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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

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

(Public)

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Tuesday, 17 May 2011

Senators in attendance: Senators Adams, Boyce, Fierravanti-Wells, Moore and Siewert

Terms of reference for the inquiry:

To inquire into and report on:
National Health Reform Amendment (National Health Performance Authority) Bill 2011

WITNESSES

Committee met at 11:34

CHAIR (Senator Moore): We will now move to the Senate Community Affairs Legislation Committee inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011. The committee is due to report by 9 June 2011. We have received 16 submissions for this inquiry and these submissions have been authorised for publication and are available on our committee website.

I remind all witnesses giving evidence to the committee that we are all protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as contempt. It is also contempt to give false or misleading evidence to a committee.

We prefer all evidence to be given in public, but under the Senate's resolution witnesses have the right to request to be heard in private session. It is important that witnesses give the committee notice that they intend to ask for evidence to be taken in camera. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer may be given in camera. Such a request may, of course, also be made at any other time.

BENNETT, Ms Carol, Chief Executive Officer, Consumers Health Forum of Australia

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

[11:36]

CHAIR: Welcome back, as always, Ms Carol Bennett and Ms Anna Wise from the Consumers Health Forum of Australia. You would be interested to know that your submission was No. 1 to this committee. I am not sure whether that has happened before, but you should celebrate the fact! It could be an ongoing standing order for our committee: you only get heard in order of your submission!

I now invite you to make a short opening statement and then we will go to questions. This session is due to go until 12 o'clock, but we will play around with the time. Do you have an opening statement, Ms Bennett?

Ms Bennett: Yes, I do. Thank you, Senators; we really appreciate the opportunity to be here, and to expand on our submission to this inquiry.

The establishment of the National Health Performance Authority is something that the Consumers Health Forum of Australia have really welcomed. We anticipate that this should result in the introduction of rigorous performance measurement at a national level, driving health system quality and performance in Australia.

Our submissions, both to this inquiry and to the House of Representatives inquiry, have outlined CHF's concerns about the bill in its current form. In the interests of time, I will not revisit those issues. However, there are three key points that I would like to make today.

Firstly, we support the establishment of the performance authority. It has the potential to not just monitor service activity, which is really the nature of most performance statistics currently collected in Australia, but also to help drive real improvements in the quality of health care in Australia.

Secondly, what gets measured gets done. The nature of what is measured is critical to the performance authority achieving its potential. This bill must stipulate the broad areas of measurement that are to be addressed, or we may end up in a default position of a body that monitors activity indicators with no outcome measures and no documentation of consumers' experiences of care. That would be a real lost opportunity.

For instance, a 2008 World Health Organisation paper outlines seven broad areas of health performance measurement that, we argue, could be included in this bill. I will not go into the detail of these areas, but we argue that at the very least the performance authority should be required to incorporate actual measures of experiences of health consumers and real health outcomes. Inclusion of a list of broad performance areas could be included in the legislation and would add weight to the bill, without limiting the scope of the work of the performance authority.

My third key point is that there are no perfect measures. All indicators have strengths and weaknesses, including measures of consumer experience and health outcome measures. This is not a reason not to have measures or not to try to measure these areas. A key point that was made in the World Health Organisation's paper is that indicators should not focus merely on measuring what is available or easy to measure. Most service industries are able to develop some form of proxy measure for their customer experience, whether it is feedback measures on eBay, hotel room cleanliness questionnaires or measures of whether customers felt welcomed. We know that these indicators are not perfect measures and they all have flaws, but they all drive improved performance.

The current situation with regard to health system performance indicators in Australia is unacceptable. Measures of the patient experience of care, particularly on a national level, are very limited. The National Healthcare Agreement performance information for 2008-09 reports against the indicator 'patient satisfaction and experience', which measures nationally comparative information that indicates levels of patient satisfaction around key aspects of care they received. But there is nothing to report. The report states: 'A measure for this indicator is yet to be developed.'

More recently, we have had the pleasure to note the release of the Australian Bureau of Statistics patient experience survey, which we understand will be conducted annually. The 2009 survey includes primarily objective measures, so things like whether a person had delayed seeing their GP due to the cost, but also some subjective measures such as whether a person considers that the waiting time for a GP appointment is acceptable.

We look forward to the inclusion of further measures of what patients actually think about their health care in this survey, and we will certainly urge the new performance authority to create new measures to address the gaps in this area.

There are already effective models in use overseas. As one example, the Euro Health Consumer Index covers 38 consumer related healthcare performance indicators across 33 countries, including broad questions around access, as well as more specific measures such as involvement of patient organisations in decision making, consumer access to their own medical records and communication of test results directly to consumers.

Canada has recently started using this index. CHF has previously called for the implementation of this, or a similar index, in Australia. The establishment of the performance authority is an ideal time to do this.

I do not want to spend any more time critiquing the current situation. Suffice to say that the default position for measures in Australia should not be our current situation, with few measures of consumer experience or health outcomes. If not implemented properly, the performance authority risks becoming data rich and knowledge poor. As I have said, CHF strongly supports the performance authority, but only if it is required to collect real performance data and not become a repository of reports of health service activity. Thank you.

CHAIR: Ms Wise, do you have anything to add?

Ms Wise: No.

CHAIR: Senators, who would like to go first?

Senator BOYCE: I have only a few questions but they may take a little while to ask.

CHAIR: We will start with you, Senator Boyce, and then Senator Siewert might have some more.

Senator BOYCE: A number of the submissions have made the point that there would seem to be some sort of overlap between the performance authority, the safety and quality commission and other bodies. There has even been the suggestion that this body really does not need to exist and that the safety and quality commission could undertake the work that is being suggested here for the performance authority. What is your view on that?

Ms Bennett: I think that at the moment it is a real indictment that we do not have national measures that really do explore the experience that consumers receive with health care and that we do not explore real health outcomes. I think that this authority does have the potential to address that limitation.

There certainly are a number of reports and organisations that are in place that do cover some of this material that the performance authority might address, and certainly that needs to be clarified in terms of the roles and responsibilities. However, we do need a body that has the capacity to undertake this measurement at a national level and is able to do that appropriately.

Senator BOYCE: You do not believe the safety and quality commission could do that?

Ms Bennett: With the safety and quality commission, as you know—we have presented to you at previous Senate inquiries—we believe that there are limitations around the degree to which that authority can actually implement, measure and follow through on its recommendations and its standards.

We feel that a body that can provide some kind of national measurement and follow through on that national measurement is required. Whilst it can draw upon the work of other organisations, and should do that where it is appropriate and where it is suitable for purpose, we think that it will fill the gap that currently exists in terms of having access to national measurements that can really drive performance improvement.

Senator BOYCE: Once we have some national measures?

Ms Bennett: Yes.

Senator BOYCE: There has also been some concern about the perceived independence of this body, in that the minister makes most of the appointments et cetera. Could you comment on that from the forum's perspective?

Ms Bennett: We would certainly like to see this body have some independence. We would like to see the various stakeholders have some say in the appointment of the body and the people—the chair and the representatives that are on that group. We would expect that it will be able to follow through on its recommendations in a way that is not influenced by government or by particular stakeholders. So we would like to see that.

Senator BOYCE: Do you think that the current legislation allows that?

Ms Bennett: We felt that it was sufficient in doing that. I guess one of the limitations for us around the legislation was that there was not consumer representation on the board, and we felt that that could be a limitation. Particularly where stakeholders are vying for representatives to be sitting on the board, we feel that

there should also be a consumer representative. At the moment we would be interested in seeing how that evolves, but certainly we would expect that it would be independent.

Senator BOYCE: In your submission you comment around section 62. You were wanting to know if written comments would influence the final report that is released. Is your concern there that the responses will not be taken into account or will be given too much weight?

Ms Bennett: We are concerned that if poor performance occurs and that body or facility has the opportunity to talk with the performance authority directly, and that is not a public discussion and is not in the public domain, it may influence the report that eventually is made public. From our perspective, we see no reason why the performance of health organisations should not be made available to the public, and the public has a right to know. These organisations are funded by the public. The public has a right to expect that information about their performance is available in the public domain, and to make their choices and decisions around that information. We do not want to see a situation where those health facilities are influencing unduly the information that eventually is provided in the public domain.

Senator SIEWERT: I have several questions following on from both your comments and your written submission. We were just talking about consumer representation on the body, and I know you have said this a number of times to a number of bodies. I want to ask you about one of the other submissions which says that one of the areas that they think needs to have expertise on the body is Indigenous health, specifically somebody with expertise in Indigenous health. Would you support—

Senator BOYCE: In primary health care.

Senator SIEWERT: In primary health care, yes. Would you support somebody specifically with Indigenous health expertise being on the body?

Ms Bennett: I think that would be really valuable because, as we know, Indigenous health in this country is an indictment on Australia and our capacity to deliver quality health services and to improve health outcomes for Indigenous Australians. It is an important area and it is one that we need to measure and improve on. So, yes, I certainly think that Indigenous representation would be an advantage. I suppose the question is—and similarly with consumer representation generally—whether that representation occurs at the board level or whether it occurs at a strategic advisory level. I guess it depends on the nature of this organisation, the governance structures that are in place and the role of the board versus the influence of the strategic advisory committees that are formed around it. So, yes, it needs to happen. At what level depends on the governance arrangements.

Senator SIEWERT: The other area that I wanted to explore was the issue around primary health care and the issue around GPs. You touched on GPs a bit, and some of the other submissions do touch on the issues about Medicare Locals versus GPs. What is your opinion of the level that the authority should be going down to? Should it be looking at individual GPs or GP practices?

Ms Bennett: We would certainly like to see that level of detail because it is core to the experience of health care and the delivery of health care in Australia. Certainly, with the establishment of the Medicare Locals, there is an opportunity here to really look at how they perform and how they provide consumers with better information about quality performance so that they can make choices and decisions around their health care. So we would certainly expect that, at least at that service level, there would be some measurement.

I guess it depends on what the performance authority does, but certainly in the legislation we would like to see some more clarification about its purpose. The degree to which we drill down to the individual service provider level remains something of a question for us in this legislation. Obviously, we would appreciate more information that drills down as far as we can go in service delivery and provides consumers with better access to information on which they can make healthcare choices and decisions.

Senator SIEWERT: Okay, thank you.

CHAIR: In terms of the issues around consent—and we had this same issue with the quality and safety commission—you would like to see it amended in the same way as the quality and safety commission legislation was amended to 'informed'. It is fairly simple?

Ms Bennett: Yes. We really appreciate the fact that the quality and safety legislation was amended to include 'informed consent'. Obviously, where consumers' personal and private information is concerned, we want to know that people have actually been informed and have given their consent, not just that they have consented in one form or another. So that is quite important. We do not see any reason why that would not translate to this legislation.

Senator SIEWERT: Since we already have it in the previous legislation.

Ms Bennett: Yes.

Senator SIEWERT: It seems fairly simple—she says. In terms of your other recommendations, is there anything you want to add around section 60? We have touched on a bit of it, in terms of minimum scope of the areas to be assessed by the authority. We have touched a bit on the GP issues.

Ms Bennett: We are happy to provide some further detail around what we believe to be some of the areas that we think should be covered.

Senator SIEWERT: I know it would be helpful for me; I am presuming it would be for the rest of the committee as well. If you could, that would be very useful.

Ms Bennett: I am happy to.

Senator BOYCE: This is globally covering health care, I am presuming, not just specific areas.

Ms Bennett: The broad areas for performance measurement. If you take the World Health Organisation, there is a background paper—*Performance measurement for health system improvement: experiences, challenges and prospects*. It outlines, for instance, seven broad areas of health performance measurement that we would probably support as being outlined in this bill. They include things like population health, measures of data on the health of the population, individual health outcomes, measures of individuals' health status relative to the whole population or among groups, clinical quality and appropriateness of care, responsiveness of the health system—that is where you have the measurement of consumers' experiences of their own health care—equity and productivity. So I do not see any reason why, at the very least, some of these broad measures could not be included in the legislation to add weight to the bill. It does not limit the extent to which the performance authority would undertake measurement in other areas.

Senator SIEWERT: So you would put that in the legislation rather than as a disallowable instrument or something like that? You said it should be in the broad scope of the legislation, so that it is really clear from the outset?

Ms Bennett: Yes, absolutely. Obviously, we have no problem with the detail being outlined in the instruments of the bill. But there does need to be a purpose. Our concern is that, if the purpose is not established at the outset, there is too much potential for there not to be the capacity to address some of the critical areas, and for it to be a repository for data collection rather than a body that drives system performance and improvement.

Ms Wise: The risk adjustment is one of those things for which we already have measures, or which are easy to develop measures for, not the things we really need to measure.

Senator SIEWERT: I have one last question regarding the issues around allied health, which I personally think is a really important point. You would like it to be clear that allied health is included in the gamut of the performance authority?

Ms Wise: That is correct.

Ms Bennett: Absolutely. Allied health is a critical part of health service delivery. Particularly with the new health reform measures and the Medicare Locals, they are expected to include multi-disciplinary care, so it makes good sense that you would include that.

Senator SIEWERT: It needs to be clearly articulated in the legislation, is that—

Ms Bennett: Yes.

Senator ADAMS: I am sorry that I was absent when you started. Local hospital networks are something that, coming from a rural area and having a lot to do with health boards, I am very interested in. I would like to know how you see the local network board working for the more rural and remote areas of Australia.

Ms Bennett: I suppose in all of our representations on that issue we have suggested that there do need to be good links to the community through those hospital networks. We know that there is stipulated to be a community member on those boards. We would certainly expect that that would be a minimum, but also that those local hospital networks will connect more broadly, either through that representative or through other mechanisms with the broader community, and use that as a touchstone for identifying performance issues and responding to those issues. Obviously, some services do that well and others not so well. It is something that we would like to see become an integral part of providing health services in this country.

We also think it is really important that those local hospital networks are included in the role and function of the performance authority and are part of the scope and that, as part of that design, consumers' experience of health will be measured. Those local networks should also link with primary health care and other services. Part of the measurement we are seeking is how well integrated the service is for the consumer, at the end of the day.

That is a really key part of measuring performance of the health system: does the consumer have an experience that is smooth, that provides for their care in a way that does not inconvenience them, disadvantage them or make them more vulnerable than they already are at a time when they are not well?

Senator ADAMS: Are you aware of how many local hospital network boards there are going to be?

Ms Bennett: Roughly. It is a moveable feast.

Senator ADAMS: I know. I am asking the question for a reason. So you do not know?

Ms Bennett: We do not know the definitive answer to that.

Senator ADAMS: I am from Western Australia. The proposal there with the Western Australian Department of Health is that they will have two country boards to cover the whole of Western Australia. From a consumer's point of view, how would you see that person, your consumer rep, appointed, and just how far is this going to get to local communities?

Ms Bennett: I think that is a challenge but it is not an insurmountable one. One of the things that the Consumers Health Forum is doing specifically is training and supporting consumer representatives who may become members of those local hospital network boards or Medicare Local boards. It would be incumbent on that consumer representative to be able to link back into a network of consumer and community experiences and reflect those back at that board level. That is something that we will provide as a service, but there are other ways in which local hospital networks will appoint their boards. Some of them already have community and consumer representatives. The ways in which they connect with the community vary across the country. It is certainly a challenge where you have a large geographical area to cover, but it is something that, at least, is a challenge that is on the table that we are now addressing, and it is actually being formalised in the establishment of these bodies. It is something that we really welcome and want to see work.

Ms Wise: A point we have made consistently about both the Medicare Local boards and the local hospital network boards is that their consumer engagement and community engagement cannot be limited to a single representative. There have to be other mechanisms in place as well, whether those are surveys, broader groups of consumers which do have experience across the whole area of the local hospital network or Medicare Local or other mechanisms for engaging to find out what the issues are that are facing people on the ground.

Senator ADAMS: The word 'local' is causing huge problems in the area that I come from because people think that they are going to go back to their local hospital boards, as they had, or even their regional health service boards. Of course, it is not going to be like that at all. This is one of the things that really worries me with using the word 'local', and 'Medicare Locals' is the same. For example, in Western Australia, there are three divisions of general practice in the rural area are looking at joining together to have a Medicare Local. The expanse of that particular Medicare Local, with the area it would cover—where the three divisions of general practice have been operating—is absolutely huge. It is geographically not aligned, and I am very worried. I have a health background and I am very concerned about it—and with 'local', it is just not local. As consumers, how do you feel about it?

Ms Bennett: Obviously the challenge is to try to connect with the community as much as possible and through a range of mechanisms, not the single consumer rep. That offers one opportunity. I guess we need to really monitor this and see how it goes and look at ways that we can improve these services. So the performance authority may well offer us the opportunity to do that and to look at how some of these consumer and community engagement mechanisms are working or not, to provide the best information to the community that enables them to make decisions. That drives service improvements in those organisations. So I agree with you. It is a big challenge.

Senator FIERRAVANTI-WELLS: Ms Bennett, can you help me here. It is very clear—you have also raised this in your submission—you are very concerned about what will and will not be made public. I think that is a fundamental flaw of this authority in the first place. But from a consumer's perspective, what is this authority going to add to the day-to-day assessment that a consumer is going to make, given that there is this multitude of bureaucracies? I think we have gone through this with the quality. We do not know how they are going to interact. We have not seen the legislative framework in its totality. In effect, Ms Bennett, is this not just another bureaucracy that the consumer is going to be faced with, and what is actually its net benefit to the consumers, in light of some of the comments you have made in your submission?

Ms Bennett: It could be just another bureaucracy if it does not achieve what it needs to achieve. Really, what we are looking to see it do is provide national measures of performance that are measurable, that are publicly reported and that are acted on to achieve service system improvements so that consumers ultimately benefit. That is what we want to see. Some of these other organisations, the Australian Commission on Safety and Quality in Health Care, the Australian Council on Healthcare Standards, the Bureau of Statistics and the information they are

collecting, the Institute of Health and Welfare and so on are doing bits and pieces that contribute to the larger puzzle, but from our perspective the big omission is that we are not actually measuring national performance in the healthcare system. That is something that we really need to do. Other countries are doing it and doing it well.

Senator FIERRAVANTI-WELLS: That is the bottom line. The gist of this is the areas of performance. The measures and the enforceability of that performance are lacking. I have difficulty with the authority as a starting point but, if you are going to set up an authority, surely for it to have some teeth it has got to have—and you picked it up in your submission and others have as well—areas of performance? Where are they? How are you going to enforce them? More to the point, what is the mechanism if you do not meet that performance? Otherwise it is just another useless bureaucracy that has no teeth. You are nodding, Ms Bennett. That is it in a nutshell, is it not?

Ms Bennett: Yes. And we are concerned about the capacity for it to become a data repository and not something that drives service improvement. We have to get that right.

Senator FIERRAVANTI-WELLS: If you look at the original agreement, which I dusted off the shelf this morning, the interim arrangement we have is with AIHW. That material says that we should develop a website through AIHW. If it is only going to be a repository for information, we have plenty of repositories of information already. Why are we duplicating them and putting more money into another data repository?

The other question I was going to ask you about was the framework. Of course, the legislative instruments that the minister can specify are not going to be disallowable. So does not that in itself take away necessary parliamentary scrutiny of this legislation?

Ms Bennett: We want the information around this and the decisions around this organisation to be made as publicly available as possible. We have heard and we have read from the various submissions all the reasons why you cannot do various things—whether it be cost, inconvenience or another layer of statistics collection and all the implications that that might have for health service providers and health service organisations. From our perspective, we want to get past that. We do not want the vested interests to continue to provide reasons for why we should not be doing this. We need to be doing it. It needs to be publicly available, publicly reported and publicly acted on, and it should have the broadest possible input and be available as publicly as possible. All of the instruments—

Senator FIERRAVANTI-WELLS: And in the absence of proper measures, the point that you are making is that all we have got is a plethora of authorities, one doing one bit, one doing another, some doing three bits and overlapping. It is just a mire and the consumer in the end just shakes their head and says, 'Well, what has changed? It has just become more complicated.'

Ms Bennett: We want to drive change so that consumers actually receive the benefits, not just be an organisation that collects information that, really, the stakeholders want the organisation to collect. It is in their interest that that continues the status quo in the healthcare system in Australia, which does not actually indicate where we are performing well and where we are not.

Senator FIERRAVANTI-WELLS: But, Ms Bennett, the way it is drafted at the moment, it does not achieve those objectives. That does not seem to be the objective that it is achieving.

Ms Bennett: That is why we are suggesting some changes that we believe need to be in that legislation to enable it to achieve its objectives.

CHAIR: Thank you very much. Thank you to the Consumers Health Forum, as always.

MILLER, Ms Cydde, Policy and Networks Manager, Australian Healthcare and Hospitals Association

POWER, Ms Prue, Executive Director, Australian Healthcare and Hospitals Association

[12:05]

CHAIR: We welcome witnesses from the Australian Healthcare and Hospitals Association. Thank you very much. We have your submission, No 11. If you would care to make some opening statements you may and then we will go to questions. Ms Power, Ms Miller, do you have some opening comments?

Ms Power: Yes. First of all, in the context of the national health reform agenda, generally we support that and we welcome the opportunity to bring some reforms into the health sector. In particular, with the National Health Performance Authority and the performance and accountability framework that will govern the activities to a certain extent, or to a great extent, of that authority, we have some specific comments.

First of all, we do support the establishment of national bodies because we think that those national bodies will drive consistency of standards across Australia. We also support the opportunity for public reporting of outcomes. However, we have some caveats around public reporting, which we can come back to. In particular, though, it also drives the opportunity to actively report back to providers. We think that reporting back to providers about the outcomes of their care is a really good tool to improve performance. We have got some concerns that these standards, or these goals, may not be met. First of all, administrative data on how health services are delivered and counted, both between and within states and territories, needs to be standardised before it can be interpreted consistently.

CHAIR: It does seem like a good idea, Ms Power, does it not?

Ms Power: Very.

CHAIR: That is your No. 1 statement?

Ms Power: Yes. It is our No. 1 concern. That is before it can be interpreted nationally and used for other purposes, such as setting a national efficient price. Although we will not necessarily focus on the national efficient price today, it is very crucial to the success of the reforms. Currently there are significant differences which obstruct the national analysis and use.

The second point is that we need to be able to link patient-centric activity datasets between the Commonwealth Department of Health and Ageing, the Australian Institute of Health and Welfare and the new national bodies. This will be essential for the interpretation of service utilisation within and across sectors, states and territories. Without having a patient-linked dataset, we cannot really analyse the sorts of services they have received. If they are discharged from a hospital to a rehab centre, for instance, at the moment that will look like two different services, not the same service for the one person.

The third point is that there are significant challenges to setting health outcome indicators. These challenges need to be overcome to achieve national conformity, while also being sufficiently flexible to guide the continuous improvement at the service delivery interface. So performance should be measured, not only by quantifiable outcomes but also in terms of learning and improving, taking into account the views and feedback from the community.

I obviously am interested to learn that you have just been talking to the Consumers Health Forum. Preferably health services should have the capacity to put the service user first, with the flexibility to meet the local goals through continuous improvement. There is a danger that using easily quantifiable, visible performance measures that are top-down, such as emergency departments and elective surgery indicators, means the political risk will be managed and the providers will not concentrate on learning from the service delivery, which could create perverse incentives. In other words, although there need to be some top-down indicators, and we have them already, the indicators that actually measure performance at the service delivery level are really critical. They need to be flexible.

I will give you an example of the four-hour rule for ED departments. It is okay to have that sort of indicator to increase efficiency but, if it is not able to be flexibly applied at the service delivery level, then we will have patients who are admitted for short periods of time simply to abide by the rule rather than being able to overstay the four hours in ED to access some other service. It might be transport, for instance.

With that, perhaps I will quickly suggest an approach. We were concerned when this particular legislation was presented to the parliament that the states and territories had not been properly consulted. You will recall that in

the heads of agreement the states and territories are system managers. That has been agreed by all jurisdictions. I think that is an extremely important aspect of the reforms. While we have a Federation with states and territories as the majority funder, particularly of hospital services, we need to make sure that their interest is well and truly in the game. In fact, they also have the experience over very many decades of providing these sorts of services. They have more experience at providing services than the Commonwealth government. So it is important and critical that states and territories are consulted about all aspects of the national health reforms and that a consensus is reached. This is in the context of the legislation and the performance and accountability framework. I think that at that point, unless, Cydde, you can think of anything we should add—

Ms Miller: No.

Ms Power: We can talk about more detailed recommendations when we respond to your questions.

Senator FIERRAVANTI-WELLS: I think you followed on from some of the questions that I asked Ms Bennett. It is very clear from the legislation that there are deficiencies about areas of performance. As I said before, we have concerns about this authority. From our perspective, first of all, in the absence of clear areas of performance in the legislation and, more importantly, clear areas of enforceability, is this not just another piece of legislation that adds another layer of bureaucracy and is really not achieving what it says it should be achieving? I seem to read that criticism into your submission, Ms Power.

Ms Power: I think that it will be really critical to ensure that the new national bodies are integrated well with the existing ones. The roles for all the national bodies are well defined. At the moment we have the Australian Institute of Health and Welfare and the National Health Performance Authority that could overlap in roles if we are not careful. There is a role for both those entities. It may mean that the Australian Institute of Health and Welfare concentrates not only on collecting data, as it does now extremely well, but also on interpreting that data in the context of policy reform.

The National Health Performance Authority we see as exactly that, monitoring performance. I believe that it has a very critical role in reporting particularly underperformance but also good performance. We do not credit good performance well enough, I think, in our health system. The role in reporting underperformance is critical. However, we contend that the Commonwealth minister needs to consult with the state minister prior to any public reporting. It is a very difficult issue because if, through the performance authority, the Commonwealth minister discovered a health service was underperforming and this could have a potential impact on the health of the people that were being seen by that service in that area no minister would want to sit on that information for too long. However, it is critical that the state ministers are also included before there is any reporting. I think that the state ministers would also consider that this information is critical and needs to be acted on quickly. As long as there is no reporting before consulting with the states, that it is a very critical role of the performance authority. There is nothing like public reporting to ensure good performance.

The issue of actually assessing performance, though, is extremely important because sometimes poor performance might be a result of under-resourcing. It might have been the result of under-resourcing for quite a long time. We might find that, for those services that are in high socioeconomic areas, big tertiary hospitals actually have the capacity to perform very well all the time, whereas services in rural and remote regions have less capacity. They do have to accept patients perhaps sometimes with critical illnesses and injuries, even if they do not have a throughput such as the big metropolitan hospitals might have. They do have to deal with it. They cannot turn you away from the door. Therefore, in purely analysing performance, the results must be adjusted—must be adjusted—for these sorts of differences, particularly in location and resourcing.

Senator FIERRAVANTI-WELLS: Ms Power, part of the criticism by the coalition has been that we would have liked to have seen the legislation in relation to all these authorities together because I think that would have assisted everybody. I see you nodding. At least we would have avoided some duplication. But at the moment we are just dealing with each of these authorities in a silo manner, so it is very difficult to ascertain what benefit, if any, is actually going to be derived from each of those authorities. I pick up your point about the functions, and yes I have gone back to the original agreement. Mind you, we do not know how much of the original agreement has actually survived. That is the other issue. I see you nodding there, Ms Power.

Ms Power: However, the system manager aspect of the original agreement, I am sure, has survived and will survive.

Senator FIERRAVANTI-WELLS: It is interesting because the second agreement is in very general terms. It does not have the same degree of specificity as the first agreement. Indeed, it simply refers to a performance framework. One assumes that we have gone back to the previous parameters. Clause 42, though, simply says that the parties agree that the National Health Performance Authority be established under Commonwealth legislation

from 1 July. It will develop and produce reports on the performance of hospitals and healthcare services, including primary healthcare services. So there seems to have been a watering down, in my reading, of those parameters. Is that your understanding?

Ms Power: I cannot answer that. It is not really my understanding. However, I would have to go back and look in detail to totally check. I think that the National Health Performance Authority has a very significant role and very significant powers as it stands now.

Senator FIERRAVANTI-WELLS: Even in the absence of having areas of performance and how you measure that performance? Picking up the point that Ms Bennett made in our discussion with her, what is the point of this authority and all these authorities if, at the end of the process, the consumer is no better off? It is all very well to have bureaucracy on top of bureaucracy for those who like a lot of bureaucracy. But surely the test, Ms Power, is: at the end, how much better off is the consumer going to be?

Ms Power: There is a lot to be said about having national standards, as I said earlier, that can have a local application and be flexible at the service delivery end. If we can bring in national standards and a national approach to collecting the data, as I have already mentioned, through patient-centric linked datasets then we will be able to more accurately measure the performance of services vis-a-vis each other across the whole nation. If we can do that then we can start to discern where there are variations in care and then work to remediate areas where there are variations in patient care or where patients are not being well served. An example of that could be in some surgeries where there are variations, maybe due to a local surgeon. Caesarean rates is one of these. If we can see that nationally and work on that nationally, the community will be better served in the end.

There should be public reporting too, as I said, with caveats, because we have to make sure that adjustments are made according to the risk and the various services. We must make sure of that. But public reporting and the ability to report back to providers are also extremely important. In fact the latter is possibly even more important in improving the quality of the services because, if providers can see the outcomes of their services compared across the whole nation to the outcomes of similar services, they will be able to discern then whether they are performing well or not so well in comparison. That, to my mind, is one of the enormous benefits that the performance authority will be able to bring to bear.

Senator FIERRAVANTI-WELLS: I am conscious of time. One last question: you say in the covering letter that you want the legislation amended to take account of the formal role of state and territory governments as system managers of the public health services. I think you will have to go into what particular clauses you feel should be amended to give effect to that.

Ms Power: Yes.

Senator FIERRAVANTI-WELLS: Ms Power, I actually take it as a bit of a contradiction, because you are obviously highlighting what you perceive to be deficiencies in this legislation, whereas if you look at this agreement the two do not marry. That is why I have said to you, going back to the original agreement, it is unclear how much of the original agreement has survived in terms of what is in mark 1 and mark 2. Then ultimately for you to make that statement there clearly has been a shift in your opinion. And that is why I would really like you to pinpoint it. If you cannot do it now, I am happy for you to take it on notice, because it really is a very broad statement. In fact, it undermines totally this whole process because you cannot have a national performance authority when you say that it just does not take into account the formal role of the states. It is quite a bold statement.

Ms Power: I will take that on notice. I appreciate your comment. But in fact, I anticipate that where we make the amendments, although they will be very important, they will not be very radical. It will be around consultation with states and territories. We are doing the same with the performance and accountability framework. We have the same comments. Although we have quite a lot of comments also about the indicators, our comments around involving the states and territories, albeit very important, really only mean about two or three changes.

CHAIR: Ms Power, throughout your whole submission, you are looking at the dynamics in terms of federal and state. I think you have put that into a context. I think that, in terms of the question on notice, it is really important that you detail how you would actually expect the changes to operate. That would be my understanding.

Ms Power: Thank you. I would be happy to do that.

Senator SIEWERT: That actually picks up on one of the areas that I had. I agree that it is not clear from what you say in your submission how you would do that. I look forward to a response there. I want to go back to the issue that you raised about the patient-linked data and the patient-centric approach. That was a really good example that you gave about the way a patient would move. My question relates to the E-health process, the

whole establishment of it, rolling it out et cetera. Would that deal with your issue or is there another step that needs to be taken there?

Ms Power: There are probably multiple ways in which we can make sure that the system works better and is integrated better. As far as the data is concerned, really we are saying that all the states and territories and the Commonwealth government need to agree on the specific ways that they collect administrative data. Hopefully the performance and accountability framework will drive change as far as indicators are concerned, but administrative data is also very important. At the moment there is no way that we can really track one patient's multiple episodes of care right through to the end of their care. At the moment, multiple episodes are counted multiple times.

Senator SIEWERT: Yes, okay.

Ms Power: That is more in the administrative data than it is in the data that comes out of performance indicators.

Ms Miller: I might just add something there. With the person-controlled e-health record, I think there are a number of issues about its capacity to do this in the first instance because, firstly, it is an opt-in system, which means that it will be incomplete, so clinicians will not be able to rely on having all of the information for every patient who comes through the door. That will be a weakness in the first instance. Whether that builds up over time will be a question; but it will take some time. I think there are probably other things that we have talked about, particularly in our response to the performance and accountability framework, regarding rationalising and looking at a stocktake of existing data collections across everything and how we should pull those together. That links into what Prue said about working to build up the data that we already have and improve the consistency of administrative datasets. I think they will fit together at some point, but in the first instance it will be an incomplete way of doing that.

Senator SIEWERT: Yes; I understand where you are coming from. I know that there is a long-term process; in the meantime, you need another process that in the long term could bolt onto the e-health process. Is that a simplistic way of saying quite complicated things?

Ms Power: Quite possibly, yes. Presumably, the person-controlled electronic health record, once it is working well and across the whole population, will then indicate the services that the person has had, but it would have to link back into the administrative data.

Ms Miller: So it relies on the strength of those datasets to populate it anyway. That is why that work needs to be done on the datasets themselves.

Senator SIEWERT: I think it is totally relevant to what we are talking about, but in that case, in terms of amending the legislation, it is more about how we will make this work, isn't it?

Ms Power: Yes.

Senator SIEWERT: I am not disagreeing with you in terms of what you are saying, because I think it is a really important point. Our committee can make recommendations about changing the legislation, but there is nothing to stop us from saying, 'But also to make this work it has to say this,' or, 'it has to do this,' or, 'these provisions have to be put in place.' So it is not actually changes to the legislation; it is actually operationalising, isn't it?

Ms Power: It is. Although this seems to be coming out of left field, I think that, if we also had national clinical pathways for patients, that would also link into the ability to collect the administrative data across multiple episodes. Also, it would assist in integrating patient care through the various local entities that are being established under the reform agenda.

Senator SIEWERT: Which then goes back to the issues that we were talking about before. If we have national clinical pathways, we also need to engage with the states and territories as part of that operation.

Ms Power: We certainly do, yes.

Senator SIEWERT: Thank you. I think that is all I have. Senator Fierravanti-Wells covered the issue that I really wanted to look at, which was the state and territory stuff.

Senator ADAMS: I have one on the states and territories. You did comment that, as far as this bill goes, consultation should have been far better with the states and territories—and Western Australia is certainly very aggrieved that there was no consultation. Something that is really worrying me from a practical point of view is that there is poor performance in reporting by NHPA of state hospitals and other health service providers—this is in clause 62(ii) of the bill. It says that, where poor performance has been identified, NHPA will directly consult

with the management of the relevant local hospital network. That really cuts out the department and just goes straight to that network. Could you comment on that?

Ms Power: Yes. That should be amended. That will be one of the items that we will come back to you with, and I alluded to that earlier. The minister for health in the state and also obviously the CEO of the state health department need to be included in all the reporting—underperformance and overperformance, for that matter. Although it is Commonwealth legislation, it needs to be written into that legislation that there is consultation with the state and territory ministers and CEOs at all levels, particularly when it comes to indicating the outcomes of the analysis of performance. We suggest that there should be no public reporting without that consultation. That would mean it would be incumbent on the state minister to respond in a timely way, because I do not think any of us should need to be waiting for reporting of underperformance in particular because of the tardiness of some response from the state. But, as I said before, I think the state ministers would also think it was pretty critical and would respond quickly. I think that does need to be written into the legislation.

Senator ADAMS: Yes, I think it does, because what is written here completely bypasses the Commonwealth department and the state department.

Ms Power: Therefore, not reflecting the heads of agreement in relation to the states being the system managers and the majority funder.

CHAIR: Senator Boyce, I know that you have just come in, but are there any issues that you wish to raise with these witnesses?

Senator BOYCE: You have covered the aspect of underperforming hospitals and how we go about knowing about that—is that right?

Ms Power: Yes, we have. In public reporting, we are saying that there needs to be consultation at the state level prior to reporting; although, as I have just said, the states would need to respond in a timely fashion. We are also saying that any reporting needs to be risk adjusted for the differences that will be encountered in different locations and different socioeconomic areas. I would like to emphasise just once more that reporting back to providers is probably underestimated. Reporting back to providers is the one single thing that will really assist with performance, because not only would providers be interested in seeing the outcomes of their performance against other people across the nation doing similar work but also it brings out a bit of a competitive nature in the providers in that they would not want to be seen as underperforming vis-a-vis their colleagues.

Senator BOYCE: Did we talk about how the standards and measures are to be developed in order to measure hospital performance?

CHAIR: Not very much. Ms Power, do you want to make a comment on that? We had not covered that much.

Ms Power: We are preparing a paper on that, which is due today. The measures at the moment are included in the performance and accountability framework. There is a concern that we need to keep those measures down to a manageable number, so we are not looking at blue sky necessarily. We have some suggestions around those measures and I would be very happy to table our response to the performance and accountability framework.

Senator BOYCE: That would be useful, yes. Does that include any assessment of e-health and how it will need to expand to cover this field?

Ms Power: Not particularly in that response. But I would also like to table our response to the National Health Reform Agenda per se, because in that you will find a section on e-health.

Senator BOYCE: Thank you.

CHAIR: Ms Power, the issue about reporting back to providers was picked up by the AMA and also by Catholic Health Australia, as you would understand. The AMA did make the point about the difficulty for small hospitals and authorities in providing information. Do you have any comment on that?

Ms Power: Obviously, if resources are constrained, providing information becomes more difficult. However, all health services can be stretched if they have to provide too much information via reporting; hence that is probably keeping the indicators to a reasonable number. It may be that smaller services, particularly those in rural and remote areas, will need additional assistance to report. I am hoping that, with a reasonable number of indicators across the nation that are standardised, all services should have the resources to provide that information in a consistent way. The same really goes to the administrative data that we have mentioned before.

CHAIR: Yes. In fact, providing data is part of the facility's responsibilities; it is just how you actually streamline it to be reasonable.

Ms Power: It is part of their responsibility. Perhaps they could make a case for funding assistance to set up their system so that they can provide that data more easily. But, however small, it is their responsibility.

CHAIR: Thank you very much. Clearly, we will get to you the question that we are asking you to respond to. It is always difficult when you do not have it in front of you. So we will get the words from Senator Fierravanti-Wells, and the secretariat will get that question to you as quickly as possible. Thank you very much for your evidence.

Ms Power: Thank you.

ACKERMANN, Dr Evan Wayne, Royal Australian College of General Practitioners

[12:43]

Evidence was taken via teleconference—

CHAIR: Dr Ackermann, I am so sorry to keep you waiting. I did not realise that you were on teleconference and I was waiting for someone to appear in the room, so my deepest apologies. Thank you for coming to give evidence to us today. We have your submission; thank you very much. Would you like to make some opening comments before we go to questions?

Dr Ackermann: Thank you. Good morning, Senators. I am a general practitioner from Warwick in Queensland and today I am representing the Royal Australian College of General Practitioners. We have made a submission to the Senate on this, as you are aware.

Just as a quick overview, I know that the college is generally supportive of the performance framework. We do say that while taking into consideration that, in the public reporting arena, the evidence for public reporting is quite fragmented and limited and there is no real evidence that this ends up with good health outcomes. But we support the framework, we support the initiative and we suggest that a full evaluation of this process go on over the years. I think I might go straight to questions, if that is all right.

CHAIR: That is fine, Doctor. What is the weather like in Warwick?

Dr Ackermann: It is cold at the moment, I must admit.

CHAIR: I would hope that it was.

Senator BOYCE: Although, with Warwick, it could win through, couldn't it?

CHAIR: Yes. Sometimes it does in terms of the weather. Senator Siewert, would you like to kick off?

Senator SIEWERT: Can I just go back to what you have said? You are supportive of the framework, so what you are looking at is amendments to improve it.

Dr Ackermann: Yes.

Senator SIEWERT: Thank you. I just wanted to clarify that. In terms of the functions, you make the point here about general practice. Could we explore that a little more just for you to articulate what you think is the most appropriate level of general practice involvement?

Dr Ackermann: Regarding the authority's functions?

Senator SIEWERT: Yes.

Dr Ackermann: We are unsure exactly where general practice is involved in this, to be honest.

Senator SIEWERT: That is what I understood from your submission. I was talking to the Consumers Health Forum about it and they said, yes, they do think some level of general practice should be included.

Dr Ackermann: Yes.

Senator SIEWERT: However, I definitely get the feeling from others that they are saying, 'No, it's going to be too onerous.' What do you think should be the position?

Dr Ackermann: I think general practice unfortunately has a number of bodies that want to set the standards for general practice. In Australia, we have set the standards from the college of GPs. Queensland wants the Health Quality and Complaints Commission to set standards for general practice across Queensland as well. We have the national performance authority saying that they want to set standards, as does the Australian council. But the reality is that the college has very, very good relationships with the Australian council of safety and quality. We have very good relationships with government to set the standards for general practice, and that is what has been happening over the years. So we feel that should be the process that should occur. I think there should be one body that sets the standards for general practice and that should be independently evaluated by accreditation functions. We feel that is the way it should happen and continue.

Senator SIEWERT: You also made the point that it should include the funding bodies.

Dr Ackermann: Yes.

Senator SIEWERT: I think that is a very good point.

Dr Ackermann: I think the issue is that, when you look at all the public health inquiries into serious issues, such as the Bundaberg health inquiry and the New South Wales activities, you get a sense of not just a clinical issue but also this culture of concealment often within, and underperformance of, these regulatory authorities,

such as the medical board, the health authorities and part of the government, that are involved in some way with these poor health outcomes. We feel that they should be subject to the same sort of scrutiny as the clinical bodies should be subject to.

Senator SIEWERT: I like the point. Sorry; I skipped over one of the other questions I was going to ask. You talk about the performance authority's composition.

Dr Ackermann: Yes.

Senator SIEWERT: I think, in my count, I have three areas where people are asking for additional expertise: the first is primary health, and you are suggesting the primary healthcare sector; the second is that the Consumer Health Forum is suggesting a person with consumer expertise—because I know that you are not supposed to have representation any more; and the third is the area around Indigenous health. I have to say that I am attracted to all three propositions. In addition to your recommendation about additional primary health care—we have made sure that we articulated that in the amendments to the quality and safety commission—would you support the other two suggestions, which are Indigenous health care, specifically because we need to continue to make improvements in that area, and somebody with consumer expertise?

Dr Ackermann: I would support those two. I think they are quite valid propositions that have been put to you. Given my experience of what has been happening, they would be two very worthwhile members, yes.

Senator SIEWERT: Thank you.

Senator FIERRAVANTI-WELLS: Dr Ackermann, in terms of this sort of package, one of the criticisms that the coalition has levelled has been that this authority and other authorities have all been dealt with on a piecemeal basis. From the college's perspective, have you worked out how these different authorities are going to interact; and, from your perspective, are they necessary in delivering for your patients, who are ultimately the consumers in the system?

Dr Ackermann: That is a very good question. From an academic point of view, I think the evidence for these performance authorities—the public reporting of health inquiries and what have you—is fragmented. Quite a bit has been done in the United States and elsewhere looking at these sorts of programs to see whether there are any positive health outcomes for the consumers, and there is very little evidence to support that. A lot of that is due to there being poor organisational issues at the start in that the studies and evaluations were not planned, so the evidence is poor because of that. But, again, performance on a public basis breeds gaming and a lot of other issues and it brings so many things into it that it does not help with improving patient outcomes.

Do I think at a local level it could possibly be? Yes, it can possibly do it, if you have the right organisations, structures and indicators and you try to engender clinical governance issues from the ground up rather than a top-down approach; I think that is far better. I wish it well, but I am not sure that it is going to work that well.

If you ask the question: 'Would this process have averted Bundaberg, New South Wales or King George?' I am not sure that it would have. It really comes down to what you expect: what is your definition of 'success' with this sort of framework and what you are trying to do? Often that is hard to put down. If you said that success is increased transparency, yes, that might work. But, if it is there to improve the quality of your health or the health care of the community, it will be very difficult, I think. I hope I have answered your question.

Senator FIERRAVANTI-WELLS: The issue here is that there is really no detail on the performance indicators that the authority is to monitor. So, certainly from your perspective as one of the main bodies in the medical field, the question is: what is the value of this authority?

Dr Ackermann: Looking at the performance indicators from the primary care point of view, they tended to be public health outcomes, which the local health authorities, the Medicare Locals, would probably have very little influence over, to be honest.

Senator FIERRAVANTI-WELLS: So we are coming back to this point: we are creating all this bureaucracy and we have all these bodies everywhere, but ultimately isn't the true test here how patient outcomes are going to be improved? It seems to me that all we are getting are multiple layers of new bureaucracy that are going to cost a lot more money. Isn't that money better put into helping front-line services rather than creating new bureaucracies?

Dr Ackermann: That is the exact point we are trying to make when we say that there should be a research thing behind this to evaluate the outcomes to see whether it is, indeed, successful.

Senator FIERRAVANTI-WELLS: Thank you.

Senator ADAMS: Where do you see the Medicare Locals and the hospital network boards getting into this?

Dr Ackermann: That relationship seems to be a work in progress, doesn't it? There certainly are very, very good people in the current divisions now, which I guess will amalgamate to become the Medicare Locals, who are used to health management and to making these sorts of health decisions. But I think the expertise is quite varied, to be honest. As for how they are going to amalgamate the hospital network and set priorities and what have you, I think it is going to be difficult in a few years to do that, to be honest.

Senator ADAMS: As far as GPs go, how do you see them fitting into this? I am from what is geographically quite a large rural area in Western Australia, so I am probably looking not so much at the metropolitan area but more at those sorts of rural areas. How do you see them working practically in those sorts of areas? I am more interested in the practical issues.

Dr Ackermann: Can I ask you to rephrase the question, please?

Senator ADAMS: You are representing GPs.

Dr Ackermann: Yes.

Senator ADAMS: Can you say how are they going to link in? Once again, I come back to the consumer and health care: with this body and their reporting, it concerns me that one clause in the bill says that, if there is a problem, the body will go straight to the local network board; that will miss out on state involvement, which would enable the state to get the results and find out what is going on. I wonder how your organisation sees this working practically; that is probably a better way of putting it.

Dr Ackermann: I think, if there is an issue with the primary health care in a particular area or region, that should first be sent to that area or Medicare Local for interpretation. When you look at the variation in populations across Australia, it is very important to interpret data in the local context because there is so much there that influences the outcome of the report. So, if there is an adverse event or someone suspects there is an issue, I would suggest that report be sent back to the Medicare Locals first for comment. I think, in that way, you will get a far better quality report and interpretation of the report.

Senator ADAMS: Would you go around the department, or do you consider that the state department should be able to be advised and be part of this?

Dr Ackermann: I would not have too many objections to the state department also being advised or involved. It depends on what the ultimate outcome is, before they make things public. From a primary healthcare point of view and a GP point of view, if there is anything adverse in the GP population, before being made public, it should be given to the general practitioners or the practitioners involved to comment first.

Senator ADAMS: I just wonder whether it will undermine the state ministers for health. I do not think they would be too pleased if there was an adverse incident that they did not know about and it was just sent straight back to Canberra.

CHAIR: I think that is a statement that is kind of a question, Doctor. Do you agree with Senator Adam's position that that could create an issue with the state?

Dr Ackermann: A health minister has a right to know those sorts of things, I guess.

Senator ADAMS: I have another question. At 3.9, right at the end of your submission, you talk about the overlap between the roles and functions of the performance authority and the Australian Commission on Safety and Quality in Health Care.

Dr Ackermann: Yes.

Senator ADAMS: I note you say that it is important that these respective roles, functions and interactions be clarified in the legislation. How would you go about that?

Dr Ackermann: That is a good question and that is what I hope our regulators would be able to do with some clarity. I think the Australian council or commission on safety and quality really should argue the standards with the college and that the college be the setter of standards. But, again, the defined role of the national performance authority is to monitor, collate and report rather than to set any of the standards—so a clear separation of the roles.

Senator BOYCE: I do not have any questions.

CHAIR: Dr Ackermann, in your role with the royal Australian college, what is the consultation arrangement that you have with the government in terms of feeding these issues into their system?

Dr Ackermann: Feeding into the government system?

CHAIR: Yes.

Dr Ackermann: Do you mean just making submissions and feeding them—

CHAIR: Regarding the kinds of issues that you have raised in this inquiry, have you been able to raise them with the department or with the government in other ways?

Dr Ackermann: Yes. We have also commented on the framework and the indicators. As for the college, at this point in time further meetings with the department are being arranged to discuss those issues.

CHAIR: So there are mechanisms not in getting all of the answers but to have ways of putting these issues into the system.

Dr Ackermann: Yes.

CHAIR: Is there anything else that you would like to add?

Dr Ackermann: No. I think that is fine. I think we have covered all of the issues.

CHAIR: Thank you so much for your time.

Dr Ackermann: Thank you very much. I hope that I have been helpful.

CHAIR: Thank you. The committee now stands adjourned until 2.30 pm. I would just advise the committee: the reason for that length of break is that one of our witnesses, Catholic Health Australia, has dropped out.

Proceedings suspended from 13:00 to 14:32

ANTIOCH, Dr Kathryn Margaret, Principal Management Consultant, Health Economics and Funding Reforms

CHAIR: Dr Antioch, do you have anything to say about the capacity in which you come to see us?

Dr Antioch: I am the principal management consultant of Health Economics and Funding Reforms.

CHAIR: Thank you very much. That is a company?

Dr Antioch: Yes.

CHAIR: I just wanted to make it clear for the record.

Dr Antioch: It is a sole trader—a management consulting firm.

CHAIR: In terms of the process, we have your submission—thank you very much. If you would like to make some opening comments, then we will go into questions. This particular session is due to go till three o'clock, so if we run overtime slightly it is because of the questions, but please share with us what you want to.

Dr Antioch: Thank you for the invitation to prepare and present a submission relating to the National Health Reform Amendment (National Health Performance Authority) Bill 2011. This bill is for an act to amend the National Health and Hospitals Network Act 2011. My submission strongly supports the intent of the bill and the work of the government in this very important area of health and regulatory reforms in Australia. I do, however, raise several issues relating to the legislation to enable greater alignment with the various Commonwealth-state health agreements and the broader policy imperatives of the government.

I have an interest in the legislation given my previous reform work undertaken as a member of the senior management of Victorian hospital networks and as a consultant in improving and evaluating hospital network quality and efficiency performance. I presented this work across all states and territories, supported by the Australian Healthcare and Hospitals Association, with the recommendation to implement the methodology nationally. I also led work on the risk adjustment reform of activity based funding for the Victorian government. I have briefed COAG and other federal and state stakeholders since 2008 on matters relating to these reforms in the context of the renegotiations of the Australian Health Care Agreements. My work until 2009 on the principal committees and Privacy Working Committee of the National Health and Medical Research Council was in areas related to the legislation. Since 2010 I have been involved in other Senate committee inquiries into health reforms.

Turning now to definitions, the National Health and Hospitals Reform Commission provided an important framework and definitions for performance measurement. The reform commission's framework and definitions could be included in the legislation. Importantly, the reform commission clarified the distinction between performance indicators, targets and performance benchmarks and provided examples of these terms. These terms are also used in recent health agreements related to the new proposed legislation. Such clarity could improve the legislation within an accountability framework. I turn now to privacy issues. Several sections of the proposed legislation refer to privacy issues. The intent of the legislation on privacy in sections 54J, 54K, 54L and in sections 120 to 124 and 127 to 129 could be improved with more specific reference in the bill to the Privacy Act 1988. These sections relate to disclosure, consent and protection of patient confidentiality issues. There is brief reference to the Privacy Act 1988 at section 127 of the bill. NHMRC privacy guidelines relating to sections 95 and 95A of the Privacy Act 1988 are under review for amendments to that act. The guidelines under section 95 protect privacy in medical research. Section 95A guidelines relate to the collection, use or disclosure of health information for research, analysis or compilation of statistics relevant to public health or public safety and also the management, funding or monitoring of a health service. There may be cases where identified information must be used without informed consent. In these cases the public interest in the research and analyses must be balanced against the public interest in the protection of privacy. Further, there are provisions published by the NHMRC on section 95AA on genetics. The Australian Code for the Responsible Conduct of Research and the National Statement on Ethical Conduct in Human Research are also published by the NHMRC. Relevant aspects could be highlighted in the new legislation where appropriate.

The Senate Standing Committee on Finance and Public Administration has an inquiry into the exposure draft of the Australian privacy amendments legislation. Any changes impacting on health issues would impact on the proposed legislation. Chapter 3 of the legislation concerns the National Health Performance Authority. The heads of agreement of the National Health Reform make explicit reference to reforms in aged care, mental health and dental health at clauses 61, 62 and 63. This concerns growth funding and also federal responsibility for funding,

policy, management and the delivery of aged care. Further, these health sectors were discussed in the National Health and Hospitals Network Agreement 2010. Specific reference is made to Medicare locals in several clauses of the heads of agreement on the National Health Reforms, including, amongst others, clause 56(a)(iii).

It is unclear why explicit reference to these health sectors is not included in the legislation. Section 60(1)(a) in the new proposed legislation specifies the following organisations that would be evaluated by the performance authority: local hospital networks, public hospitals, private hospitals, primary healthcare organisations and other bodies or organisations that provide healthcare services. I recommend amending the above part of the legislation by adding new categories of primary healthcare organisations with including Medicare locals, aged care and mental health.

In relation to section 60(2), hospital services in states such as Victoria may also be provided in Hospital in the Home programs and the proposed legislation captures only services provided in a hospital. I suggest this may be amended to include Hospital in the Home or to clarify how these programs would be defined in the legislation. This program is part of the usual hospital services provided by local hospital networks.

Section 60(3) makes reference to the provisions of paragraph 60(1)(C) which refers to functions of the performance authority to formulate performance indicators. The legislation could provide further specification of the use of standards by the performance authority. Would there be any circumstances where the authority would have a role in the development of standards?

Section 61 makes provision for the performance authority to have regard to intergovernmental agreements and other instruments. The heads of agreement of the National Health Reform make reference to national standards at clause 35, 36 and 37. Clause 38 links these standards to the four-hour national access targets to reduce emergency department waiting times and the national access target and national access guarantee for elective surgery. A COAG expert panel will advise COAG on the implementation of the standards in the national partnership at clause 39. Clause 42 specifies that the NHPA will develop and produce reports on the performance of hospitals and health services. A clear framework for evaluation is referred to and further developed in the National Health Reform Agreement National Partnership Agreement on Improving Public Hospital Services. Standards, performance benchmarks, performance indicators and reporting are covered. Further, at clause 28 it makes it clear that funding beyond 2013-14 and performance against the agreed outcomes and outputs will be considered in the context of the review of the agreements in clause 48. The legislation could be much more explicit about this performance framework.

Regarding subsection 72(4), I recommend explicit reference be made to Indigenous health representation as a member of the performance authority. I suggest that paragraph 72(4)(d) be amended to read as follows: 'the provision of healthcare services in regional and rural areas including Indigenous health services'. This will enable consistency with all federal-state financing agreements which include Indigenous health as an overarching top priority for Australian governments.

I will turn to performance evaluation mechanisms to ensure validity and reliability. The legislation provides provision to determine poor performance in section 62(1). National classification systems used for various sectors of the health industry should ensure adequate risk adjustment of the data. Risk adjustment enables greater precision of classifying patients according to clinical severity and need and will be essential in data analysis by the National Health Performance Authority to enable valid comparisons.

Government could consider use of the recent American classification systems developed by Arlene Ash and Randall Ellis for primary healthcare organisations, with possible application to Medicare locals. Their analysis uses the Verisk Health DxCG classification system. Australia has well-developed hospital classification systems, and risk adjustment mechanisms have already been considered in Victoria in the context of activity based funding.

The National Health and Hospitals Network Agreement 2010 includes an adjustment factor for risk adjustment called patient complexity, including aboriginality, which is excellent. Risk adjustment for aged care could also be considered. I recommend that the legislation make explicit reference to the need for implementing valid mechanisms for ensuring risk adjustment of the data and classification systems. This can ensure validity and reliability of the evaluations.

Turning to interaction with other government bodies, there is a lack of information about how the governance agencies will interact. There could be merit in an explicit mention in the legislation of the nature of the interaction to ensure consistency in approaches to data collection, classification systems, risk adjustment mechanisms and data sharing. This would involve the National Health Performance Authority, the Australian Commission on Safety and Quality in Health Care and the Independent Hospital Pricing Authority. The legislation does not

specify the data sharing pooling and analysis of the global data. This could be done by one of the governance bodies or independently by the Australian Institute of Health and Welfare.

Importantly, resolution of the efficient price of hospital services and the need to achieve quality standards should definitely be addressed. This could be assisted by the proposed functions of the state centres of evidence based medicine, health services and workforce redesign and the International Centre for Evidence Based Medicine and Health Economics. The relationship between the NHPA and the service providers to affect changes requires attention in the legislation. The proposed state centres could assist by synthesising data at the level of the health services and also regionally and at the state level. This could facilitate changes in performance at the local level.

Turning to private hospitals, section 62(1)(c) of the legislation refers to reports that may indicate poor performance in private hospitals. It is unclear how this will be managed. Currently, private hospitals are accredited by the Australian Council on Healthcare Standards. Will the information compiled by the performance authority be shared with the council? Will the council share information with the performance authority? Likewise, the extent of data sharing on private hospitals between the state governments and the performance authority has not been specified.

I will now turn to the state centres of evidence based medicine, health services and workforce redesign. Work was undertaken at a Victorian hospital network called Bayside Health, now called Alfred Health, over a seven-year period to 2005, and then at Western Health to 2007, on implementing evidence based medicine, economic and clinical evidence and clinical practice guidelines through the development and implementation of clinical protocols, pathways and management plans. I led this initiative as the Bayside Health CEO's principal adviser on evidence based medicine and funding reforms using NHMRC and international methodologies, including those of the Netherlands. Given evidence of improvements in quality and efficiency, the Australian Healthcare and Hospitals Association and the Women and Children's Hospital Australasia sponsored my presentations in all Australian states and territories and in New Zealand in the context of the renegotiation of the Australian health care agreements 2008. The key recommendation from stakeholders participating in the national presentation was to implement the evidence based methodology nationally. In subsequent briefs to COAG and other federal and state stakeholders from 2008 to 2010 I recommended that the methodology could be implemented with economies of scale by establishing the state centres of evidence based medicine, health services and workforce redesign and for the 2010 COAG briefing also by creating an international centre of evidence based medicine and health economics. These recommendations, along with associated savings based on reductions in hospital length of stay and adverse events, were included in my submissions to four federal Senate committees undertaking parliamentary inquiries during 2010, which were published. The Senate Community Affairs Legislation Committee inquiry into the National Health and Hospitals Network Bill 2010 and the Senate Economics Legislation Committee inquiry into the Federal Financial Relations Amendment (National Health and Hospitals Network) Bill 2010 published my submission, showing estimated cost savings nationally and by state and territory. They also cited some of my views on aspects of the government's reforms in their reports.

The national annual savings associated with the reforms are $273.5 million, or $1,367.6 million over a five-year period. Recent work in Victoria has involved a cost-benefit analysis and found that the cost of establishing a state-wide centre within an existing hospital network would result in net savings of $76.6 million per annum or $383 million per annum over a five-year period in Victoria. This is extremely cost-effective.

In my recent work with some sectors of the health industry in Victoria, I have emphasised that the state centre could be located at a Victorian local hospital network providing information to other networks, Medicare Locals, aged care, community care and lead clinical groups across Victoria. Centre staff would have expertise in health economics, clinical evaluation, evidence based medicine implementation, information technology, health administration and health service research. A bottom-up approach would be used to identify the key medical and surgical areas in each local hospital network, Medicare Local and other organisations that require priority in the evidence based medicine process through identifying access, quality and, importantly, efficiency issues. There will likely be similarities in priority in the medical and surgical areas between local hospital networks, thereby achieving economies of scale in the evidence based medicine process state wide.

The state centre staff could assist the local hospital networks and other organisations to establish quality and efficiency performance evaluation systems relating to the use of quality instruments, such as clinical pathways and protocols, to facilitate meeting the national health performance reforms associated with the Australian Commission on Safety and the National Health Performance Authority on the outcome data. It could provide input into the deliberations of the independent pricing authority about the quality and efficiency implications of the efficient price by public hospital services.

The costs associated with establishing the state-wide centre at a local hospital network are approximately $491,000 per annum. Given state-wide savings of $77.1 million, the costs would result in a net saving of $76.6 million. The proposed centre is extremely cost-effective. Applying these costs to the benefits calculated for other states and territories, the cost-benefit analysis shows net savings across Australia are $269.6 million per annum or $1,348 million over five years.

This type of initiative could be funded under the provisions of the National Health Reform Agreement. *National Health and Hospitals Network: National Partnership Agreement on Improving Public Hospital Services*, under clause E13(c) of schedule E, entitled 'New Subacute Beds Guarantee Funding', which makes provision for project eligibility criteria purposes:

… coordination across relevant Australian Government and State and Territory programs and activities to ensure seamless and high quality patient care, including: development and application of agreed nationally consistent performance measures; uptake and dissemination of relevant evidence-based guidelines; and IT systems to improve the management of patient flows across the health care system.

CHAIR: I just want to clarify this. In the current proposal there is a seven-member group. Would you be proposing that these areas of specialist expertise be part of the seven, because we only have three positions that have been identified—the chair, the deputy chair and the one on rural and regional health. Would you be suggesting that these other specialist areas be part of the seven or, if necessary, augmenting the number?

Dr Antioch: I think augmenting the number might be required.

Senator BOYCE: Could I just follow up on that? There will be other groups who would also suggest that they should be at the table. Could you tell us what, if any, other sectors should be represented on this board?

Dr Antioch: Indigenous health was the main one that really came to the fore. Someone with health economics expertise would be valuable, but it may well be that someone you appoint will have that sort of expertise.

Senator BOYCE: One would hope.

Dr Antioch: There are other areas. My main concern really was for indigenous health, I must say. Given the overarching priority in every Commonwealth-state financial agreement you can look at, it really is the No. 1 over arch. I really felt quite strongly about that one in this instance.

Senator SIEWERT: I will go back to the beginning where you talk about the definitions, including those in the legislation. Can you explain a little bit more about how you would see that included in the legislation?

Dr Antioch: Certainly. It is an excellent question. What I would like to do is refer directly to the excellent report put out by the National Health and Hospitals Reform Commission where they address this, because I have said in my submission that they give very good definitions and clarify the issues. I would like to read out what I think are the key points, particularly the definitions of what I think could go in. Section 4.4 on page 24 of *Beyond the blame game: accountability and performance benchmarks for the next Australian Health Care Agreements—a report from the National Health and Hospitals Reform Commission*, April 2008, is entitled 'Guiding criteria for the development and use of performance benchmarks.' Part of that section states:

The criteria that we developed on setting and using performance benchmarks are as follows:

1. Clear distinction between performance indicators, targets and performance benchmarks

In this report, we have distinguished between three types of measures:

- Performance indicators that measure an attribute of the health care system (for example, we may want to use indicators to 'track' changes in health status even if there are not identified targets or clear accountabilities for this measure);
- Some performance indicators will have associated targets that can be used to measure performance or set quality improvement goals;
- Benchmarks are a subset of these targets, where performance against the target will have a clear consequence (usually financial) in terms of accountability.

To illustrate this distinction, the current Australian Health Care Agreements have many performance indicators (such as the share of public hospitals that are accredited or the cost per casemix adjusted separation in public hospitals). But the Agreement is essentially silent on the targets, or expected standards of performance against these indicators. For some of the performance indicators in the AHCAs, it is not even clear whether an increase or decrease in the indicator constitutes improved performance! Using the example of cost per casemix adjusted separation in public hospitals, should all states be required to reduce their costs to the level of South Australia (about $3,300 for each treated public hospital patient)? Or, are higher costs such as in New South Wales at over $3800 for each public hospital patient better? In the absence of targets for the indicators in the current AHCAs, there are also no financial consequences associated with not achieving benchmark levels of performance. While not every indicator can have an associated target or benchmark (where there are consequences of not

meeting the benchmark), the Commission believes that there is a clear commitment by all governments to introduce better accountability through greater use of targets and benchmarks across the whole health system, not just public hospitals.

Essentially, the government has taken on board these ideas and I think it would be extremely helpful for the legislation to simply clarify performance indicators, targets and benchmarks, and the accountability side which is associated with the benchmarks. It makes reading much clearer.

Senator BOYCE: I have some questions which are close to that area.

CHAIR: You are going to make them close to that area!

Senator BOYCE: They are about who is going to do what, basically. You have said on the second last page of your submission to us:

The extent of linkage between the National Health Performance Authority, ACSQHC and Independent Hospital Pricing Authority would be subject to further consideration once the legislation is passed in the Parliament and details specified.

Would that not be something that should be done before the legislation is passed?

Dr Antioch: One would hope that the legislation clarifies to some extent some of the datasharing issues and roles. Following the implementation of legislation that would be further developed. The main thrust of my submission talks about the need to clarify how they will interact. My comment in the submission relates to the role of the state's centres of evidence based medicine, health services and workforce redesign and how that could assist with some of the deliberations of those organisations—

Senator BOYCE: So that was not meant as a stand-alone comment or was it? Do you actually understand how those three bodies are going to interact?

Dr Antioch: The main thrust of my submission suggests that the legislation should be clearer on it. In addition to being crystal clear there would be further development happening after the legislation is passed. The important issue here with how these organisations may interact is looking at the quality implications of trying to drive improvements and efficiency. This is the whole issue here. There needs to be a feedback loop back into the pricing authority so that people understand clearly that in trying to push efficiency further and further there may be quality implications. It is really a matter of teasing that out.

Senator BOYCE: Is it not important that we know who is using, developing and applying performance indicators, targets and benchmarks before we start this?

Dr Antioch: Yes. There are lots of different agreements and there is a different emphasis depending on which agreement we are looking at. There are a lots of access targets in the most recent heads of agreement. There are previous partnership agreements that were signed in 2008 that are still functional which include, again, other sets of indicators such as cost per DRG, readmissions, adverse events, length of stay and so on and clearly some of those areas will be captured by the quality commission. But you are absolutely right we do need more clarification of who is collecting what.

Senator BOYCE: And using what, measuring what and recording what.

Dr Antioch: There are lots of different agreements at the moment that are all relevant. Some components of the agreements have been overtaken by the recent heads of agreement and some are still functional. Each of them do relate to different sequences and requirements for performance indicators and data. So there really does need to be a good look at that. The federal Department of Health and Ageing usually do a very good and thorough job in these areas. They will be looking at this and further developing it through their policy arms I am sure. It is just a question of how far you go in the legislation in clarifying this sort of thing.

Senator BOYCE: Following on from that the question I had is: if this legislation is passed, are there currently the tools for the National Health Performance Authority to start functioning—do we have those right now?

Dr Antioch: It could probably function but it is a question of how well it will function. Unless these other things are clarified it probably will not function as well as it could do. I think we do need greater clarification on this issue. This has come up through other submissions to your committee.

Senator BOYCE: How should that clarification be done? Should it be done by the federal department?

Dr Antioch: There could be some mention within this proposed legislation to add some clarification at this stage. It would need to be drafted but there could be more added to this legislation and amendments put forward to further clarify that.

Senator BOYCE: Thank you.

Senator ADAMS: I am from Western Australia and I would like you to comment on whether you consider that there was enough communication between the Commonwealth government and the states as to how they

were going to legislate this bill, seeing that it does affect the states. One comment—I think it is in 62—is that, with the local hospital networks, the direct consultation between the NHPA and the individual hospital networks can go ahead with any problems without actually consulting the minister for health for the particular state. Have you looked at any of those issues?

Dr Antioch: No, I have not had any involvement that would enable me to have insights in the communication between the federal government and state governments, other than what is in the press. So I would not want to comment on that side of it, given the nature of my work has not been involved in that nexus of communication between federal and state governments.

Senator ADAMS: It appears to have gone quite outside the heads of agreement as to what has come up in the bill. That is the reason I was asking whether you had any information on that, but obviously you do not. The other part that I am very concerned with is rural health. I have a lot to do with rural health, coming from a rural area. What really worries me with the local hospital networks and Medicare Locals is how local it is going to become and whether primary care is not going to get to the people it really needs to get to. Have you looked at any of that?

Dr Antioch: No, I have not in the work I have been doing to date.

Senator ADAMS: This is probably not really relevant to the bill, but I know you have done some work with the NHMRC. Are you looking at health effects on renewable energy at the moment? Is that one of your briefs?

Dr Antioch: In terms of my involvement with the NHMRC, I was appointed to two of its principal committees over a six-year period and to the Privacy Working Committee and the Lead Committee. My roles on the NHMRC have finished. That occurred in 2009. I have a very big interest in the health effects of the whole climate change scenario, including the reduction in carbon emissions—I am very interested in that and have done some preliminary work—and the health effects relating to wind turbines. That is another area. In fact, I have put forward a submission to one of the Senate committees on their inquiry into the social and economic impacts of wind farms. That is an area of interest. In that process I did an update of the NHMRC's public statement. I thought their work was excellent. I just did the review of the literature since their work was published. I did that as a submission. It looked at the effects of flicker of the turbines on seizures and the infra-sound level of noise in affecting balance and other hearing issues, dizziness and so on. That is my involvement. That has been undertaken as a priority that I have identified for my own work. It is not linked to any of my roles on the National Health and Medical Research Council. As I said, I have completed my roles with the council.

Senator ADAMS: I read that and that is why I thought you may be doing something else.

Senator FIERRAVANTI-WELLS: Having done the work that you did with the NHMRC, it seems that the bulk of what the NHMRC originally contemplated as hospital reform bears very little resemblance to what is ultimately the end product. Do you have any comments in relation to that?

Dr Antioch: I am not sure what part of the National Health and Medical Research Council's work you are referring to.

Senator FIERRAVANTI-WELLS: The original report.

Dr Antioch: Are you referring to the National Health and Hospital Reforms Commission? Is that what you are alluding to?

Senator FIERRAVANTI-WELLS: Yes.

Dr Antioch: They have similar acronyms. There are components of the final documents which include themes, I think, from the reform commission's work, and we have talked about the benchmarking concepts and the whole accountability frameworks. Certainly what was not implemented was one of the recommendations from the reform commission which really related to some early reforms that Dick Scotton and Helen Owens had put forward where there was a lot of contracting between different sectors of the health industry, between public and private, and that certainly did not go ahead. The relative proportion of Commonwealth funding into the Commonwealth-state agreements ended up being quite different.

Senator FIERRAVANTI-WELLS: I want to pick up your point about the private hospitals. These health proposals—health proposals mark 1 and 2 as I have called them—go out of their way to make specific comments about the noninclusion of private hospitals. There are about 750 public hospitals that are covered by these changes, and that is 60 per cent of the system, roughly; 40 per cent of the system is a lot of private hospitals. Is the point you are getting to that this legislation, and this is only one of the silos, is purporting to try and exercise some control over private hospitals when really the base agreements say that the agreement only covers public hospitals? Is that your understanding?

Dr Antioch: Not quite. The original Australian healthcare agreements which were signed in 2008—

Senator FIERRAVANTI-WELLS: I am talking about—

Dr Antioch: They are the base, and some of that is still operational. That did include data collections for private hospitals that were clarified in that. The wording in those original agreements was quite broad. Those agreements clarified a lot of different data collections for public hospitals which included, as I alluded to earlier, things like adverse events, length of stay, costs, readmissions and so on, and there were some statements within those agreements relating to private hospitals. They were not overly specific on the data collections, but they were alluded to at the time. I think it has evolved over time. As you quite rightly point out, as to the most recent heads of agreement, there is not a huge elaboration around private hospitals. Also the partnership document that is sort of a companion document to that talks about the performance authority collecting data and evaluating it as part of its functions. But you are quite right. It seems to be a bit left-field—is that what you meant?

Senator FIERRAVANTI-WELLS: No. I am just making the point that clause 34 of the last heads of agreement says: 'It is not intended that as a result of this agreement there will be any change to the financial arrangements in respect of private patients in public hospitals.' I guess the point of looking at private hospitals—but I will not go there; I am conscious of time. I just want to ask you this: in the end, isn't this just another bureaucracy on top of other layers of bureaucracy? Ultimately, in your view, is this really going to help, at the end of the day, the patient, the consumer, of health care in Australia? What is it really going to add to the bottom line except more bureaucracy?

Dr Antioch: My view is different from that statement. I think it has the potential to make a huge difference. The sheer collection and monitoring of this sort of information will have an impact on performance. A lot of studies have been done overseas where just monitoring data relating to performance does impact for a start. There are Canadian studies and some American studies. But more importantly than just the psychological effect, so to speak, on organisations of collecting and doing monitoring, there is the feedback that can occur from these collections, which will really inform people about their quality outcomes and their efficiency. As I alluded to earlier, I think what is really important to sort out is the nexus between impacts on quality and driving greater efficiencies. I know from my work across the networks that it is a huge issue—you really have to keep your eye on both levels. Having rigorous performance data compiled, analysed and fed back gives people an understanding of how the system is working, so I think it is an excellent initiative. I have raised a lot of issues in my submission, so even though I have said I strongly support the concept I think there are a lot of issues to be sorted out.

Senator FIERRAVANTI-WELLS: From the coalition's perspective, we just think that this and the other authorities are just layers of bureaucracy, so I think you know where we sit. But even as far as the deficiencies in this legislation are concerned, suffice it to say that, if you do support it, you support with a lot of qualifiers, because I think your submission has highlighted quite a number of deficiencies. But when the functions of the authority do not even contain the areas of performance—and this is some of the stuff that was picked up before—it really calls into question the effectiveness. Is this just going to be a collection authority and nothing more than that?

There are other organisations in the Commonwealth which already collect data, and every year the state of the hospitals is prepared and reports are prepared based on data. The point is that you are talking about potential, but aren't we just finding another way to collect the same information? You have not explained that—that is all, Dr Antioch. You have not explained what the big thing is that it is going to make this authority the whiz-bang centrepiece of this new reform that is going to value-add to the consumer at the end of the spectrum. You do not have to answer that. I will read your submission again and see if I can find the answer to what I am seeking.

Dr Antioch: Okay. In response to that I would like to say that I have raised a lot of issues around amendments to the legislation, which are not that hard to do. I have talked about linkages to NHMRC's privacy guidelines and greater linkages to the Privacy Act 1988 and so on, and I—

Senator FIERRAVANTI-WELLS: It would have been helpful, though, would not you agree, if we had considered all this as one package so that we knew how they all interacted rather than considered them as silos? Then we probably would have advanced the situation a lot more.

Dr Antioch: Your point is well taken. We are at a point now where you have the quality commission's legislation quite well developed, you have this performance authority legislation quite well developed and this current bill does include components that improve what came before on things like secrecy and data protection and so on, and—

Senator FIERRAVANTI-WELLS: You had a national funding authority that was dumped. It was the centrepiece and it was dumped, and now we have a new pricing authority. It does not all seem to gel.

Dr Antioch: Once the pricing authority side comes through, maybe there will be a greater clarity around the interactions, but I just wonder at this stage whether it is possible to add some fairly simple amendments that can clarify issues. For example, I have talked about data pooling and which organisation will do that. Will an independent organisation such as the AIHW do that? Maybe the performance authority itself could have the pooling data role and do it from there. It just needs to be clarified with DoHA. They, no doubt, are thinking about these issues internally and will have some ideas. I am sure you have some questions for DoHA that fall out of your various inquiries of each submitter. So I am very positive, but I hear what you are saying. I do not think we should throw out the concept; I think it is a great concept once we sort out the privacy issues and the data pooling and the functionality side.

Senator FIERRAVANTI-WELLS: And the rest.

CHAIR: Thank you, Doctor, for your evidence and your submission. I will now call the next witness.

Dr Antioch: Thank you very much.

SULLIVAN, Mr Francis, Secretary-General, Australian Medical Association

[15:14]

CHAIR: Welcome.

Mr Sullivan: Thank you.

CHAIR: You had the second submission to the committee, pipped out by the consumers, who had the first one in. Would you like to make an opening statement? We will then go to questions.

Mr Sullivan: Thank you very much, as always, for the chance to address you on another important matter. You may recall many times in submissions before and in public debate that the AMA has been vigilant about hospital bed capacity, the capacity generally of the public hospital system to meet demand. We regularly put out a public hospital report card and in recent times we have been calling for a bed watch mechanism. I say that as part of an introduction to these introductory comments.

The AMA fully supports a strong framework of transparent reporting against national standards and performance indicators. We recommend that the new national performance authority be given powers to investigate instances where it suspects that data provided to it has been manipulated and to apply penalties if it is proven that the data has been deliberately manipulated. We know from media and articles in medical journals that some public hospitals manipulate their data to improve their apparent performance. The Victorian auditor-general reported in 2009 that Victorian public hospitals inconsistently interpret reporting rules, that data-capture methods were susceptible to error and that the accuracy of data was impossible to check.

Our members—people working in public hospitals—report that data manipulation is par for the course in public hospitals. I will give you four examples: fake wards created on public hospital computer systems so that emergency department patients requiring admissions to wards with no available beds are admitted to a ghost ward so that emergency department targets appear to have been met.

CHAIR: Where was that one?

Mr Sullivan: Two, phantom admissions to create the administrative discharge and readmission to hospital of inpatients who have not left the hospital so that the hospital is funded twice for the one patient admission. Three, hospitals directing patients requiring assessment for potential public patient elective surgery to private doctors for pre-operation consults where they incur out-of-pocket costs so they are not yet on the public hospital waiting list. Four, hospitals inappropriately removing patients from waiting lists or admitting them to fake wards to apparently improve elective surgery waiting times.

We know that without strong scrutiny state governments cannot be held to account for how the Commonwealth money is spent. Recently the Minister for Health and Ageing told us that 378 new hospital beds were opened in 2009-10. Only 11 beds were opened in the previous year. This is despite the Commonwealth providing an extra $4.8 billion to states and territories for public hospitals and a one-off injection of $750 million in 2008-09 to increase hospital capacity and reduce elective surgery waiting lists.

Skewed data does not provide a true picture that the services being provided are the services the community actually needs. We need strong measures to stamp out data manipulation so that there can be a proper planning for service delivery at the local level. I am happy to talk about all that with you. Thank you.

Senator SIEWERT: I want to go to your comment halfway through your paper. You say that passage of this legislation should be deferred until a regulation impact study is done. You go a little bit through it, but could you talk us through how you would see such a regulation impact study done and why you think that needs to be done before the legislation?

Mr Sullivan: I may go to some of the previous questions of the previous submission. The idea of a performance agency, the idea of a pricing authority and the idea of a safety and quality commission intellectually are no brainers—why not, you would say. But they need to fit inside a construct of what we are trying to achieve and why it is necessary to invest here as opposed to there. That is partly the conversation you just had. I think it would be fair to say these concepts of performance assessment, safety, pricing, local agreements about what will be produced and paying for that production through utility payment is the construct that was brought to the table in 2007-08 and part of 2009, but part of that construct has been a hybrid that we are dealing with now.

That may be acceptable, but I would venture to say most of the people working in public hospitals, private hospitals, aged-care homes, surgeries or in the community in allied health professions would struggle to see how these structures will immediately impact on their life in a positive way. They would probably take a view that this may impact on their life in a red-tape, compliance, administrative way, which is what they do not want.

Look at regulation. I know the parliament has done this; I know the Senate has called for it before, and we have agencies that are trying to look at breaking down compliance burden on businesses and on the community generally. I think we could use agencies that are presently in place to examine what will be the regulatory impact. I would be interested if you knew the difference here—I do not. Is this ultimately an assessment of the performance between governments? The only performance reward is a transfer from one government to another. Those that are meant to be the indicators of that performance are the services on the ground, and there is no guarantee that the performance money gets to the service that did well.

I think even that regulation needs to be examined. I think it is important. It is not trying to be obstructionist. I think that, in order to get health reform commonly embraced and passionately progressed by people who deliver health care, they have to feel the case for it. They have to see that this will actually improve the service delivery, will actually be able to shift services from one end to where resources are needed: at the bedside, in the surgery, in the community clinic or wherever it is. I think that is part of our cautious approach here. Conceptually we see things. We just want to note that resources can shift.

Senator SIEWERT: And at this point you are not convinced that they will.

Mr Sullivan: No, we have always been concerned about this. As I pointed out in the introduction, every year the AMA particularly focuses on public hospital capacity, and it has astounded us that in the last two years we have an extra maybe 390 beds in the country. I do not know about you, but I do not understand that.

Senator SIEWERT: So what do you think the next step should be? How would you go about doing that?

Mr Sullivan: You could commission the AMA to do it for you!

Senator SIEWERT: Bar that.

Mr Sullivan: I think there will be wiser heads than I that can tell you what mechanisms currently are available to governments to look at regulatory impact studies and to look at what will be the distribution of resources between administering a system as opposed to investing on the ground.

Senator SIEWERT: To actually get change.

Mr Sullivan: Yes.

Senator SIEWERT: Thank you.

Senator FIERRAVANTI-WELLS: As I said earlier today, from the coalition's perspective, we see all of these new authorities as simply a raft of new bureaucracies that ultimately are not going to add anything to the bottom line—which is better health services for consumers and a better framework for those providing those services. If I understand correctly, you are saying effectively these agreements—marks I and II—are agreements between the federal government and the state governments. What this raft of authorities is seeking to do is monitor and report on the nitty-gritty of it, but the entities that are ultimately responsible are the state and territory hospital systems because they appoint the local hospital networks and the framework that ultimately is going to deliver the services on the ground. Do I understand you correctly?

Mr Sullivan: You are halfway there, I think.

Senator FIERRAVANTI-WELLS: Good. Fill in the other half for me.

Mr Sullivan: I think it is a complex narrative. We have been here for three years. Originally the AMA wanted a single public funder. The reason we wanted a single public funder was we thought that conversations like this may not be that necessary and that in order to have a funder of the system we thought there would be fiscal responsibility clearly put. We do not have that.

Senator FIERRAVANTI-WELLS: That could have been the case with the national funding authority which got dumped by the government. If you go back to the red books, the blue books and the green books, this funding authority was portrayed on page 48 of the red book, I think, as the centrepiece of transparency and accountability. That got dumped and now we are left with this silo of authorities which just does not seem to be getting anywhere near at least attempting to achieve what the government said that authority would achieve.

Mr Sullivan: At the beginning of our submission we said we support transparent reporting. I think that addition of real transparent reporting will be beneficial. The concept of how the performance agency relates to the pricing authority, which will relate to the service agreement struck between the LHN and state department, is still in the air. It is difficult to know how that is going to work. There is no question that these authorities were the result of negotiations between governments. There is no question that these authorities will ultimately only work if there is compliance and collaboration between governments. That is for another place. I cannot tell you if it will, but that is something I am sure COAG and health ministers will need to thrash out the protocols around.

Our point here is that in this process even the establishment of the indicators of performance are contestable. For example, in working papers that are currently around there will be certain identified indicators for hospital performance, general practice performance and so on. We, the AMA, were not consulted in the initial work-up of that. This was something done at officials' level across the country. People on the ground were trying to get a say in how hospitals work and you can see where the debate has gone on the four-hour rule. I am sure we will be back here in a little while to talk about that, but you can see that debate or the debate about picking an indicator like how many general practices have bulk-billing or how many categories of patients with diabetes are getting access in what time. Why does that become a performance indicator for a state government who does not own the practices? Or why does bulk-billing become an indicator in a suburb where the average income is over $150,000 a year, which is just a topical number?

So I think there are a lot of questions around indicators, particularly when the reward goes to some other entity. That is just a point.

The second point here on a more positive frame is that, although it sounded a bit more sensational at the beginning, there is no question that organisations get very exercised in how to present themselves well with data so why would we bother going through a process where we may be only going to perpetuate this? Again, if we are going down the path of the more transparent and rigorous arrangement then ultimately we need to be convinced that this is going to work. The spirit of our submission is trying to be constructive but also not letting some things go through that need to be said.

Senator FIERRAVANTI-WELLS: I guess in the end, in relation to monitoring, preparing reports and doing that sort of thing, there are sufficient entities now that prepare those reports. Every year we have a state of the hospital report. Clearly, that is relied upon by governments across Australia for a whole range of issues. I cannot understand the value of this authority given that the agreements themselves make provision for interim arrangements with existing parameters. I have not quite understood the value of this authority. What is it going to add to the bottom line when all it is doing is publishing and monitoring? If there were some stick associated with breach of performance, one could even contemplate its validity in the broader spectrum, but it does not have that. It seems to me on the legislation we have before us—and correct me if I am wrong—that it is all about generating more reports and more paperwork in an attempt to be seen to be doing something. Ultimately the sanction against the bodies that are not performing is simply not there in the legislation and not there, quite frankly, even in the agreement. That is just a comment—

Mr Sullivan: I will just take that as a statement.

Senator FIERRAVANTI-WELLS: that you agree with. That was a nod, Senator Moore.

Senator ADAMS: I want to come back to the consultation with the states that seem to have gone beyond the COAG agreement. I will use the local hospital networks as an example. The National Health Performance Authority can go straight to the local hospital networks and query performance or something like that completely bypassing the state department of health or the minister. Could you comment on that?

Mr Sullivan: I will just assume that that is correct. I do not know.

Senator ADAMS: It is actually here. It is proposed section 62(2) I think in the legislation.

Mr Sullivan: I meant more out of the context of the IGA. I think the issue is that, again as I understand it, a local hospital network in negotiation with the state health department would determine what is actually going to be done in a region, what will be performed by hospitals in that area. They strike a service agreement. So in a sense that means that the state health department is in a planning role and the local hospital network is in a service provision role. You can think of it like that. The performance agency, as I would understand it, is attempting to see whether performance is improving so they would not look at the state health department for that; they would look at the provider end of it for that. So I can see how that logically works.

There are a number of questions inside this of course. One is the actual nature of the agreement struck with the state health department is crucial. Suppose they say, 'This area traditionally needs 1,000 hip replacements, so let's write into your service agreement that 1,000 hip replacements will be done.' As it turns out, it is a bad year and 1,100 hip replacements need to be done and there are incentive moneys to get that done in your public hospitals or in the private hospitals or whatever way they want to do it. Then the performance agency may say, 'That's great, there has been increased performance there.' But maybe it happened at the expense of something else. It is all done on the basis that, in theory, we have the right money lined up to make sure that things can happen.

All of us who have worked in the system on the ground can tell you that money in hospitals is gobbled up very quickly. It is very difficult, in theory, to be efficient; it is very challenging, but possible, to be effective. That is why, even in this whole process, the AMA are not very taken with the idea of the efficient price of services but

much more into having an effective price that will in a sense be cognisant of the human interaction which is health care and what it takes.

So the service agreement is crucial. The fact that the performance agency may look at the networks on their performance makes sense but the point I was making earlier is that, regardless of that, there is no guarantee that, if that network does perform well or the hospitals within it perform well, they actually get the money for their performance and they actually get the reward. It will go to the state and then I do not know what happens.

Senator BOYCE: I have two questions. You mentioned in the beginning of your submission your concerns about the fact that we do not currently have nationally consistent data. I presume you would also agree that we do not have nationally consistent definitions either in the health sector. Say, on a scale of one to 10 how close are we to nationally consistent definitions in your view?

Mr Sullivan: Four or five, middle of the road.

Senator BOYCE: How does this affect any proposed performance authority and its ability to even monitor.

Mr Sullivan: It was difficult in the early days. If we take a positive view, the authority will have to build that up just as we are hearing from the Health Workforce Australia people that they do not really have the modelling in place, the data in place, to tell us what the projections need to be on various medical specialties or whatever. This is a constant bleat that everybody has and in a sense you could say the national performance authority's first performance indicator for itself might be that it will get national performance data in place by a certain time.

Senator BOYCE: That is quite hopeful. There have been a number of submissions expressing concerns about the independence and the composition of the proposed authority with the minister making all the appointments and so forth. There have also been some suggestions about particular sectors that should have their own legislated position on the board. Could you comment on that please?

Mr Sullivan: Obviously we would be keen to see that there is appropriate medical representation on the board. We are quite clear that assessment needs to be done by an independent authority. It is hoped that the structure not only looks like it is independent but acts independently. Obviously it is Commonwealth legislation, so the minister responsible will be the health minister unless it becomes a statutory body reporting to the parliament. In the past the AMA has hoped that an authority of this type would report to the heads of government or to health ministers more broadly.

Senator BOYCE: Do you prefer it to be a statutory authority or are you comfortable with it the way it is?

Mr Sullivan: The more independent the better.

Senator BOYCE: Thank you.

CHAIR: Thank you, Mr Sullivan. Was there anything you wanted to add that we did not ask?

Mr Sullivan: No, thank you very much for your time.

CHAIR: Thank you very much.

Proceedings suspended from 15:39 to 15:51

BAZEN, Mr Derek, Acting Director, Transition Office, Department of Health and Ageing

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

HEAD, Mr Graeme, Deputy Secretary, Department of Health and Ageing

MASKELL-KNIGHT, Mr Charles, Principal Adviser, Acute Care Division, Department of Health and Ageing

SHERBON, Dr Tony, Deputy Chief Executive, Transition Office, Department of Health and Ageing

CHAIR: I welcome representatives of the Department of Health and Ageing. The same ruling that happens in estimates applies to this hearing in that you will not be asked matters of opinion and you will be there to provide information on the background, the intent and the action in the document—but that will probably not stop senators asking those questions. I cannot say that we have received your submission because we have not and I would like to get something on record as to why we have not received a submission from the department.

Mr Head: We took the view, given that the National Health and Hospitals Network Agreement set out the context for establishing the performance authority and that a detailed explanatory memorandum was available to senators, that there was nothing substantive that we could add to that information in a submission at this point in time.

CHAIR: Was there no thought of sharing that view with the committee before this afternoon?

Mr Head: I apologise if that did not occur.

CHAIR: It did not occur.

Mr Head: I understand that now. My advice to the committee is that we had determined that we would not be providing additional information beyond what was in the explanatory memorandum. I apologise if there was a procedural problem in communicating that to the committee.

CHAIR: I will leave it to other senators to follow-up with their own views, but as chair of the committee I would deeply appreciate it in the future that if anyone takes a view about how they will interact with the committee they will put it in writing to the committee. My understanding is that we have provided the department with a number of quite specific questions and timed responses for those, which we thought would make it easier by having a pre-warning of those. I was going to say that no issue that was raised in those questions would need to be covered this afternoon but that bet is off now because we have taken the view that we can talk about anything in this particular session.

Senator FIERRAVANTI-WELLS: I support the chair. Mr Head, from the coalition's perspective, you know what the issues have been out there in the arena in relation to this authority and the other authorities, and the issues that we have had with these agreements. I am appalled to think that you would not even bother to put in a submission. In my time as a senator I have never come across an instance like this—thinking that an explanatory memorandum suffices as part of a hearing. Not even to have the courtesy to let senators know that that is all you are going to be relying on I think is most unsatisfactory. I think the chair was putting it mildly; I will put it a lot stronger. If you could pass on to Ms Halton and to the minister, from my perspective and on behalf my coalition colleagues, I think this is absolutely appalling. It is just another chapter in this sad and sorry saga that has become the mess that is so-called health reform in this country. Now we have to wait until 26 May because chances are—you can bet your bottom dollar, Madam Chair—that the moment I start asking a question you are going to turn around and say, 'Senator, I am taking that on notice and we will provide it to you on 26 May.' We have come here and you can bet your bottom dollar that is the response that we are going to get.

CHAIR: Senator, it is important to know that we set the date as 26 May because of the detailed questions. At the time we set that date, we did not know there was going to be nothing written this afternoon. We have your point on record. I feel sure you will take it up in other fora as well.

Senator FIERRAVANTI-WELLS: I will.

CHAIR: In light of our limited time, could we move on to the questions that you need to ask. The department is aware of the concern about taking too much on notice. If anything needs to be taken on notice, and that is quite probable because of the complexity of this process, we would appreciate those answers on 26 May with the answers to other questions we have asked.

Senator FIERRAVANTI-WELLS: Why do we need this performance authority? We went through all the kerfuffle with the previous authority. Mr Head, please explain to me what this authority is actually going to add to the bottom line of delivery for patients. It is basically monitoring and providing reports—something that is already done by the Commonwealth. Please tell me and other committee members why we need this authority.

Mr Head: Commonwealth and state and territory governments have agreed, through the April 2010 National Health and Hospitals Network Agreement and subsequently through the February heads of agreement, to establish a national performance authority. The agreement sets out the role of that authority in complementing a range of other activities that comment on the performance of the health system. In particular, the national performance authority is there to provide a very strong emphasis on assessing the performance of local hospital networks, primary healthcare organisations, Medicare Locals and public and private hospitals. This essentially provides a different quality and focus for the information that is available to members of communities about how their health systems and health services are performing and, importantly, actually assesses the performance of those organisations in producing those reports. It complements arrangements that currently report at jurisdictional levels and report on a range of indicators but with a strong emphasis on performance assessment and complementing those other arrangements.

Senator FIERRAVANTI-WELLS: Clause 42 is the only reference that I can find in the mark II agreement. Is that the case? Does that mean that the parameters of this authority are wholly contained within the mark I agreement?

Mr Head: The clause to which you refer does in fact reference this, but there is a clause—and I cannot recall the number off the top of my head—in the heads of agreement which—

Senator FIERRAVANTI-WELLS: The second one?

Mr Head: The 13 February heads of agreements, which preserves all of those elements that were not specifically amended by the heads of agreement, so the performance authority provisions. That is clause 64, where governments agreed to preserve all other elements of the 2010 NHHN agreement and the national partnership agreement on improving public hospital services that are not amended by this document or are not otherwise amended by COAG.

Senator FIERRAVANTI-WELLS: But my question, Mr Head, is this: clause 42 is the only reference there, so are the lead parameters the ones that are in the mark 1 agreement, as opposed to this more general statement that is contained in—

Mr Head: That is correct. Clause 42 in this agreement restates the commitment to establish the authority by a particular time and talks broadly about its focus, but as per clause 64, all of the detailed arrangements around the national performance authority remain those that are in the NHHN agreement in the section on performance monitoring, so clauses E23 through to—

Senator FIERRAVANTI-WELLS: E24 and 25?

Mr Head: Yes, but contextually they also relate to the rest of schedule E—26, 27, 28 and 29. Those clauses in total comprise the section of the agreement on performance.

Mr Broadhead: For the record, Senator, there is also mention of the performance authority in clause 56(a)(iii), saying that the National Health Performance Authority will transparently and publicly report on primary healthcare services and outcomes in the local communities and regions of each Medicare Local, including on local demography and health status, local services and health outcomes such as rates of avoidable hospitalisations.

Senator FIERRAVANTI-WELLS: Can you then explain to me why something that appears to confine itself in a combination of those clauses then in terms of its functions at clause 60 of the legislation purports to extend to private hospitals and other bodies or organisations? It seems to be an expansion, does it not, of what you agreed to with the states?

Dr Maskell-Knight: E24 in the April agreement refers to private hospitals, Senator.

Senator FIERRAVANTI-WELLS: Sorry, that was?

Mr Head: E24a says that the functions of the national performance authority are to provide clear and transparent quarterly public reporting of the performance of every LHN, the hospitals within it, every private hospital and every primary healthcare organisation et cetera, where primary healthcare organisations refers to what we now call Medicare Locals .

Senator FIERRAVANTI-WELLS: Every private hospital.

Mr Broadhead: That is also echoed in D3 of the April 2010 agreement as well. That talks about the performance and accountability framework.

Senator FIERRAVANTI-WELLS: That was B?

Mr Broadhead: D3, on page 34.

CHAIR: Perhaps a very large whiteboard would be useful.

Senator FIERRAVANTI-WELLS: Perhaps if we had had a submission to start off with we would not be wasting our time this afternoon asking these sorts of questions, Madam Chair. Mr Head, you have heard the comments that have been made by the AMA in particular. What is your response to those?

Mr Head: Which specific comments?

Senator FIERRAVANTI-WELLS: Did you not hear Mr Sullivan's evidence earlier?

Mr Head: I was not here while that evidence was being given.

CHAIR: Senator, the AMA made a number of comments. We could go issue by issue on those things. Their submission sets that out.

Senator FIERRAVANTI-WELLS: Where can I find where all of these authorities that are in mark 1 and mark 2 are going to interact? One of the criticisms that I have is why did you not put all this together as one legislative package? This criticism was levelled when we talked about the quality authority. Would it not have been sensible and perhaps less time consuming to have presented all this as one legislative package so that, firstly, we know how they interact and, secondly, we would not have had to go through a whole series of separate inquiries effectively approaching this very much with a silo mentality?

Mr Head: The institutions that form parts of this package have a range of discrete functions in terms of different aspects of the health reform agreement. The safety and quality commission legislation was making permanent something that had been in place administratively for some time.

Senator FIERRAVANTI-WELLS: And operating quite well, I might say, under current arrangements in a much more cost-effective manner, but we will not go there.

Mr Head: The performance authority legislation deals with, as I said, introducing a set of new arrangements which complement a range of other measures that are in place to make available relevant performance information to the community. The independent hospital pricing authority is referred to along with other funding arrangements in the heads of agreement where, because of its integral role in that, those arrangements will be considered once governments have finalised the detailed agreement.

Senator FIERRAVANTI-WELLS: When the National Funding Authority was dumped, was the Transition Office involved in that decision? When did you become aware that the National Funding Authority was going to be dumped?

Mr Head: Are you referring to the changes in 2010?

Senator FIERRAVANTI-WELLS: Yes, Mr Head. You know what I mean by the 'announcement'. The answer to the question we got from Prime Minister and Cabinet was that the National Funding Authority, barely after the ink was dry on this document, was going to be dumped.

Mr Head: As I think I have explained previously, the role of the Transition Office is in implementation. We are set up to effectively either coordinate or directly implement those things that have been agreed to.

Senator FIERRAVANTI-WELLS: In that case, when did you first become aware of the decision to dump the National Funding Authority?

Mr Head: I could not tell you that off the top of my head.

Senator FIERRAVANTI-WELLS: In that case, had you done any work where you looked at the interaction between the National Funding Authority and the other authorities, the rest of the bureaucracy, you are going to set up around these health changes?

Mr Head: As I have indicated when I have given evidence previously, the Transition Office is involved in and has undertaken planning on all stages of implementation of health reform.

Senator FIERRAVANTI-WELLS: I just asked you when you became aware. If you do not know or do not remember then tell me that you do not know and do not remember. You have told me what the Transition Office does. I asked you a specific question about when you became aware.

Mr Head: With respect, Senator, I answered that question by saying that I did not know.

Senator FIERRAVANTI-WELLS: Did you undertake work where you looked at the role of the National Funding Authority and its interaction with other authorities?

Mr Head: The roles of each of the authorities are set out in the relevant parts of the agreement, so it is not the Transition Office's role to change that. Governments have agreed on the relative roles and responsibilities of these organisations. It is the job of the Transition Office to coordinate the process of implementing those—

Senator FIERRAVANTI-WELLS: Can you tell me then what your role has been in relation to putting the meat on the bones of clause 42 and the other clauses we discussed earlier in schedule E about the national performance authority? Are you the primary driver behind this legislation?

Mr Head: The Transition Office is the part of the portfolio that is responsible for all of the processes within the department on the development of the legislation.

Senator FIERRAVANTI-WELLS: All right. You talk about clause 60 and the following functions—monitoring, publishing, collecting data and all sorts of things—but you do not identify there the areas of performance. Is there a reason why that has not happened? After all, it is a performance authority; one would have thought there could have been some performance indicators. This comment has been made in the various submissions received.

Mr Broadhead: The legislation sets out to establish the authority to perform, in a broad sense, the functions that were set out in the agreement. The understanding is that the way in which performance—this thing will stand for some time—will be measured, the nature of the measurements used, the data that is available will evolve over time. So the view has been taken that it is better to give a general description of the functions of the authority rather than try to specify, certainly in statute, the areas of performance that would be covered. That has been dealt with under the agreement through the performance and accountability framework which sits alongside, if you like, the statutory arrangements for the establishment of the authority. That is a framework that is to be agreed by COAG. It is in the process of being developed and it sets out the performance and accountability framework, which the authority would then be responsible for implementing.

Senator BOYCE: So that framework is not agreed yet?

Senator FIERRAVANTI-WELLS: No, it is not agreed and, if I am correct in this, and this has certainly been a criticism that has been levelled by various submissions, those areas of performance, as you add bits and bits to this legislation, it will be done by non-disallowable instrument. Is that the case?

Mr Broadhead: Yes.

Mr Maskell-Knight: The performance and accountability framework is a COAG agreement, so section 61 of the draft bill requires the performance authority to have regard to COAG resolutions, yes.

Senator FIERRAVANTI-WELLS: So in other words this parliament will have no scrutiny. If this government decides to add A, B, C, D by instrument to give effect to this legislation through instruments, they are not able to be disallowed by this parliament. Is that the case?

Mr Maskell-Knight: Senator, I think that the intent of the Legislative Instruments Act at section 44 is that instruments that give effect to intergovernmental agreements are not disallowable.

Senator FIERRAVANTI-WELLS: So they are not subject to public scrutiny. This is not subject to public scrutiny. I am raising this because this has been raised in various submissions; I am just asking for an explanation.

Mr Maskell-Knight: The performance and accountability framework will be agreed by COAG and it will receive extensive publicity once that is done.

Senator FIERRAVANTI-WELLS: It might receive publicity, but it is not going to be able to be scrutinised by this parliament. Why is the framework of this authority different to the framework of the quality authority? For example, in terms of the people on the board, the governance structures: can you explain to me why there seems to be different procedures followed for this one?

Mr Broadhead: Governments, when they agreed the 2010 agreement, and as we have mentioned before, reconfirmed through the heads of agreement, determined the governance arrangements that would apply to the

performance authority, including the composition of the authority, which has a chairperson determined by the Commonwealth, a deputy chairperson determined by states and territories and five other members agreed by COAG. Those are the arrangements.

Senator FIERRAVANTI-WELLS: But you cannot shed any light on why this is different? I do not know whether you gave evidence at the time, but you would probably be aware of the controversy that arose when we discussed the quality authority. There was an issue about the composition. Composition has caused some angst to submitters on this occasion. What is the rationale behind this? Can you provide any insight into it, or you are just saying: 'That's what COAG agreed to and I can't help you any further. That's the bottom line.'?

Mr Head: They are the arrangements the governments have agreed for the governance of this organisation.

Senator FIERRAVANTI-WELLS: Madam Chair, I could go on and on—but I won't. Can I just ask: after we receive the answers to questions on the 26th, I think in fairness I would like to reserve the opportunity to have a look at those answers, just like had we had a submission before us I would like to reserve our position in relation to getting the department back and asking questions. I would like to formally put that request on the record, if I may, to this committee. It would have been so much easier to just provide us with a submission in the normal course, and then we probably would not have had to go through the process again.

CHAIR: I feel we could not have made that guarantee, Senator. Senator Siewert.

Senator SIEWERT: The problem is that some of the questions I want to ask are the questions that are on record.

Senator BOYCE: Yes, and I don't see any reason why we should not.

CHAIR: No, I have actually said we can ask them.

Senator SIEWERT: One of the issues that I want to go to goes back to comments that have been made in a number of submissions about defining more the functions of the performance authority. Why is it not more explicit in the current bill?

Mr Head: To build on Mr Broadhead's earlier comments—if I understand your question correctly—the functions are set out in broad terms in the legislation, with the understanding that the legislation will interact with the performance and accountability framework. There is a reference in section 61 in relation to the performance authority having regard to intergovernmental agreements, and of course references in the 2010 agreement to the performance and accountability framework. So the detailed operation of how the new authority goes about producing its reports is dealt with through that set of functions and by reference to the COAG agreed framework, which deals with a range of different factors on how the performance authority will produce its reports.

Senator SIEWERT: I do not want to rehash the discussion you have just had with Senator Fierravanti-Wells, but I also have concerns about referring to agreements that actually are not part of the legislation. You should be able to go to a piece of legislation and understand what a body that the legislation is setting up to do is actually going to do, without having to then refer to subsequent frameworks which are in various states of development and a health agreement that was reached between governments.

Mr Head: The functional remit of the organisation is set out in section 60. The framework is to be an agreement between governments which provides an additional level of detail and focuses on those things that the authority will have regard to in meeting its functional remit.

Dr Sherbon: We are in the process of consulting the states and other key stakeholders over the formulation of the framework. As Mr Head pointed out, it is a very detailed document—far more detailed than perhaps is required in legislation. But the necessary framework for that document is built around a platform for the early establishment of the National Performance Authority, and then its subsequent development. So it will need to change over time, and it is not really going to lead to a responsive organisation if every time that agreement changes there is a need to return to parliament. It needs to be a flexible and responsive organisation.

Senator ADAMS: Thank you, Dr Sherbon. As far as you saying that you are now consulting with the states, after the legislation has been framed—we have had to have an inquiry about the whole thing, and you are now consulting with the states. Why did you not do it before?

Mr Head: The legislation was introduced without the issuing of an exposure draft. There has been an ongoing dialogue with the states and territories, since the legislation was introduced, very specifically about the framework but also dealing with some issues that have arisen in respect of the bill itself, some of which I believe senators are aware of. The minister has indicated her preparedness to consider some parliamentary amendments in respect of some of those issues which we are currently in the process of developing and discussing with states and territories. There has been an extremely rigorous consultation with states and territories on the framework which

is where, as Dr Sherbon has said, a lot of the detail is addressed. There have been a number of workshops as well as discussions with key stakeholders and responses to draft documents as part of that process.

Senator ADAMS: Have you read the Premier of Western Australia's submission to the committee?

Mr Head: I have.

Senator ADAMS: And Minister Hames as well?

Mr Head: I have.

Senator ADAMS: The Premier says here:

… I believe the Commonwealth has gone beyond what is contemplated as the role and function of the NHPA in the HoA I signed at the COAG meeting on 13 February 2011. Further, the Bill undermines the States' and Territories' role as system managers of the public hospital system with the potential to significantly disrupt and destabilise the on-the-ground operations of the State's hospitals and health services.

Could you comment on that?

Mr Head: As I indicated in developing the legislation we obviously were focused on giving effect to the terms of the agreement. Some states and territories believe that the current drafting does not make clear the role of states and territories as system managers that was reinforced through the heads of agreement process. As I earlier indicated, the minister has indicated her willingness to consider a number of parliamentary amendments to respond to some requirements for clarification about these things that the states and territories have sought.

Senator ADAMS: Looking at the bypassing of the state minister—if a problem arises with the local network boards, the NHPA can go straight to that network board, get all the relevant details, do all the work, without actually having any interaction with the state. The state is supposed to be the body that is actually given the duty of doing the hands-on work in that particular area. The whole thing, I think, practically is just not workable.

Mr Head: Clause 62(2) is in essence a natural justice provision given that local hospital networks are to be established as separate legal entities.

Senator ADAMS: I have lost my place in the bill.

Mr Head: I believe the clause you are referring to is on page 27 of the bill, 62(2).

Senator ADAMS: It is not numbered here.

CHAIR: It is the clause takes up the interaction between—

Senator ADAMS: It does.

CHAIR: That is the clause that actually has the process directly between the authority and the local networks.

Mr Head: It indicates that before completing the preparation of a report the performance authority must give a copy of the draft report to the manager of the entity or the facility and invite comments from the facility about the draft report.

Senator ADAMS: I can just go with my experience, having been on a number of boards in Western Australia. If you have a real problem and something has got to the stage where the Commonwealth is looking at it and the local network board is going to come back and comment, the department of health in that state and the minister for health surely should be advised and have some role to play.

Mr Broadhead: The intention of this was always to provide advice to the Commonwealth and the states. In the original April 2010 agreement, in E24, there is a particular provision that says:

The functions of the NPA are to—

and then it goes on to say:

b. monitor the performance of LHNs, PHCOs—

that is, primary health care organisations—

and hospitals against these performance measures … In order to identify:

ii. poorly performing LHNs and PHCOs to the Commonwealth and States, to assist with performance management activities as outlined in provisions—

et cetera. So the intention is there as per the agreement, and this was to give effect to that intention to advise the Commonwealth and the states of poorly performing organisations, but in the process of doing this, prior to providing that advice, the act is drafted so that the organisation which may be identified as poorly performing has the opportunity to respond to the draft. I think it is an issue of natural justice that the organisation at least gets the chance to consider what is about to be said about it before that is finalised. That was the reasoning behind provision 62 in the bill. It is an issue of natural justice for the organisation that is about to have an adverse report

made about it—that it had the opportunity to respond to that draft before that is finalised. Then the intention is that it becomes available to governments. In the case of the Commonwealth, they would be the lead hand in responsibility for Medicare Locals, for example, and in the case of LHN the states of course are system managers under the heads of agreement. It is really an issue about: before one puts a report out that identifies an organisation as poorly performing, does it have the opportunity to at least consider the draft report before that report is lodged?

CHAIR: It is only intended to be in the case of a nonperformance clause?

Mr Broadhead: Yes. The theory is that, if you are going to make an adverse finding or an adverse report about an organisation in this instance, it is only fair that they have the opportunity to—

CHAIR: So the clause specifies that the only time it goes directly between the authority and the local agency is in the area of a nonperformance position. That is your point, isn't it?

Senator ADAMS: Yes, but I am getting onto something else.

Mr Head: The scope of this section refers to poor performance by a class of entities or facilities.

Senator ADAMS: Regarding the expertise in the local network board and within the state department of health, surely this would have to go to the state department of health. I am going to ask you how many local network boards you actually envisage will be throughout Australia. I know that in Western Australia, just in the country alone, there are going to be two boards. Western Australia is a huge area. I have been part of the Metropolitan Health Service Board and also country boards, so I am fully aware of the health problems right through WA. Practically, this does not make any sense at all.

Mr Head: As I indicated before and as you have made aware through reference to one state's submission, this is an issue that we are in discussion with states and territories about in terms of notifications of poor performance. As I have previously indicated, the minister has indicated a willingness to consider some refinements to the bill.

Dr Sherbon: Furthermore, the aforesaid framework that we mentioned does clearly outline a role for states in the accountability sections of the framework that we are currently negotiating with the states. They will be reaffirmed in their role as system managers through that framework and, as Mr Head mentioned, there are also other amendments being considered as we speak.

Senator ADAMS: As a frustrated senator, it really annoys me when you get a bill like this that has to come to a Senate committee and it is obviously going to have so many amendments. This could have been fixed if there had been some consultation done earlier on and the practical issues were looked at. As a committee—

Senator FIERRAVANTI-WELLS: Doesn't it have to begin on 1 July? Do I understand that correctly?

Senator ADAMS: That is right.

CHAIR: That is the intention.

Senator FIERRAVANTI-WELLS: So are we going to see deferral of this? How can we possibly think that this is going to be done by 1 July?

Senator ADAMS: How can we vote on it? You can't.

Dr Sherbon: One key philosophical emphasis in recent healthcare agreements in Australia amongst the Commonwealth and the states has been the need to devolve hospital management to local communities. So this clause was drafted with that in mind. Clearly, the states have asked for further reconsideration of the matter. Most governments in Australia are now looking to devolve as much of their system locally, and that is where this clause derives. The local hospital network is an independent statutory authority under most state legislations, or will be according to the agreement, so there was an emphasis in our thinking in instructing the drafting organisations to recognise that independence. That is where this clause has come from. We are now in the process of reaffirming with the states their role as system managers, but in doing so it has to be remembered that governments have agreed to devolve management of the hospital system to local organisations.

Senator ADAMS: How local is 'local'? It is fine to use the word 'local', but really and truly where do you start and where do you stop?

Dr Sherbon: Each state and territory government is currently considering their own legislative response or administrative response to that question and to varying degrees. You know the situation well in Western Australia but alternatively in Victoria they are looking to establish 86 local hospital networks which are extremely local to a very small locality. It is a matter for states and territories and local communities to decide their own interpretation of 'local' and to come up with their own consideration of the governance of their hospital systems.

Senator FIERRAVANTI-WELLS: That is all very well. I will not traverse through all the issues that we did in that. Buried away on page 14 of the first agreement 'local' does not really mean local. In any case the services that are purchased by that local hospital network are completely determined by the state authority because A19 says that the states will be responsible for purchasing services from LHN. You talk about local and you bandy the word 'local' about, but it certainly is not run locally. You might give it that local name but ultimately it is the state that has the determining purchasing authority.

Dr Sherbon: Governments in New South Wales, Victoria and elsewhere throughout Australia are working through that issue now and they are in consultation with their own communities. They are working through what they see as local.

Senator FIERRAVANTI-WELLS: Yes, but all we have before us is this agreement. That is our point. We do not know ultimately what is going to come out at the other end. In this agreement is what you promised and said would happen, and there is a marked difference. That was the point. I am sorry, Senator Adams, I just wanted to pick up Dr Sherbon on that point.

Senator BOYCE: The performance indicators, targets and benchmarks will be decided by the performance authority when it is set up; is that right?

Mr Head: The details around performance indicators et cetera are matters that are for dealing with in the performance and accountability framework, which is in fact agreed by COAG and which the authority must have regard to in framing its reports. Dr Sherbon could add some more detail to that.

Dr Sherbon: Just to confirm that: the authority will operate to a framework as agreed by COAG, but—

Senator BOYCE: But the framework will include performance indicators; is that right?

Dr Sherbon: Yes. The framework that we are negotiating currently with states, territories and key stakeholders will include an initial set of indicators. As I indicated to Senator Siewert in an earlier answer they may evolve over time and will require flexibility. But there will be an initial set of indicators to get the system off to a running start, so to speak. They will be based broadly on information that is either currently available or can be reasonably rapidly developed. The actual standards against which those indicators are measured will need to be endorsed, either by health ministers in the case of safety and quality standards or COAG in the case of non-safety and quality standards such as access or efficiency indicators.

Senator BOYCE: So the framework is not meant to be a document that you can rely on into the future for how this will work?

Dr Sherbon: I would see the framework that we are negotiating at the moment as being of particular use to the authority at its inception but it would probably provide the authority with at least 12 to 24 months of serious development work before I would recommend to the authority that it alter its approach. So there is a very substantial and challenging set of indicators that the states and territories and some other key stakeholders are lining up with us to get the authority focused in its initial operation. It will be a challenging set of indicators. It will be very important for the public to know just how well each of our Medicare locals is performing and they will have a range of information to make that assessment upon themselves.

Senator BOYCE: And it will be up to two years before the authority measures performance?

Dr Sherbon: That is only my opinion or consideration, Senator. The authority could seek an alternative view from governments soon after inception, but I would suggest there is a significant challenge in the indicator set that we are proposing for the states, territories and other stakeholders that would preoccupy the authority for some time to come and that would provide the public with new information that they have never been able to access before—to compare the performance of their LHN or their Medicare local would be a very substantial advance.

Senator BOYCE: The other point has been made by a number of witnesses that without nationally consistent data and nationally consistent definitions it is very hard to develop anything that is going to give us an overview of performance.

Dr Sherbon: There are some nationally consistent definitions either in place at the moment, either developed by the safety and quality commission or its partner organisations, such as the Australian Institute of Health and Welfare. Some definitions will require refinement. The National Health Performance Authority will be the final point at which those definitions are set and then measured throughout the system. As I mentioned in an earlier answer, though, we are looking to minimise the disruption on states, territories, private hospitals and other operators by using existing data sets wherever possible.

Senator BOYCE: The AMA suggested that currently we are probably about four or five out of 10 in terms of having national consistency on data sets. What would your figure be?

Dr Sherbon: It is a matter of opinion. What I can say is that for most of hospital data sets, having managed a state and territory health system for the last 4½ years before coming here, I can assure you that most of that data is available—

Senator BOYCE: In one particular state, you are saying, Dr Sherbon.

Dr Sherbon: Yes, but most of the—

Senator BOYCE: But I am asking whether it is nationally consistent data.

Dr Sherbon: It requires some work but I believe that we are close to national consistency in hospital information. For Medicare locals, given that they will be new organisations, it is fair to say that there will be quite a lot of work for the authority to do to establish consistent definitions and data collection protocols. But for hospitals I believe the information is easily available—I would give it much more than four or five out of l0; I would give it about seven or eight.

Senator BOYCE: Do we have a 100 per cent nationally consistent definition of a hospital bed?

Dr Sherbon: We do require some work on the definition of 'a hospital' and 'a hospital bed'—

Senator BOYCE: A hospital, as well as a hospital bed?

Dr Sherbon: Yes, because many small hospitals provide very little in-patient care. I am sure you are aware of the importance of maintaining health services in remote communities where often the demand for in-patient services is best met at another centre but communities still require access particularly to residential aged care or primary care as in emergency departments. There is some development work there required around defining where to draw the line. I am confident that we can agree amongst the eight states and territories, the Commonwealth and the authority on a definition that can be readily used. As I said earlier with, most of the performance indicators that we are using for hospitals we already have a substantial amount of agreement on the definitions and protocols for data collection.

Senator BOYCE: I would have thought that defining 'a hospital' and 'a hospital bed' were probably fairly critical to having nationally consistent definitions.

Dr Sherbon: I do not think that will be a major challenge. We easily can categorise hospitals as they are currently categorised by the states and territories. There will be, as I said, some debate at the margin for very small facilities that provide very little in-patient service but that is something that we can work through readily with the states and territories. We will be gearing up to provide information to the public as soon as possible.

Senator BOYCE: Did you have something to say there, Mr Broadhead?

Mr Broadhead: Might I suggest that in essence you are making the argument for the authority in the sense that these are the issues that have to be addressed—

Senator BOYCE: I have had this discussion with the Institute of Health and Welfare for some considerable time. I am not sure that we need a multimillion dollar authority for the states to simply agree that they could be nationally consistent if they chose. I realise there are costs involved to the states in doing that. The AMA gave us a number of examples of fraudulent or misleading reporting by state systems at the moment in terms of double counting of patients or admitting patients to what they referred to as 'fake' wards et cetera. How are you going to avoid that issue continuing?

Dr Sherbon: The performance and accountability framework does describe a role for the national health performance authority in data validation. States and territories as you know are subject to audit by the Auditor-General. In South Australia where I was recently chief executive of SA Health, the Auditor-General checked our waiting lists regularly and independently. I have to tell you I am not aware, having worked in the system for 25 years, of anything of the order that Mr Sullivan outlined to this committee this afternoon.

The authority will have a data validation role. It will have the ability to question data and interrogate data that it receives from either states, territories, private hospitals, Medicare Locals or any other organisation. As I said there are other audit avenues available to government organisations.

Senator BOYCE: What would you do if you found intentional fraud?

Dr Sherbon: The authority's role is to notify the relevant government or governing body in the case of private hospitals. One would hope that they would be responsible and notify the relevant audit organisations be it the Auditor-General or in the case of private hospitals, external auditors.

Senator BOYCE: But there are no provisions in the bill.

Dr Sherbon: As I said, the framework is clear on the strong role for the authority in data validation.

CHAIR: What about public hospitals? Certainly, Mr Sullivan's evidence did not indicate whether it was private or public. You have given us what you would hope would happen for private hospitals, what about public hospitals?

Dr Sherbon: I would expect that the relevant government minister would be notified and one would hope that they would notify the Auditor-General or other investigatory body.

CHAIR: There will be further questions which will be made available to the department by the end of this week to meet the 26 May deadline. If senators have further questions from this afternoon could we please get them to the secretariat.

Senator FIERRAVANTI-WELLS: When are we due to report on this?

CHAIR: On 9 June.

Senator FIERRAVANTI-WELLS: And then we will have to consider after 26 May whether we call the department again.

Senator BOYCE: Is that the first sitting day?

CHAIR: No, it is in the middle of the first week. As the department just heard, we get the answers back on the 26th. Should senators have a need for further discussion, we will be in contact through the minister to hold another hearing with the department. Thank you very much. The hearing is adjourned and the committee will reconvene as required. Thank you to the departmental officers, Hansard and the secretariat for providing help today.

Committee adjourned at 16:45