong—

Senator BOYCE—Is that an export?

Prof. Woodruff—It is. It is a multimillion-dollar industry. It is by competitive tender, and we have won tenders. We are currently negotiating a tender in Bahrain, although I do not think we have actually won that one yet. I perhaps should not have mentioned that. But we have won the one in Hong Kong, which was worth millions of dollars. It is a big export industry where we have competed against the American accrediting authorities and won in competitive tender.

Senator FIERRAVANTI-WELLS—What do you make of the comment by the Australian Institute for Primary Care, who have argued that the bill is not in keeping with international standards? They state that comparable legislation in the UK is far more specific than the bill in targeting consultations with consumers, in particular. I know it was in relation to consumers, but generally do you think that the bill does meet international standards?

Prof. Woodruff—You have placed me in a very delicate position, because we do want to maintain a collaborative relationship.

Senator FIERRAVANTI-WELLS—I will take that as a 'no comment'.

Prof. Woodruff—They would not pass international accreditation as it currently is constituted, but it is formative, there is a learning curve and it will evolve and develop. But it has not yet reached the quality improvement capability or inducement standards of ACHS.

Senator FIERRAVANTI-WELLS—You said that you wanted amendments to clause 9. You say, if I understand correctly, that the standards, the guidelines and the indicators referred to in those subclauses relating to healthcare safety and quality matters should be a matter for public consultation before this bill becomes legislation. In other words, they are part of the bill. Is that what you are saying?

Prof. Woodruff—Yes. I was moved by the senator's comment in relation to the establishment of an entirely independent authority. I would just hate the wording of this bill to establish an authority that did not really have to engage people that have been working in this field with a good track record for decades. I do not think it necessarily does, but I share the concern that you expressed to the previous contributors.

Senator FIERRAVANTI-WELLS—You have obviously had the opportunity to have a look at the agreement. Are you aware, Professor Woodruff and Ms O'Connor, of the terms of the COAG agreement between the states and territories?

Prof. Woodruff—I have read it, but I would need to re-read it.

Senator FIERRAVANTI-WELLS—My concern—and I raised this earlier—is that, given the parameters of the agreement, which is very much still entrenching the states' role, the adoption of the provisions in schedule D relating to the performance and accountability framework within which this new commission comes into it are really then a matter for the states and, whilst the standards can be established, there are two hurdles, I think. One is that the standards are not mandatory; if you want to comply, you comply. Given the fact that the problems on quality which this commission is seeking to address are the very problems that the state hospital systems are now floundering under, how are we going to enforce any standards? There are two issues. One is that there is no enforcement. But, even if you did have enforcement, how are you going to enforce those standards within the parameters of an agreement that really puts the states in charge? If they do not want to play ball, how are you going to make them play ball?

Prof. Woodruff—One way of enforcing control is financial. That is what I mean with regard to the pricing authority. Obviously, there will be penalties or bonuses for compliance. I tried to illustrate how these are divvied out and on what basis. It is open to manipulation and anything other than safety and quality as the driving force. And that is the crux of the problem.

Senator FIERRAVANTI-WELLS—Of course another problem is now that the national funding authority has also been ditched—and it was ditched shortly after the agreement was signed—it leaves the pricing

authority as the only potential mechanism and we do not know what the parameters of that pricing authority will be.

Prof. Woodruff—I am one of those old retiring doctors!

Senator BOYCE—So your professor will not have to bear the—

Prof. Woodruff—No, but what I would like to say is that I think we have suddenly rediscovered, particularly in Queensland, following the Davies and Forster reports, that good clinical governance is the answer to safety and quality. In my own hospital we have David Theile AO as our executive director—a retired surgeon—and we have Richard Ashby AM as our executive director of medical services. Both have been presidents of their respective colleges of surgery and emergency medicine. I believe I work in the best hospital in the country. There should be more emphasis on clinical governance as the controlling entity of safety and quality.

Senator FIERRAVANTI-WELLS—Another concern I have about this framework, and it is all very well you have the national standards, but, on the ground, the standards that have to be implemented have to be implemented at the local hospital network level and that involves state entities. You spoke about clinical quality overview. Another problem we have is that the clinical expertise in these local hospital networks will not come from the local area; it will come externally to the local hospital network. My question to you is: how do you enforce good clinical quality, when that clinical oversight and clinical expertise will come from somewhere outside that hospital network? Isn't it better done if you have local clinical expertise, enforcing local clinical quality?

Prof. Woodruff—Exactly. I agree. That is the point of my reference to the clinical governance of my own hospital. One of the problems is that administrative data, particularly the ICD-10 coding system, is grossly inadequate for measuring outcomes. For instance, Patel was not an outlier on his ICD-10 profile. The research group at Flinders University, looking into standardised hospital mortality rates, has done a comparative study based on using administrative data and the more definitive technique of studying case notes—which is laborious, time consuming and expensive—and found that there is very little correlation between the two. But this new entity will have, as one of its guidelines or one of its measurables, standardised hospital mortality. These are the sorts of issues that really need to be debated by people who know what is going on before they are all set in stone.

Senator FIERRAVANTI-WELLS—Chair, I have a lot more questions but, in view of the time, I will leave it there.

Senator BOYCE—Was your organisation formally consulted about this legislation to establish the commission?

Prof. Woodruff—We have regular meetings. My chief executive and I meet with Professor Chris Baggoley and Bill Lawrence. We try to aim for a monthly meeting, but it usually turns out to be once every two months.

Senator BOYCE—Are they departmental?

Prof. Woodruff—They are the acting commissioner and his chief executive.

Senator BOYCE—Did you have any consultation with the minister's office or with the Department of Health and Ageing around how this legislation should look?

Prof. Woodruff—No, I do not believe so. I certainly have not.

Senator BOYCE—The organisation, as far as you are aware, did not. Was the consultation you are talking about with the commission around how the commission looked or simply about your commercial relationship, so to speak, with the commission?

Prof. Woodruff—It was about how we might work collaboratively not only for commercial reasons. They were also seeking advice. We have piloted some of their programs. I think we piloted three of them.

Ms O'Connor—Yes, we did.

Prof. Woodruff—There has been considerable feedback to the commission as a result of those pilots. We work together, but we are concerned that the proposed arrangement has not got sufficient emphasis on inducing continuous quality improvement. I do not want to put words in their mouths, but I think they have tried to simplify things because some people have complained to them that our process is a little unwieldy and a little more than necessary.

Senator BOYCE—What is your response to that critique of your processes?

Prof. Woodruff—I think it comes down to what you want as an end point. If you want a 'tick the box' exercise, a minimalist basic requirement, we offer more than that. If you want you can strive to get the best that our developers have put together. We started with assistance from the government in 1974 with efforts from the AMA and various colleges and we are made up of hospital administrators, consumers, medical officers and the Department of Health and Ageing. It is a very knowledgeable body.

Senator BOYCE—So, in fact, would a better structure from your perspective be for you to be the service provider and developer and for the commission to be the policeman?

Prof. Woodruff—That is my personal opinion, yes. It is widely shared by a lot of people. I am also an adviser to the commission and sit on one of their committees, but they know that those are my thoughts on that subject.

Senator BOYCE—We have to look too at not just the quality of the submissions but also the volume of opinion in particular areas. Again without putting words in people's mouths, could you perhaps just expand a little bit when you say that a lot of people agree with you in that area.

Prof. Woodruff—I cannot put a figure on it, but I know that at our board meeting and at our international meetings—and there has just been a meeting of the International Society for Quality in Health in Paris—

Senator FIERRAVANTI-WELLS—Is that the one that Minister Roxon attended?

Prof. Woodruff—No, she actually attended the OECD meeting.

Senator FIERRAVANTI-WELLS—I know that she gave a two-page speech there.

Prof. Woodruff—One of the attendees of that meeting who attended the society for quality meeting gave an account of how Minister Roxon performed as chair of the OECD meeting and was full of glowing praise.

Senator FIERRAVANTI-WELLS—I am sure there was a lot packed into those two pages.

Senator BOYCE—Perhaps you can take this on notice. I am not expecting you to put a huge amount of effort into this. We have to report soon, so this would have to be provided to us by Friday. If you could you perhaps ask associates and colleagues who support your view on this particular aspect of the bill to provide that information to us that would be useful.

Prof. Woodruff—Could you just define that information. Do you want to know exactly how broad the support is for what you might call basic plus?

Senator BOYCE—That the commission not deliver or develop services but simply police the delivery and development of them, so to speak.

Prof. Woodruff—And record results. We would be delighted.

Senator BOYCE—Could you flesh out for us the council's current relationship with the commission?

Prof. Woodruff—We are in constant dialogue, we contribute to each other's meetings. In fact, on my board, the ACHS, we have three committee members of the commission. I am one of those. And one of my board members is a commissioner. So there is a lot of cross-fertilisation and dialogue.

Senator BOYCE—So the commission would contract you to develop work or undertake work on their behalf?

Prof. Woodruff—We have offered that and they have not accepted that offer to date. They are building a considerable body to do this work themselves. They are doing it very well and very scientifically, but to date there is no evidence that that will actually produce any better outcomes than what we have already got to offer.

Senator BOYCE—One last question. We spent the morning today with the pharmaceuticals industry. Skin in the game was an issue that came up quite a lot. Can you tell me what the effect on the council would be if the commission were to become the body that established, developed and monitored standards nationally?

Prof. Woodruff—At the moment they have made it quite clear that they are not going to be an accrediting body, they are not going to do any accrediting, they are going to accredit the accreditors. They anticipate that there will be 12 applicants or players in the game. We will be the principal one, but I was at a subcommittee meeting of the commission last Friday at 1 Oxford Street and I think it is fair to say that that was pointed out to me, that there were 12 projected applicants for the accreditation program. Our concern is that we have enough trouble—we have 400 accredited surveyors and we have a challenge to produce interrelated reliability even in our own organisation. If there are 12 organisations all in the accrediting business and judging against met or not met using that as the criteria, we think it is going to be very difficult to report on performance of

various accredited authorities. It is easy enough to report on compliance but we have to go further than that, we have to report on performance.

Senator BOYCE—The idea is to get continuous improvement, one hopes.

Prof. Woodruff—Exactly, and we think that would be very difficult with the projected system that is coming forward.

CHAIR—Thank you very much for your appearance. We will now take a short break.

Proceedings suspended from 4.08 pm to 4.26 pm

LAVERTY, Mr Martin, Chief Executive Officer, Catholic Health Australia

CHAIR—Welcome to the representative of Catholic Health Australia. We have your submission. Please make your opening statement, then the senators can go to questions.

Mr Laverty—This bill is enabling legislation that is affirming a practice that is some years old. We are supporters of the commission; we are supporters of the work of the commission. The tabling of this legislation gives us an opportunity, as the representative of 54 private hospitals and 21 public hospitals around Australia, to commend Professor Chris Bagley and the chair, Bill Beerworth, for the work that the commission has done in the last few years. We are supporters of the draft National Safety and Quality Healthcare Standards that have been developed. We are also supporters of the wider work that the commission has undertaken in the last few years—its focus on the imperatives of safe clinical handover and its focus on the World Health Organisation's surgical checklist. These are illustrations of the good work of the commission. It is difficult to argue with the good work that the commission has done to date. To the extent that this bill is enabling that work to continue, we are supporters of it.

That is not to say that we would not like the opportunity to consider the structure of the legislation as it relates to the foreshadowed Independent Hospital Pricing Authority and National Performance Authority to be established by this bill. Section 9 of the bill lists the proposed functions of the commission. Again, we are supporters of those. The listing of those functions in section 9 points to the obvious challenge that this legislation is only going to reinforce.

We are going to give an illustration, an illustration of what it is to run a private hospital in Queensland. To run a private hospital in Queensland you have to comply with the accreditation arrangements of the Australian Council and Healthcare Standards. You have to comply with the Queensland Private Health Facilities Act of 1999—the mandatory licensing provisions. The private health insurance funds require demonstration of your compliance with accreditation and with law, and then, in addition, the Queensland Health Quality and Complaints Commission has certain mandatory reporting requirements. If I were to choose another state, I would run through the same list.

Our obvious disappointment is that the opportunity existed for some harmonisation around these matters and the bill has not achieved that. That should not be misinterpreted as us criticising or arguing against the passage of this bill as drafted. We recognise that the good work of the commission warrants certainty and its being created as a permanent independent body, but we foreshadow, in respect of the issues raised by previous speakers relating to the compliance function to be given to the new entities that are to be established by this legislation and further foreshadowed pieces of legislation, that we would be seeking harmonisation and indeed the removal of the duplication, the removal of the cost to the healthcare system, that exists through these multiple reporting frameworks that this legislation unfortunately is simply replicating.

We recognise that, as section 12 of the bill says, the commission can only perform its functions within the constraints of the Australian Constitution, so the bill as proposed is not seeking to go further and deal with the multiple layers of quality and safety reporting that exist in each of the states and territories. We are pragmatic and recognise that the bill is probably as good as it is going to get. But, for the future, this must be an opportunity to bring a national approach to how quality and safety is regulated and how it is complied with, and to ensure that we can remove layers of cost, arising from this duplication, from the operation of hospitals.

Previous submitters before me today have suggested that the governance arrangements of the legislation should give rise to representation of, say, consumers or of other specific bodies to be written into legislation. We would be supportive of consumers, in particular, receiving within the bill a guarantee that they might be represented on the board. But we would also point out the other obvious group that might be represented, and that is non-government providers of hospital services. The requirements for appointment to the board are recognising a broad range of skills, and we are supportive of that, but there is not necessarily a recognition that a majority of surgical procedures in Australia are performed in the private sector and that it would be appropriate that non-government representation be considered in the event that representation is to be given to consumers and potentially others.

They are the observations I would make, but in concluding those opening remarks I would point out that Catholic Health Australia is represented within the working of the commission to date. We are represented on the private hospital committee of the commission. We are also a councillor body of the Australian Council on Healthcare Standards. In both of those roles we are making the obvious observation that at a future time we

must be dealing with the opportunity to bring each of these different layers of reporting around quality and safety together for the benefit of consumers and also to ensure a more efficient and effective health care system.

CHAIR—Thank you. Can I just ask a question before I pass on, Mr Laverty. I did pick up in your submission that it was a process for continuing work—you see the issues that you have raised could be picked up in future legislation. So it is not a matter, as one of the previous submitters said, that everything should be done at once in terms of the process? I want to clarify those positions.

Mr Laverty—It would have been our preference to see within this bill the different bodies identified, but also through the Council of Australian Governments meeting of early this year to deal with the different quality of reporting frameworks that each of the states and territories are going to continue to operate. We are pragmatic and we recognise that to delay this bill any further is causing a loss of momentum for the commission as it currently works. For that reason alone we say that the commission is a valuable contribution to promoting continued improvement in quality and safety and we see no reason for further delay at this point. But we would certainly say, if the issue of compliance with standards is to be promoted, a necessary trade-off of that is going to need to be bringing national harmonisation. A national group like St Vincent's Health Australia or the St John of God Health Care group that operate public and private hospitals across state boundaries continue to be subjected to different reporting regimes, at cost, in each of the jurisdictions within which they work. That is not efficient healthcare.

CHAIR—Which this is designed to impact. You have raised these issues with the department?

Mr Laverty—We have raised these issues with the department; we have raised these issues with the commission; and, indeed, through our own participation in the Australian Council on Healthcare Standards. We recognise these multiple bodies—state, territory and Commonwealth—at a point in time need to address their areas of duplication. The one plea that we would make—which does not speak to the legislation; it speaks to how the commission performs its functions—is that there is not another layer of compliance or another layer of reporting created. But we have got to distinguish that from what is described in the bill. The bill is an enabler of the commission to become permanent. It is not necessarily the legislative trigger as currently drafted that is going to add another layer of reporting requirements; it is how the commission fulfils its functions.

CHAIR—That is the core issue for you, yes.

Senator FIERRAVANTI-WELLS—Mr Laverty, do I understand that you think that the three bodies we are talking about should be considered in legislation at the same time? Is that how I read what you say in your submission?

Mr Laverty—It is our preference.

Senator FIERRAVANTI-WELLS—Okay. Of course the legislation talks about quality assurance but does not talk about non-public hospitals. Just from memory I think it is about 40 per cent or 60 per cent of patients are in public hospitals—

Mr Laverty—Sixty per cent of surgical procedures in Australia are performed in private hospitals.

Senator FIERRAVANTI-WELLS—I knew I was pulling that figure from the top of my head. I guess the other issue is mandatory compliance and what is the point. As I read, in summary, what is the point of having standards if they are not going to be mandatory?

Mr Laverty—The real issue is that in each state and territory hospitals have licensing requirements. Where they are private hospitals, they must demonstrate an additional fulfilment of accreditation and compliance with law to those private health insurance funds. Overlaid are bodies such as healthcare complaints commissions that have their own reporting requirements. We argue not against transparency and a demonstration of quality; we argue against a multitude of those bodies and a multitude of those requirements. There is a dollar cost in having to report to each of these bodies. The establishment of this legislation, indeed the COAG reform agenda, was an opportunity to address that—an opportunity lost.

Senator FIERRAVANTI-WELLS—Absolutely, because it is very clear—you heard the questions I asked earlier—from the agreement with the states that in effect this agreement entrenches the role of the states in the hospital system. I will not traverse the local hospital networks and all that sort of thing. But the concern that we have here is that in any case any national standards that may be enforced will only be done so if the states agree that they will be done.

Mr Laverty—There are two issues. The first is that the drafting of the bill was an opportunity to address had there been state and territory agreement with the Commonwealth around the different licensing procedures and the different accreditation processes that are required under state law at present.

Senator FIERRAVANTI-WELLS—Mr Laverty, are you aware, through I suppose informal sources, or even formal sources, whether those issues were raised as part of the COAG process? In all of the various inquiries that we have had about the hospital reforms, I have not come across discussions in relation to state licensing trade-offs, if I can put it that way.

Mr Laverty—We have certainly raised with the Commonwealth and with the states and territories our desire to be no worse off with the establishment of this new commission's function to develop national standards. Our aspiration is that we do not create another layer of duplication. We have also been quite specific in our dealings with state, territory and Commonwealth health departments that the opportunity to bring a national harmonisation and to remove a layer of repetitive reporting is going to result in cheaper delivery of health care and it gives the opportunity to ensure that all Australians, no matter where they reside, are protected by a nationally agreed healthcare framework. That is not spoken to in the legislation at present.

We see no reason to oppose the bill in its current drafting because of that, but we express our disappointment that the Council of Australian Governments has not yet advance to that important work. And it perhaps has not because this is not a front-of-mind issue when it comes to some of the issues that dominate media reporting around our health system. These are the issues of clinicians, of health administrators; they need to become the issues of consumers. That is why we are very happy to say—earlier speakers' suggestions that there should be a role for consumers in this are very reasonable. But similarly, if you do not have non-government hospitals participating in the operation or the governance of the commission, again that might be another lost opportunity. So, if there were to be any amendments to this legislation that would speak to the proposed governance arrangements, recognising that provision has been made for representation of skill sets, it might also be wise to formalise a representation of different bodies with that background.

Senator FIERRAVANTI-WELLS—In other words, clause 20 not only would be amended, if I understand correctly what you say—the sort of skill set set out in paragraphs (a) to (m)—

Mr Laverty—Yes.

Senator FIERRAVANTI-WELLS—but also would specify that the body needs to include certain organisations. Do I understand correctly?

Mr Laverty—Absolutely, and we made the same argument when I appeared before this committee when it was examining Health Workforce Australia, and we did not achieve that outcome. I put it to you that Health Workforce Australia suffers from not having non-government representation at its governance level. This commission as well—noting our absolute support for its work to date. We are very pleased with the progress of the commission in its last four years and we see its quite broad work agenda as being a valuable contributor to improvement of quality in health care. However, as we seek to progress this agenda of removing the multitude of duplicative reporting requirements around Australia, if there is not NGO representation—indeed, if there is not consumer representation—you perhaps will not have that same focus.

Senator BOYCE—Can we just go back to the point that I have asked a number of people about. Minister Roxon, in responding to the second reading speeches on this bill, said that the ones for the pricing authority and the performance authority would be in the parliament early next year. Can this piece of legislation wait till then?

Mr Laverty—It could, but it need not either. You have heard me suggest that our preference would be to see all of the different components of this legislation together, but we have taken the government at face value, and we have had discussions with the government around—

Senator BOYCE—We do not often take the government at face value—

Mr Laverty—I understand, Senator; I have come from a different perspective on this matter. We have had discussions with the government and the department around ensuring, particularly in the establishment of the Independent Hospital Pricing Authority, that, in Australia, public hospital services are delivered by state and territory governments and Catholic services. We express loudly and clearly our invitation to contribute to how the independent pricing authority goes about its work. That is a major focus of non-government hospitals. So, whilst we say it would be preferable to see the legislative instrument for that at the same time that the commission's bill is debated, we do not necessarily say that this current bill should be delayed. I think there

are a set of issues around the establishment of the Independent Hospital Pricing Authority that are still to be worked through, and, if the government requires that extra time to do that, that extra time should be taken.

Senator BOYCE—Could you perhaps flesh out a little bit what CHA's—members is not the right term; I am just trying to think of what to call them—organisations have had in their relationship with the commission to date? What work has happened between CHA and the commission?

Mr Laverty—Catholic Health Australia is formally represented on the private hospital working group of the commission. Professor—

Senator BOYCE—What does the private hospital—sorry; continue.

Mr Laverty—The function of that private hospital committee is to ensure very specifically that the development of the draft standards has been shaped in such a way that they might have value to private hospitals around Australia. We have had the opportunity to review and comment on those draft standards—as an illustration of the commission's work—and we are quite comfortable that those draft standards add value to the promotion of quality and safety in hospitals around Australia.

Perhaps more importantly, Professor Bagley and his staff have been, at an informal level, very active with Catholic Health Australia and the CEOs of our hospitals. A week from today Professor Bagley will be speaking to us in, I think, this very room on the evolution of the draft national standards and how they are benefiting the delivery of non-government public and private hospital services. I think what the commission has done quite well is understanding the requirement for it to consult broadly with different parts of the healthcare community and being very aware of the many different bodies of accreditation—a speaker before me suggested there are 12 across Australia that might seek participation under the commission's new mandate—and seeking to the best that it can to avoid duplication. However, the commission in its construct is going to be limited because the Council of Australian Governments—and that is of all governments—have not yet dealt with the opportunity of harmonising the licensing and reporting requirements at each state and territory. This is perhaps more of an issue for non-government providers than it is for state health departments. A state health department that only operates hospitals within its state is not necessarily going to be focused—and I am not intending to criticise state departments—on bringing national harmonisation. The departments are not going to be focused on how to save money within hospital service delivery by having a nationally harmonised quality and safety framework. We see value in that framework. There is a consumer value in that you would have a more nationally transparent system whereby accountability can be demonstrated across the nation instead of on a state-by-state basis. It becomes more complicated in the uncertainty as to how local hospital networks are going to fulfil their functions within state boundaries. That is unclear to us. It will not be clear until LHNs in different states and territories start their work.

Senator BOYCE—Following on from that and on the governance of the commission, do you have any concerns about how the bill would structure it?

Mr Laverty—The bill provides for the representation of appropriate skillsets and we think that the list there is sufficient. We make the point, triggered by the discussion of my colleague Carol Bennett earlier today, that it would be appropriate for consumer representation within that governance structure. In the case of a review of the bill as to how governance is to be exercised, we point out that non-government health services—be they for-profit private hospitals or not-for-profit private hospitals—would quite rightly be represented within that environment as well. That would then necessarily trigger representation of other groups—colleges and other associations.

Senator BOYCE—So do you see this board as representational? I ask because that does not entirely seem to be the way that it is going.

Mr Laverty—As for the result of a board of directors, when this body becomes independent, not having in practice a broad representation, we think it would suffer from that. Now do not misinterpret what I am suggesting. I could only guess at the moment as to what decisions, if any, have been made about how the initial board or future boards could be comprised. The minister may have very well in hand the need for a broadly represented body when this board is established. We did make the case, in appearing before this committee in relation to its review of the Health Workforce Australia legislation, that ideally in the enabling act would be created the requirement for representation perhaps of consumers and of non-government hospitals and other areas. We think it is a lost opportunity that in relation to the HWA act that was not achieved.

Senator BOYCE—Just following up further on that, you have made the point that the states do not have the same incentive that the not-for-profits, the private sector, have to work for harmonisation. The structure of the board of this is that the federal minister appoints after consultation with the state ministers. Does that give you any concerns that with this states focus a national harmonisation is not quite so relevant and might be not as focused as you would like it to be?

Mr Laverty—The point is perhaps not about the composition of the board or the mechanism by which the board is established but rather of a lost opportunity of the COAG agreement not to tackle this issue.

Senator BOYCE—I am not sure it is a lost opportunity.

Mr Laverty—The bill is not the vehicle by which harmonisation of quality and safety regulation at state and territory level is to be addressed. I think we should separate out the purpose of the bill, which is to give permanency to the commission, to create a board of directors and to allow it to get on to its work. We say that should occur and the bill should be passed. If there were to be amendments, it might focus on ensuring that there was NGO and consumer representation. Other than that, the bill should be passed. However, we have lost the opportunity and in fact by the passage of the bill we are probably delaying for some time into the future reviewing how states, territories and the Commonwealth go about quality and safety reporting and compliance. That is the lost opportunity of COAG, not necessarily this particular legislation.

Senator BOYCE—I was suggesting that lost opportunity was rather a mild way of describing the potential costs way into the future of not getting that fixed within this reform.

Mr Laverty—There is cost, there is confusion and there is indeed wasted effort. We are very comfortable and in fact are promoting greater transparency around efficient pricing of hospital services and around the demonstration of quality outcomes. You will not have us opposing measures that achieve that, even measures such as the My Hospitals website. We have been happy that our public hospitals have mandatory reporting requirements under that that we have signed up to and our private hospitals are voluntarily signing up to that proposal, to demonstrate that we are very comfortable with this notion of transparency around the performance of our hospitals. We think that this bill and indeed this discussion has perhaps lost the opportunity to take the next step further so that we deal with the duplication of each of the different bodies—the accreditation bodies, the licensing bodies, the complaints commissions at state and territory level—to bring in a single quality and safety regime for the benefit of all consumers.

CHAIR—Thank you, Mr Laverton. I do not believe there are any questions on notice for you but we may have some. If you have anything further, just get it to us as quickly as you can.

Mr Laverty—Surely. Thank you for having me.

[4.54 pm]

BROADHEAD, Mr Peter, Acting First Assistant Secretary, Transition Office, Department of Health and Ageing

HEAD, Mr Graeme, Interim Chief Executive Officer, Health Reform Transition Office, Department of Health and Ageing

KINGDON, Ms Anne, Acting Assistant Secretary, Governance, Safety and Quality Branch, Regulatory Policy and Governance Division, Department of Health and Ageing

McDONALD, Ms Mary, First Assistant Secretary, Regulatory Policy and Governance Division, Department of Health and Ageing

MURNANE, Ms Mary, Deputy Secretary, Department of Health and Ageing

SOMI, Dr Masha, Assistant Secretary, Transition Office, Department of Health and Ageing

SPELDEWINDE, Mr Steven, Acting Assistant Director, Department of Health and Ageing

CHAIR—Welcome. Is there anything any of you would like to add about the capacity in which you appear today?

Mr Speldewinde—I am here as an observer.

CHAIR—Thank you. As departmental officers you will not be asked to give opinion on matters of policy, although this does not preclude questions asking for examples of policy, or factual questions about when and how policies were adopted. We have your submission. I sincerely hope you have been listening to the evidence, because the best thing to do is to actually get something on record and then to see whether we can work through some of the questions that they have had. Ms Murnane, do you have an opening comment?

Ms Murnane—I do.

CHAIR—Please go ahead.

Ms Murnane—First of all, Madam Chair and Senators, thank you for inviting us to appear at this inquiry into the National Health and Hospitals Network Bill 2010. This bill was passed by the House of Representatives on 27 October. The bill establishes the Australian Commission on Safety and Quality in Health Care as a permanent, independent body under the Commonwealth Authorities and Companies Act 1997, and it provides a framework for an expanded role for the commission from 1 July 2011. The expansion of the commission and its establishment as a permanent, independent body was agreed by the Council of Australian Governments in April 2010 as part of the reforms agreed in the National Health and Hospitals Network Agreement.

The reforms introduce fundamental and structural changes to Australia's health and hospitals system. The commission is one of three key governance bodies to be established under the reforms. This legislation establishes the commission as a permanent body and sets out the functions and governance arrangements for it.

It is intended that the legislation will be amended at a later date to include provisions to establish the other two governance bodies, the National Performance Authority and the Independent Hospital Pricing Authority. Safety and quality are key aspects of health reform. Data from the Australian Institute of Health and Welfare's report showed that 4.8 out of every 100 patients leaving an Australian hospital in 2007-08 had been exposed to an adverse event—a total of 382,000 patients.

The work of the commission is to reduce harm caused by preventable errors and reduce health costs resulting from unnecessary or ineffective treatment, and to have a positive impact on community trust. As an independent body, the commission will continue to build on its current work in the acute care sector and expand into other areas of health care. In addition, the commission will develop a nationally consistent set of clinical safety and quality standards, ensuring high-quality healthcare for all Australians.

The establishment of the commission as a permanent, independent body with an expanded role was recommended by the national health and hospitals reform council and was supported by an independent review of the commission's operations. The review recognised that the commission had made good progress in enhancing safety and quality. It noted that a new governance model for the commission is warranted, as the current arrangements, in which the commission is hosted by the Department of Health and Ageing, do not provide the independence and flexibility it requires to work within the jurisdictions and with private and non-

government sectors. The review also noted an imperative to ensure that many of the commission's current and future projects will be conducted over multiple years, and there is a need for assurance of business continuity through ongoing funding.

The commission in its current form will cease to exist from 30 June 2011. It is currently run out of the Department of Health and Ageing under the auspices of the Australian Health Ministers Conference. Under the bill the independent commission will be established from 1 July 2011. The bill to establish the commission is being introduced now to ensure that a board and a CEO can be appointed and business and operational arrangements, including staffing, can be put in place in time for the commission to smoothly transition from its current arrangements to an independent authority by 1 July next year. This will allow the governance and operational structures to be put in place without compromising its important work in improving safety and quality. It is anticipated that these arrangements will take six months to put in place. Establishing the commission as a permanent independent body will ensure that it has the appropriate governance and financial framework to progress its expanded work program and provide independent and trusted advice on safety and quality matters. The governance arrangements for the commission reflect the shared funding and policy interests of the Commonwealth and the states and territories.

CHAIR—Does anyone else have an opening statement? If not, I will go to questions from senators. There are a number of questions we have on specific things that other witnesses have said. We may well give you questions on notice today. We would need to have answers to them back by the end of the week.

Senator SIEWERT—I want to go to the issue of the timing of this bill. As you would be aware, a number of submissions and a number of our witnesses today have raised the issue of timing and this bill aligning with the other bills they are going to be putting in place—the other agencies/authorities. I am wondering why the three bills and the authorities were not established at the same time.

Ms Murnane—I will answer that question in two parts. Firstly, this bill was introduced and passed through the House of Representatives before the parliament was prorogued for the election, so it was proper to introduce it again. The reason that this bill has been introduced before the other bills are ready is that the commission is already an ongoing operation in some ways. Its governance must be changed and its overall status within government must be changed because there is no possibility of the current arrangements being extended beyond 30 June next year. As I said in the opening statement, there was a need to give us enough time to put in place a transition pathway for the commission as it is now but at the same time to enable it to do the work it is doing in developing standards, in developing indicators of those standards and in developing the work it has in relation to a model for accreditation of health organisations. If it did not have the assurance of being a permanent body with permanent funding, that is much harder to do. So that is the reason—to have this absolutely locked in, a part of the structure, so that the commission can go on doing what it has to do and we can provide the assistance needed so that it will become a permanent authority, ready to go, with new arrangements from 1 July 2011.

Senator BOYCE—Can I follow up on that. There have been a number of concerns raised about overlap or gaps and the centrality and importance of the pricing authority as well as the performance authority. The minister has said that she will be introducing legislation for those 'early next year'. Why don't you share those concerns?

Ms Murnane—My colleague Mr Head is the acting CMO of the transition authority and he will deal with issues around the other parts of the governance architecture.

Mr Head—The agreement as it currently stands spells out in some detail the quite specific roles of the three bodies. As Ms Murnane said, the commission's role is really changing the status of something that has been undertaking activity for some time.

Senator BOYCE—But the point is that the people who have made those submissions would have read that agreement. They would know what you have said already and yet they still put in submissions saying that they have concerns around 'the clarity on roles and responsibilities' between the three organisations.

Mr Head—As I indicated, the roles and responsibilities are set out in the agreement. There is a process in respect of the Independent Hospital Pricing Authority where interim terms of reference for that authority as set out in the agreement are yet to be confirmed. It may be that some of the concerns relate to that element. Those interim terms of reference are to be confirmed by COAG in line with the timing you have indicated for introducing legislation next year.

There have been a lot of briefings of stakeholders on various elements of reform both at a general level across the entire suite of reforms and also with specific stakeholders around key elements. So this issue, when it arises, is subject to that explanation. In my experience, people generally have been comfortable with the process that has been set out.

CHAIR—Mr Head, have the issues that Senator Boyce has raised been raised with you and your organisation before? Have any of the issues about confusion and uncertainty about roles that have been in some of the submissions and some of the evidence today been raised with your body before?

Mr Head—Certainly in the stakeholder consultations that I have been involved in that issue has not been a major focus of the questions. I could not rule out entirely that it has come up.

Senator FIERRAVANTI-WELLS—It is very clear from this agreement that, yes, there is the framework for these new national standards, which are voluntary. How are you going to be able to enforce quality when you have really got only a set of non-mandatory standards? Ms Murnane mentioned that 384 people have had some problem. They have had problems because the system is not working at the moment, and a lot of the problems that we hear about are about the state hospital systems. How are you going to improve quality when you will have a set of standards that do not have any teeth?

Ms Murnane—I will start and one of my colleagues, either Ms McDonald or Ms Kingdon, might come in. The functions of the commission are set out very clearly, very explicitly, in the bill. To summarise, but not completely: the core of those functions is to articulate standards and articulate indicators by which those standards can be measured. What is envisaged—and I think that we have every reason to expect that this will come to pass, given the agreements there have been on health and hospital reform—is that all of the states and territories will sign up to those standards.

Currently the commission runs. It has an independent chair and members that are selected from the states and territories. There is also an interjurisdictional commission that is chaired by a senior person from the Victorian Department of Health. I sit on that for the Commonwealth and I can tell you that there is a strong agreement across the Commonwealth and the states about national standards being articulated by the commission and about those standards being complied with.

Senator FIERRAVANTI-WELLS—That is all very well, Ms Murnane. You have set up this framework. We have quality problems in the state hospitals now, and this agreement enforces the role of the states. Whatever you may try to gloss and whatever you may try to put forward, it is very clear from this agreement that the states have the governing and controlling element of what they do. They have the control for local hospital networks and for all sorts of other mechanisms in this agreement. If I read literally what is written here, they will have overwhelming control of what is done in the hospital networks, which includes quality and quality assurance. So if the current state systems are not working, how are you going to assure the Australian public that these new standards, which are not mandatory, will work in the very system that they are now complaining about?

Ms Murnane—Senator, I draw your attention to part 2 section 9 of the bill, which starts in part 5—really, it is a cascade upwards of the functions of the commission. I draw your attention specifically to (j), which is line 16:

(j) to monitor the implementation and impact of:

(i) standards formulated under—

Senator FIERRAVANTI-WELLS—Yes, to monitor—but there is no enforcement. There are no provisions. If these standards that you are talking about are not adhered to, what enforcement process is there and what assurance does the Australian public have that, if standards are not met in public hospitals now, these standards are going to make things any better? You monitor standards now.

Ms Murnane—There is more than this, but I think that the availability of information is actually very powerful.

Senator FIERRAVANTI-WELLS—But you have information available now, Ms Murnane. You monitor and do all sorts of things now and there are problems. How will this bill give assurances to the Australian public who are complaining about the state hospital systems that quality will actually mean something other than just the usual spin?

Ms Murnane—This information that is the result of what they will collect from the hospital networks will be available, of course, not only to the Australian public and to various interested parties. It will also

specifically be available to the two other key governance structures in the architecture—that is, the National Performance Authority and the Independent Hospital Pricing Authority. At this stage we are not in a position to say exactly how that will work, but there will be a flow of information, including to the pricing and the performance authorities.

I run regulation for aged care. The starting point of any regulatory scheme is information. And while I am on regulation, under the arrangements and the functions of the commission is the responsibility to formulate model national schemes that provide for the accreditation of organisations that provide healthcare services and relate to health, safety and quality matters. It is a matter of not one lever but of bringing to bear of a number of levers. These model national accreditation schemes are another part of a quality system that will also report and will also generate information.

You are saying, 'Okay. We have the information. What will then happen?' We have the information. We have an agreement from the states and territories that these standards will be upheld. The states and territories already have a range of regulatory measures that they can use in relation to events in their hospitals, which they do use. Added to that now are the additional national agencies that can take a national perspective on this. Again, this information will be available to the pricing authority.

Senator FIERRAVANTI-WELLS—I hear all that, but the reality is that we do not know what the interaction is. Unless and until I see the legislation, I will wonder whether the fate of these authorities will follow that of their national funding authority—that they will be ditched—so we will just wait and see if they are still current. I will get back to the basic point: you are about to set up a set of standards that are not mandatory; they are voluntary. How is that actually going to change? We have problems in the hospital systems now. Are you telling me that the pricing authority is going to be used as a mechanism to withdraw funding from the states if they do not comply with standards?

Ms Murnane—I actually do not agree with you that the standards are voluntary.

Senator FIERRAVANTI-WELLS—That is what it says in the explanatory memorandum that I have been reading. In fact, would you like me to read it to you? It is specified in the legislation:

> The note to this clause refers to clause 57 which makes it clear that compliance with standards and guidelines formulated by the Commission is voluntary.

That is what it says in my explanatory memorandum.

Mr Broadhead—Perhaps I can assist. It is absolutely correct—

Senator FIERRAVANTI-WELLS—Is that wrong?

Mr Broadhead—No—

Senator FIERRAVANTI-WELLS—Is the minister wrong?

CHAIR—Senator, please let the officer answer. You have asked your questions. Mr Broadhead is trying to be clarifying. Is that right, Mr Broadhead?

Mr Broadhead—Yes, I am. You are absolutely correct that the legislation is not premised on enforcement. It is premised on the fact that one of the barriers or impediments to good practice is information, standards and guidelines. The absence of same, developed in the way that this legislation contemplates, is an impediment to safety and quality in health care. There are already a vast range of mechanisms for the regulation of medical practice, the registration of medical professions, the recognition of medical professionals to practice in hospitals and so on and so forth. But all those processes take place, in part, in the absence of a mechanism such as this to provide information on what are good standards or excellent standards of practice and care. This body is established to assist in that regard. It is not there to be the police, if you like, of medical practice; it is there to provide information that has been properly developed about what is good practice and good care in order to ensure safety and quality. A range of other mechanisms can draw on that, including the clinicians themselves and how they conduct themselves, what practices they follow and so on. But it is premised on the notion that one of the key areas where we could do better is in providing standard information on safety and quality guidelines and standards.

Senator FIERRAVANTI-WELLS—It talks about formulating standards, guidelines and indicators which are not defined in the legislation. I cannot see the definition of them. Time precludes us, but Professor Woodruff gave certain evidence and raised certain issues in relation to the potential role of the commission and the usage of the commission's work, and I wonder if you would take on notice and comment on his evidence. I will take you to the comments made by the Consumer Health Forum of Australia, the specification of the role

and the contribution of consumers and carers, and the changes and suggested amendment to clause 20 of the legislation. If you are talking about quality, the person who ultimately has to be satisfied is the consumer, in that broader definition of consumer and carer. What is their proposed role, not only in terms of formulating the various guidelines but their ongoing role in ensuring that those standards are met?

Ms Murnane—The commission currently has a practice of consulting widely with consumers in the development of standards and in the other work they do in the preparation of guidelines on infection, on hand hygiene. There is also a consumer representative on the commission and it is certainly envisaged that there will be a consumer representative on the board and that there will be wide consultation and dialogue with consumers about not only the standards but also the indicators and the reports that come back on compliance with the standards. I just want to draw your attention to subclause 57(1) of the bill. You talk about 'voluntary', but it is a particular form of voluntary because it does not prevent compliance with a standard formulated under paragraph 9(1)(e) or a guideline formulated under paragraph 9(1)(f) from being a term or condition of a grant or a contract or any other legally enforceable agreement.

Senator FIERRAVANTI-WELLS—Hence my question: does this mean you are going to use the pricing authority as basically the carrot and stick—if you do not comply with the standards, we will use the various funding mechanisms to make sure that you do. Given your comments earlier, is that what the intention is? In the absence of mandatory compliance, you are going to use other means of encouraging compliance?

Ms Murnane—I am saying there is a relationship across the governance architecture. My colleague Mr Head has been right in the middle of development of these other key parts of the architecture.

Mr Head—For the purposes of what we are discussing at the moment, the most significant linkage between the work of the commission and the other bodies set out in the National Health and Hospitals Network Agreement is with the National Performance Authority, and particularly in respect of the issue that you have raised, Senator, about the performance of hospitals. The relevant part of the agreement is schedule D to the agreement, the performance and accountability framework, which talks about, amongst other things, new hospital performance reports and healthy communities reports, which will be the responsibility of the new National Performance Authority, and specific mention is made of the fact that one of the things that will be reported in the hospital performance reports is performance against selected clinical quality and safety measures drawn from the quality and safety standards developed by the commission. So there is a linkage there.

Senator FIERRAVANTI-WELLS—I appreciate all that, and the agreement talks in terms of reporting, it talks in terms of monitoring, it talks about indicators, it talks about all that but it does not talk about enforcement; it does not talk about compliance and what are the repercussions if you do not comply with those standards. That is really the issue. I will put further questions on notice, but I really think that is the hole in the argument.

Senator BOYCE—There have been a number of submissions around your use of the term 'clinicians' in subclauses 10(2) and 11(2), suggesting that 'clinicians' could be misinterpreted as meaning only doctors and specialists. Is that your intention?

Mr Broadhead—No, my understanding of the word 'clinician' in common understanding is that it is anybody who lays hands on the patient, so to speak—although they do not literally have to do that!

Senator BOYCE—Organisations that are perhaps not involved in actually laying hands on patients but certainly working in that space are suggesting that the term 'clinician' should be defined and should be added into clause 5.

Senator SIEWERT—I think that the point there is that most people think of the doctors as the clinicians and not the allied health professionals, for example.

Senator BOYCE—Yes, but the general understanding is—

CHAIR—Mr Broadhead and Mr Head, surely that issue has been raised with you before. There is no way it has not.

Mr Broadhead—Perhaps I move in the wrong circles, but where I do move the common understanding of a clinician is somebody who deals with the patient in a clinical sense, not only somebody who is qualified as a doctor.

Senator BOYCE—Nevertheless, organisations that are stakeholders in this area have put in submissions saying that they are concerned that people will think you mean GPs and specialists. Could that please be examined.

Ms Murnane—If there were a misunderstanding about this—and I think these terms are understood fairly inclusively—then any other persons or bodies who in the commission's opinion are stakeholders in relation to the formulation, which leaves it open to almost everyone—

Senator BOYCE—But the point that these groups would make is that that leaves it open to the commission to decide rather than giving it to them as of right, which appears to have been the intention as Mr Broadhead and Mr Head have described it, if we are talking about allied professionals, nurses et cetera.

Mr Broadhead—I strongly believe that the term 'clinician' in this legislation means somebody who deals in a clinical way with a patient or another person, and therefore I think that, if the commission were to confine itself to talking only to doctors, it would find itself not honouring the spirit of the legislation. I can understand the concern—whenever everything is not spelt out to the nth degree, there is always room for interpretation that somehow it is not extending the territory as people think it is—but I do believe that in this instance it is talking about clinicians as broadly understood, not clinicians only as doctors. I think that the notion that clinicians are only doctors is something that has not had currency for quite some time.

CHAIR—Except in a number of submissions we have received and the evidence we have had today.

Mr Broadhead—I understand they are being cautious and careful, but I—

Senator BOYCE—Also, although you say 'to the nth degree', I think there have been only two or three suggestions around clarification of definitions, and this is probably the most mentioned of them. Is there a standard definition of 'clinician'? Does the Institute of Health and Welfare or some other group have a standard definition of 'clinician'?

Ms Murnane—I am not sure of that, but what I can say is that, in the consultations and discussions that the commission have had in respect of standards and other guidelines that they have developed, they have had wide discussion, certainly not limited to doctors, nurses and allied health professionals. The whole gamut of health workers has been included, as well as other people. I would not think that that is going to be interpreted very narrowly. I agree with my colleague Mr Broadhead on that.

Senator BOYCE—The other point where clarification has been sought is clause 12(a). A number of the submitters have been concerned that in 12(a) you say:

The Commission may perform its functions only:

(a) for purposes related to:

… … …

the provision of medical or dental services;

They are concerned that that could be somewhat narrowly interpreted to mean only services provided by a doctor. Does it include those provided by nursing and allied health professionals? Does 'medical' have a different—

Ms Murnane—Yes, 'medical' would. 'Medical' is provided by nurses and paramedics. There would be a range of services. Dental services are provided by hygienists. If you started to stipulate everything, you would be in danger of leaving something out. If you try to be exhaustive, the problem is that it is not going to be possible to be. I think there is a common and open meaning of those terms.

Senator BOYCE—Let's look at one, 'the provision of pharmaceutical sickness or hospital benefits'. Are you talking there simply about government benefits or about private benefits including, say, private health insurance as well?

Ms McDonald—These provisions relate to the constitutional powers of the Commonwealth and therefore they are described in the way in which the powers of the Commonwealth exist and so the commission can function in the same areas that the Commonwealth has powers.

Senator BOYCE—So this replicates wording elsewhere?

Ms McDonald—That is exactly right.

Mr Broadhead—It replicates wording in the Constitution.

Senator BOYCE—Could you advise on notice whether there is a standard definition used in Australia for the word 'clinician'. ABS or AIHW or someone must have one.

Ms Kingdon—In relation to the use of the word 'clinician', it was not defined on the basis that it would be useful in terms of future-proofing the legislation not to have an inclusive and an exhaustive definition. That allows the legislation to go on in perpetuity, and as the definition of clinician moves—

Senator BOYCE—As NRAS spreads, so to speak. Is that what you are talking about?

Ms Kingdon—As our definition of a clinician moves, it enables that to be encompassed.

Senator BOYCE—You used the term 'definition of a clinician'. I can imagine, if this is concerning people who are making submissions before the legislation comes in and you are telling me that you deliberately did it so that you can broaden the definition of a clinician when it suits—

Ms Kingdon—But that is not actually what I was saying. I was saying that the use of the word 'clinician' is based on its ordinary meaning. The ordinary meaning at this point in time includes allied health professionals—for example, psychologists, physiotherapists et cetera.

CHAIR—Ms Kingdon, what I think we are asking is: where is that definition?

Ms Kingdon—It is based upon the ordinary usage of the word.

CHAIR—I want to know where the ordinary usage is.

Senator BOYCE—A number of our submitters, who work in this field as well, apparently do not share your view on what the ordinary usage is.

CHAIR—I think, Ms Kingdon, we will have a number of questions on notice. One of them will be how you define 'ordinary use' in terms of legislation, because I think it is quite dangerous.

Mr Broadhead—We are happy to take that on notice.

Senator FIERRAVANTI-WELLS—How do you define 'medical expertise' in the hospital agreement? You keep using it, but there is no definition, and people want to know what that actually means.

CHAIR—We have a number of questions to put on notice. We have some here that we will be able to put on notice almost immediately. The other specific question that Senator Fierravanti-Wells raised—and I think it is really important because there were quite detailed questions—is that Professor Woodruff raised a number of quite specific issues. We will be seeking the Hansard transcript as quickly as possible and we would like a response to the issues he raised about duplication and about how organisations will work together into the future. There were a range of things he specified. I am not going to put specific questions on notice. I want a response to his questions. Is that clear?

Mr Head—Yes.

CHAIR—We will check. We will probably get these questions on notice out to you first thing tomorrow morning rather than tonight. I think that would be best. We need the answers by Friday. Thank you very much.

Committee adjourned at 5.34 pm