COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

FINANCE AND PUBLIC ADMINISTRATION LEGISLATION COMMITTEE

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

WEDNESDAY, 7 SEPTEMBER 2011

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SENATE

FINANCE AND PUBLIC ADMINISTRATION LEGISLATION COMMITTEE

Wednesday, 7 September 2011

Senators in attendance: Senators Fierravanti-Wells, Polley, Ryan and Stephens

Terms of reference for the inquiry:

To inquire into and report on:

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

WITNESSES

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

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

Committee met at 09:36

CHAIR (Senator Polley): The committee will now commence its inquiry into the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011. I welcome representatives of the Consumers Health Forum of Australia. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has your submission. I invite you to make a short opening statement, and at the conclusion of your remarks I will invite members of the committee to put questions to you. Thank you both for making yourselves available to appear before us. Would either of you like to make an opening statement?

Ms Bennett: Thank you for the opportunity to appear before this committee today. For too long hospital funding has disappeared into the black hole of state and territory health budgets. There has been too little transparency, too little real accountability, and that is an unacceptable situation for health consumers and taxpayers alike. CHF supports the establishment of the hospital pricing authority. Developing a national efficient price for hospital services on which Commonwealth hospital funding will be based has the potential to introduce into the system the efficiency and transparency that has been sorely lacking to date. This includes public reporting and transparency in appointments to all advisory structures.

We have concerns, however, about elements of the legislation establishing the authority. The detail of our concerns is set out in our submission, so I will not go into detail about those today, but there is one particular omission that I would like to discuss in more detail, and that is the omission of any reference to health consumers or community involvement at any point in this bill.

It is disappointing that the broader policy intent of government to place consumers at the centre of health care and health reforms is not reflected in key pieces of legislation such as this. There is now widespread recognition of the benefits that result from involving health consumers in health policy and processes. Health consumer representatives provide a unique voice that balances the perspectives of others involved in decision making, including government, health professionals and industry lobby groups. Involving consumers in health policy ultimately leads to better health outcomes and better outcomes for the health system and the users of health services.

All this appears to have been overlooked in the drafting of this legislation. Despite the legislation containing sections that set out the membership of the pricing authority and its supporting committees, there is no reference anywhere in the legislation to how consumers will be engaged in the work of the authority, let alone whether they will get a seat at the table. The omission is particularly notable given that the bill specifically states in clause 131(3):

In performing its functions, the Pricing Authority must have regard to …

(a) relevant expertise and best practice within Australia and internationally;

Consumers are the users and, ultimately, the funders of the health system. The system needs to service their needs, not just the needs of those who work in the system. Their expertise cannot be overlooked.

Developing an efficient price for hospital services will be a complex technical process. CHF argues strongly that this technical process cannot be limited to only quantitative considerations such as resource costs and length of hospital stays or classifications of diagnosis. Health outcomes and patient experience must also play a role in determining the efficient price, and it is here that consumers can play an essential role. We have previously argued, in relation to the National Health Performance Authority, that measures of patient experience are an essential component of assessing the performance of hospitals and other health services. These measures can and should also play a role in determining prices for hospital services that are delivered in a way that meets patient needs.

CHF has identified several areas throughout the legislation where simple amendments can redress the omission of consumer experience and ensure consumers are involved in this essential pillar of health reform. In clause 144 of the bill, we argue that the pricing authority must include a member with expertise or knowledge in the consumer experience of health care. In part 4.10 of the bill, we recommend the inclusion in the legislation of equivalent advisory structures that include the views of health consumers and community members. Third, and finally, clause 205 of the bill allows the pricing authority to establish committees to advise or assist it in the performance of its functions. CHF recommends that the legislation requires the establishment of a consumer or community advisory committee equivalent to and complementing the role of the clinical advisory committee. CHF would also welcome advisory structures that see clinicians and health consumers collaborating. This would

require a structure that is based on balance to consumer and clinician membership. Inclusion of a single consumer representative on the clinical advisory committee, for example, would be tokenistic and of limited value.

In conclusion, CHF welcomes the establishment of the Independent Hospital Pricing Authority. We view it as an essential pillar of health reform that can provide much-needed transparency and efficiency in hospital pricing. But we do not see how this health reform body can contribute to health system improvements and improved health outcomes without the direct involvement and engagement of health consumers in its work. We ask the committee to recommend amendments to the bill that will see health consumers play a central role in the important work of this authority.

CHAIR: Thank you. In relation to having a consumer representative, do you not consider that a clinician would be able to fill the role? It is a very complex issue, so perhaps the consumer representative would have to have some health expertise and background. Do you think a clinician could carry out that role?

Ms Bennett: Thank you for the question but, no, we probably do not. Twenty years ago, I suppose, we were having these sorts of arguments—that consumers would find these processes and these issues far too complex, demanding and technical and therefore they would not have a place at the table because they would not be able to contribute to the discussion. We have since moved on and, in almost every area of health care and health service delivery, there is consumer involvement and representation in recognition of the fact that it adds value and ultimately provides better outcomes for the people who use the service.

Health consumers bring to the table their experiences of health care as the recipients of health care, and that can add significant value to those discussions. Particularly when you are pricing and putting a value on the quality of health care, it seems a real omission to us that you would not include those who receive that health care. In every other industry where you are servicing a particular constituency, you would always ask for the views and reflect the views and factors that those recipients find important in that service delivery, product delivery or whatever you are providing to them. It seems really strange that you would not do that, particularly in an area like health care, where the outcomes are so critically important to the individuals who receive that care.

Senator FIERRAVANTI-WELLS: Thank you, Ms Bennett. I have a sense of deja vu. We have been here before and have had this discussion in relation to the involvement of consumers. Looking at your submission, you talk about clause 131, on the functions—relevant expertise and best practice in the sense of the framework. The amendment that you are specifically suggesting is at proposed section 144. Proposed section 144(4), goes to (a) and (b) and then the following fields: the health care needs of people living in regional and rural areas, and the provision of health care services in regional and rural areas. Are you suggesting that we should include a consumer perspective?

Ms Bennett: Yes. Certainly, in part of proposed section 144, we welcome the inclusion of a representative with regional and rural expertise. Clearly, that is quite an important factor, particularly when you are talking about the pricing of hospital services in those areas, where there are different factors that impact on the cost of services. Ultimately we would like to see consumers in those areas benefitting from specific expertise that is provided through that representation. However, we also believe that the broader consumer movement, or consumer recipients, across Australia deserve to have a place at the table in order to reflect the specific needs that health consumers, as recipients of health care, have. We believe that proposed section 144 could be amended to include a clause that enables a member with experience of health care.

Senator FIERRAVANTI-WELLS: That is separate to the establishment of the clinical advisory committee. Following on from what Senator Polley said, there are various components to this authority's work, where you say consumer involvement should be inserted, just in the framework and as part of the clinical advisory committee. Obviously, following on from what Senator Polley said, there is potential 'conflict' when the clinician is delivering and the consumer is receiving. You are saying that, regarding the eight members, you would probably have to amend that because it just says that it needs to be all clinicians. You are saying that the provisions of 4.10 need to be amended in various parts. We are looking at 179(3).

Ms Bennett: Actually, we do not see consumers necessarily playing a role on the clinical advisory committee. We would like to see an equivalent structure for consumers. Our concern would be that if one or two consumers are included on the clinical advisory committee it would be tokenistic and their voices would be drowned out by the majority of clinicians who make up the group.

Senator FIERRAVANTI-WELLS: So, in other words, you are saying that as part of the provisions about subcommittees there really should be a subcommittee which is consumer focused?

Ms Bennett: Yes. The proviso on that would be that it has a value that is significant—that it is not just a subcommittee where the advice can be taken or ignored. It needs to be a significant part of the decision-making process and the price setting process.

Senator FIERRAVANTI-WELLS: There would be a specific inclusion of the establishment of a consumer advisory committee—in effect, a separate section, just like part 4.10 deals with the clinical advisory committee. You would perhaps insert there part 4.11, which talks about a consumer advisory committee.

Ms Bennett: Yes.

Senator FIERRAVANTI-WELLS: With it are similar provisions that deal with the various aspects of consumers. Have you thought through how you would see a potential amendment to part 4.11?

Ms Bennett: We would like to see a separate section that would include an equivalent advisory structure to the clinical advisory committee. That would not be a unique situation. There are many structures in the healthcare environment that provide for that kind of input and advice. In fact, ideally we would like to see consumer advice provided at all levels of decision making in this authority. There is a range of mechanisms for doing that and we have talked about those many times. I suppose our concern would be that there is a single consumer representative tacked on to a clinical advisory committee that has limited value. They are bound by confidentiality, they cannot actually reflect the broader views of consumers and their input is of limited value.

Senator FIERRAVANTI-WELLS: As an alternative, Ms Bennett, how do you feel if without the amendment to section 144 and the seven other members there is perhaps a consumer advisory committee that feeds into the framework? Would that, in your view, suffice?

Ms Bennett: That would suffice as long as that committee had some weighting in terms of its advice up throughout the structure because it is important that it is not just a tokenistic committee that provides the tick for consumer input.

CHAIR: I have a question that follows on from that. You have obviously thought about this, Ms Bennett. What would be the criteria for selection of the consumer representatives? Have you thought about the detail of those people that would be qualified to participate? I think it would be for the committee's benefit if you could answer that but if you cannot do that now perhaps you could take that on notice and provide something back to us very quickly.

Ms Bennett: That is a good question. I suppose the key criterion would be consumers who have an experience of the hospital system by which we could perhaps get a range of perspectives through the use of outpatient services and inpatient services and various different parts of the hospital system. So that would be a key criterion. The essential thing is that people who have used the system have the opportunity to provide some advice about how that system works for them in terms of its efficiency and its effectiveness and what the key elements of health service delivery are that provide for an effective and efficient service and ultimately good health outcomes for them.

Senator FIERRAVANTI-WELLS: I want to pick up your point about proposed section 211 and comment before public reports. Obviously, as it is written it seems to imply a lack of transparency or at least a lack of opportunity for any report to be vetted, if I can put it in those terms, before it is released publicly. Is that the gist of your concern, Ms Bennett?

Ms Bennett: I suppose we are a little bit concerned to see that this authority is a transparent functioning body that does provide public accountability specifically to those who use and pay for the system. I think that there is some scope within proposed section 211 for there to be changes to reports. We would like to know, should that be the case, whether or not those changes would be made public and whether the comments that are made by ministers as part of that consultation process would be made public. That would be a quite critical part of making the work of the authority more transparent.

Senator FIERRAVANTI-WELLS: Having now watered down, in effect, and re-established the roles of the states we have really gone effectively back to where we are now but we are now putting this authority in. If you now give state ministers the right to, in effect, vet reports then we are back to square one and we really are not achieving the end objective.

Ms Bennett: That is our view and we agree. If there is not open transparency and accountability around this then we run the risk that we continue with the status quo, which is that the states and territories tend to run their own agenda, the money disappears into state coffers and we never see where it actually goes. We have just seen the COAG Reform Council report released yesterday showing that every state and territory other than South Australia—as I think it was—has increased waiting times for elective surgery despite additional funding going in. We would like to see the states held accountable for the money they receive from the Commonwealth and for the

services that they deliver and that, where there are any decisions made in relation to those jurisdictions, how they use that money and what services they provide, that is made transparent and public. That is ultimately going to be the way of achieving health service improvements and ensuring that the system performs better. It drives performance to have that kind of—

Senator FIERRAVANTI-WELLS: From the coalition's perspective, we have always asked: what is the point of all this bureaucracy and all of these authorities? But, in effect, this section affords the opportunity for a status quo situation if they really want it. In effect it says that, apart from the annual report, just about everything, if that is the intention, could be kept non-transparent and out of the public arena. That is in effect what those two sections together mean, on their face.

Ms Bennett: I suppose this authority does have the real potential to improve efficiency and transparency and to drive better performance, But, again, the legislation is critical to getting that right and ensuring that that non-transparency does not happen. We think that this is an important piece of legislation that needs to be amended to reflect those needs if it is to achieve those outcomes.

Senator FIERRAVANTI-WELLS: Thank you.

Senator STEPHENS: Thanks for your submission. I want to go to your other recommendations around sections 222 and 228 and that issue of informed consent. To me, there is a pretty logical argument there to actually make the bills consistent, but in raising that issue I wonder if you want to elaborate on the concerns that you have about informed consent, particularly in relation to section 222.

Ms Bennett: In all of our work consent is a critical component of ensuring that consumers' needs are reflected, and very often consumers tell us that they have given consent without necessarily being informed of all the implications of that consent. So it is a key issue for our members, and it is something that we believe should be addressed as part of this legislation. It has been addressed in the legislation for the establishment of the National Health and Hospitals Network Bill, and we believe that this should be reflected here as well. Would you like to answer that, Anna?

Ms Wise: Our concern would be that consent is provided but that it is consent that is based on a full explanation of all the implications of sharing the information or having the information about identification shared. As Carol said, we do hear from people who say that they have provided consent but after the fact have realised that there are a number of implications of which they were not made aware and so they feel that while they provided consent that it certainly was not informed. That is what we want to avoid.

Ms Bennett: It is an issue that was raised in our consultations. Although they were brief and short, given the time frames, it was certainly specifically raised by our members.

Senator STEPHENS: Has the forum actually produced a discussion paper or guidelines around this issue of informed consent?

Ms Bennett: We have certainly done quite a bit of work on the issue. It comes up in nearly every consultation.

Senator STEPHENS: If you could provide that to the secretariat, that would be helpful.

Ms Bennett: Yes, we would be very happy to do that.

Senator STEPHENS: Thank you.

Senator RYAN: I just wanted to clarify, Ms Bennett, the comments you made earlier with respect to, shall we say, holding ministers accountable. Do you consider those should apply equally to the Commonwealth? You talked about state ministers being held accountable. My concern with this is that we always seem to have these grand plans that come out of a department in which no-one actually works in or runs a hospital. A number of the states would say—and I notice Mr Laverty is smiling; I accept that you run some hospitals—that these proposals are developed in the absence of what it is like to physically work in a hospital. There seems to be an attitude in Canberra that somehow it is all the states that get up to dodgy behaviour. I just want to clarify that you think that those comments about transparency and holding ministers accountable and holding governments accountable should equally apply to the Commonwealth and not just the state departments of health.

Ms Bennett: Certainly we would like to see transparency reflected throughout this key piece of legislation and, yes, that works both ways.

Senator RYAN: Are you satisfied that this authority is independent enough from the Commonwealth Minister for Health and Ageing and the Commonwealth Department of Health and Ageing?

Ms Bennett: We have a federated structure. This is the way that—

Senator RYAN: Is this agency, which is being set up under Commonwealth legislation, independent enough from the Commonwealth minister, because we do not want a situation in two years, five years or 10 years where in order for the Commonwealth health minister to be able to put out a press release, they tweak what this health pricing authority wants so they can blame someone else—blame-shifting actually goes both ways? Are you confident that this authority is independent enough from the Commonwealth minister to be able to provide the transparency that is needed, even though it does seem to be closer to the Commonwealth than the states.

Ms Bennett: There does need to be transparency around what is done. It is not necessarily the structures that will determine whether or not this body provides the level of accountability and drives the performance and the efficiency that we need in the system; it is more about how accountable some of those decisions are. The reporting and ensuring that there is an open, transparent process for the discussions and decisions must be—

Senator RYAN: This is my final question. You are confident that those reporting provisions, those transparency provisions, are independent enough from influence from the Commonwealth minister or the Department of Health and Ageing to meet the standards you think are important? It is clear they are independent enough from the state departments.

Ms Bennett: We believe it is about getting the legislation right, and at the moment it is not necessarily reflective of the kinds of reporting and accountability that we would like to see. That certainly needs to be strengthened in the legislation. If that is done we would be more satisfied that the authority will meet the levels of independence that we would like to see—or certainly enable the rigour that we would like to see in the decision making.

Senator RYAN: Thank you.

CHAIR: As always we have run out of time. I would like to thank Ms Bennett and Ms Wise for appearing before us and your submission. We need the additional material as soon as possible—by Friday afternoon, if we could.

Ms Bennett: Sure.

CHAIR: Thank you very much

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

[10:02]

CHAIR: Good morning and welcome, Mr Laverty. You are representing Catholic Health Australia. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has your submission. I now invite you to make a few short remarks and at the conclusion of your remarks I will invite members of the committee to put questions to you.

Mr Laverty: Thank you, Chair, and thank you for having Catholic Health Australia before this inquiry today. We have had the opportunity to review the dozen or so submissions that this inquiry has received in the last week. There are two themes that come from nearly all of those submissions that we support. The first is that this authority needs to be established and operate in a very transparent manner. We have some comments to make about how the bill can be amended to reflect that. The second is that nearly all of the evidence presented to this inquiry from organisations will argue, and we are no different, that the operation at both governance and operational level of this authority should involve people from outside of the public sector, outside of government. We are no different in that regard. You have just heard a very similar argument from the Consumers Health Forum.

But we differ a little from the other applicants to this inquiry in that we have a unique status across our public hospital network that we think should be reflected in the drafting of this bill for it to be effective in the years ahead. Very specifically, senators will be aware that Catholic Health Australia represents about 10 per cent of the nation's hospital beds. Within that there are 2,700 public hospital beds operated by Catholic hospitals, mostly on the east coast, but broadly around Australia. For the bill to be effective it needs to have regard to the unique nature and the slightly different legal status under which those 2,700 public hospital beds actually operate. We do not see that reflected in the bill at present, but we think minor amendments can adequately incorporate the impacts of the differing legal structures that operate those 2,700 public hospital beds, and we have proposed that to you in our submission.

However, we do support the intent of the bill. We think this is sensible legislation. We think once a pricing authority is established, if the definition of a public hospital price is adequately worked through, it will give the opportunity for Commonwealth, state and NGO hospital providers, and indeed the ultimate consumers of those hospitals, to understand the price drivers of the delivery of public health care and for public health care to then be purchased from the most efficient providers. That is why we are unabashed supporters of this component of the health reform agenda. When an efficient price is determined and defined correctly, we are relatively confident that it will show what other studies have proven to date: that NGO providers of health care provide high-quality and efficient services and that, over time, local hospital networks, or districts in some states, should in fact be purchasing their services from the best-quality providers and the most efficient providers of that public health care.

In order for that hospital price definition to be properly constructed, we put before this inquiry a number of components that are essential to how we operate our 2,700 public hospital beds but are perhaps not clearly of priority to how state health departments currently account for hospital services that would ultimately feed into the creation of this national hospital price. For example, as a non-government owned provider of public hospital services, we have to account for capital, depreciation, insurances, council rates, long-service leave and information technology, even down to whether or not a Microsoft licence per user is applied to each cost of patient admission. Different states and territories use different accounting systems, which affects whether or not these various components will ultimately make their way into what is an efficient price. For an NGO provider of hospital services, all of these form the component of what is the price or the cost of delivering a service. Some states and territories account for these things differently; indeed, within states different areas at present can account for them differently.

I provide this list simply to say that the design of the bill that eventually passes through this parliament should have regard to the different nature of how hospital services are delivered and a recognition that NGO hospitals actually have to cost and manage their service delivery somewhat differently to government owned hospitals. Therefore, we argue that the governance of this new authority should allow for the appointment to its board of someone who has experience in the delivery of NGO hospital services. I want to acknowledge that our discussions with both the government and the department have on that matter been very positive in that government and department have expressed interest in ensuring that somebody in the initial round is appointed with that type of capacity. We would like to build on that interest of government and department and go a step further by enshrining it in legislation.

We also say that the authority should be required in its operations to give consideration to those variables that exist in NGO hospitals when determining a national efficient price. Specifically, we say the legislation should be amended to require the authority to consider cost drivers and variables within delivery of non-government hospital services. We think that is particularly important given that the services we represent are, in fact, in some cases larger in breadth than some smaller states, which are represented in the Council of Australian Governments. Finally, we have made some recommendations around transparency. We are pleased that the department and government have acted on the discussions that I and others have had with them about ensuring that public submissions to the setting of the annual efficient price will be made from governments and others. Publication of those submissions means that there will be transparency around what governments and others are putting forward.

That is a welcome development. But we importantly think that if the authority is to be independent it should not be in a position to provide confidential advice to the Commonwealth in particular; that an independent regulator needs to be independent of government in its workings. And we think that that is an important amendment this inquiry should consider.

I am very happy to take questions in relation to our submission and any other matter that is occupying the minds of senators.

Senator FIERRAVANTI-WELLS: I have just had a look at *The state of our public hospitals*, the last report. Of course, private hospitals in Australia account for 43 per cent of hospitals, and this is really about public hospitals. So the point that you make about the involvement of the private hospital sector is a very valid one, because we are talking about almost 50 per cent of the hospitals in Australia. I think that has really been a feature of the whole issue about this reform. I note your comments on the public record repeatedly about the involvement of the private sector, so I thought I would reiterate that.

In relation to the changes that you are proposing, you heard the comments that Ms Bennett made earlier in relation to consumers. She was talking about the possibility of consumer involvement in clause 144 and/or a separate consumer advisory committee. You are simply talking about the insertion of the private hospital framework into just that clause—that is, one of those seven being from the private hospital sector?

Mr Laverty: I would not argue against Carol Bennett's submission to this inquiry—

Senator FIERRAVANTI-WELLS: I appreciate that.

Mr Laverty: Consumers are the ultimate end-users of public hospitals and it is appropriate that they be represented at the right level. But if I could turn to your opening comments. Yes, we have regularly said that there is more opportunity for the government to involve private hospitals in the delivery of public services, and we think the Council of Australian Governments agreement struck a few weeks ago affirmed our view throughout the health reform process that the opportunity to use private hospitals for planning of delivery of public services was not fully realised. But, in coming to this bill, there is a specific characteristic of what has been drafted that does not relate to traditional private hospital services. We have 21 public hospitals within the Catholic health network that operate 2,700 public beds. Because of different establishment requirements in different states, some of them are classified as private hospitals. For example, the Queensland Mater Public Health Services Act 2008 establishes the Mater, Brisbane as a private hospital, but that clearly delivers public services and has done for in excess of a century.

What we are arguing to this inquiry is that the authority is being established ultimately to regulate a portion of pricing in public hospitals but in its current draft ignores some of the requirements of how we operate 2,700 public hospital beds. We do not think that was the intent of the drafters. We do not think it was the intent of the government to in fact ignore the differences under which 21 public hospitals around Australia—21 in some cases large, iconic, well-known public hospitals—

Senator FIERRAVANTI-WELLS: Absolutely—particularly metropolitan Sydney and St Vincent's.

Mr Laverty: The remedy that this inquiry can recommend is pretty simple. We are simply suggesting that provision be made, in two of the bill's provisions, for a director on the board of governance to have experience in the operation of NGO public hospital services. We are not arguing that the number of directors be expanded from the proposed eight to nine; we are simply saying that one of those eight should be skilled and understand the differences of NGO public hospitals and, similarly, that the workings of the authority in the setting of the price should give consideration to the variances of running a public hospital.

I will give an illustration. Queensland Health provides insurance costs to government owned public hospitals such that a hospital as an individual cost centre is only exposed to $15,000 of either the legal costs or a legal settlement from any medical negligence claim that might come forward. The hospital is only charged a maximum, capped amount of $15,000 per claim. An NGO hospital, on the other hand, has to purchase the insurance premium

and is then exposed to the excess on the payment. In one of our institutions, that access is $8 million aggregated among claims. In thinking about the cost of insurance under this national efficient price, it needs to be taken into account that, just in the state of Queensland, for a government owned public hospital, the cost of insurance of $15,000 per claim differs dramatically to that of an NGO hospital, which faces the cost of the premium and upwards of an excess of $8 million. In calculating that we argue that the authority needs to have on its board of governance as part of its regulatory functions someone that understands and respects that and, in turn, we argue that in the annual workings of the authority consideration needs to be given to illustrations like that.

If the bill is not amended to take into account those two considerations, states and territories and the Commonwealth will have me, and my successor in years to come, returning to, potentially, this committee or to the government and saying that the price is not reflecting the actual delivery of services. We have an opportunity to get the bill right so that there will not be that need for us to revisit this topic in years ahead.

Senator RYAN: Would you say that the absence of such expertise on this panel in the draft bill is actually reflective of the problem you outline? Would you say that the fact that you have not been involved and had this opportunity from day one, although you said you have had some positive discussions since, is an example of how there is not necessarily in Canberra the expertise to understand some of the problems you just outlined, and, therefore, there needs to be that voice on the board?

Mr Laverty: I think the intent of this bill is sound but, in its practice, if it does not require the authority by law to give consideration to the variances that exist in NGO hospitals, we will not get the efficient price being set correctly and we will not then get the payment of those prices operating effectively. That is our experience at present in many of our dealings with state and territory governments. The states and territories understand and have regard to their own public hospitals, they have that immediate responsibility. The NGO hospitals tend to get dealt with last.

We are loath to regularly be putting into the public domain our concerns about money, because we are actually in the business of providing health care. Our mission is about providing health care, particularly to the disadvantaged and marginalised. So we come to these discussions in the public domain about money with some reluctance. But, if the infrastructure that is going to define this national efficient price is not structured correctly, Catholic public hospitals, operating principally in Queensland, New South Wales and Victoria and here in Canberra, will not be given a level playing field. So our request to this inquiry is to establish in the legislation from the beginning a level playing field for all public hospitals in Australia—NGO or government owned. The authority needs to give consideration in its workings to all of the cost drivers that come into setting this national efficient price so that, when the states determine the state-wide payment, at the very least there will have been consideration given to differences that exist in the running of NGO hospitals.

CHAIR: Senator Stephens has a follow-up question.

Senator STEPHENS: Really, Mr Laverty, I just wanted to know whether or not you have raised this with the minister's office in the department and what their response was.

Mr Laverty: We have, and the response has been favourable both within the minister's office and, indeed, the department. The discussions we have had have given us confidence that, in the appointment of the first round of directors of this new authority, consideration will be given to the arguments I have outlined today. This gives me an opportunity to thank both the minister and indeed the department for hearing the case we have put and giving every indication that the matters we have raised are going to be addressed.

We are not so concerned about this first round of appointments. We are thinking about the years ahead. This legislation is going to guide the authority for the foreseeable future. It is important that, whilst the intent of the current minister—that there will be, on that first board of directors, those skilled in the operation of NGO public hospitals—has been put to us, in the years ahead we do not necessarily have that guarantee.

It is perhaps even more important that the authority, in its operations, when established as an independent entity, is itself required to give consideration to the cost drivers and the differences of NGO hospitals. If I were to put in order what we are most concerned about, it would be: that the authority, once established, be required to consider the differences of NGO hospitals—over, perhaps, some of the other concerns that I have outlined to this inquiry this morning.

Senator FIERRAVANTI-WELLS: Coming back to that point: in your submission, Mr Laverty, you say the bill does not define 'public hospital'. Are you suggesting there that we should have upfront a definition that says, 'A public hospital is …' and includes those categories of public hospitals that are of the nature that you have described here this morning?

Mr Laverty: We commenced drafting such an amendment and we soon got to the reality that, among our own 21 public hospitals, each of them are different: some are defined under state legislation—

Senator FIERRAVANTI-WELLS: That is much more complex.

Mr Laverty: Indeed.

Senator FIERRAVANTI-WELLS: And it is better to describe them in a more generic way—simply the way that you have suggested by the inclusion of a set of words that refers specifically to what they are without going into the definitional complexities; I understand that.

Mr Laverty: We have proposed at section 131(3)(d) that it be amended to include: 'the authority be required to consider the varying operations of public hospitals and non-government hospitals providing public health services'. We think that is a sufficient catch-all, because to define 'public hospital' when, at each state and territory level, they are in fact different—

Senator FIERRAVANTI-WELLS: You would end up with a schedule a mile long.

Mr Laverty: And you would exclude someone and you would have to come back and amend the legislation.

Senator FIERRAVANTI-WELLS: Point taken. I am conscious of the time; I will just ask one question in relation to transparency. You make the point that it gives the confidential advice to the Commonwealth, and you question why that needs to be in there. Can you just elaborate on that?

Mr Laverty: Our aspiration is this authority be: an independent regulator. And an independent regulator is not a department of government that gives advice to government. Our experience has been, in dealing with state and territory governments over many decades, that how hospital prices and payments are determined has not been in the public domain, and that there are differences as to how state governments, even within their own boundaries, have enabled payments to be made to public hospitals in the past. This is the first opportunity we have had as a nation to set up a genuinely transparent process whereby those interested in hospital pricing will be able to scrutinise and understand which governments are paying what and which are actually meeting the full expectation of the authority setting of the national efficient price. If advice is given to COAG or to the Commonwealth department that organisations like mine are not able to scrutinise, it will be reinforcing some of the existing challenges in the way that states and territories have historically delivered public hospital services. There is no reason why all pricing decisions and their determinations should not be on the public record. Indeed, if advice needs to be given to government, it should be made public so that organisations like mine might have the opportunity to either agree and support or disagree and point to another way.

Senator FIERRAVANTI-WELLS: Can I take you to a point that Ms Bennett raised about section 211 and the comments on the reports before they are made public; do you have a view in relation to that and the concerns that Ms Bennett expressed? Do you share a similar view?

Mr Laverty: We are speaking to whether or not this is an independent regulator or not.

Senator FIERRAVANTI-WELLS: It fits into the same point that you are making about section 131—the point you were just making. It is the same concept.

Mr Laverty: Ideally, an independent regulator would determine its decisions through public consultation and then publish their determinations for public review. That is how we would perceive an independent authority to be working and we would hope that an amendment could be considered to ensure that that is actually what is delivered.

CHAIR: There being no further questions, thank you very much again, Mr Laverty, for your submission and appearing before us today.

Mr Laverty: Thank you, Senators.

CHAIR: We will now take a short break.

Proceedings suspended from 10:25 to 10:47

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

CHAIR: Welcome. Information on parliamentary privilege has been provided to you. That protects you as a witness and the evidence that you provide to us. The committee has your submission. I now invite you to make a short opening statement. At the conclusion of your remarks I will invite other members of the committee to put questions to you.

Ms Power: Thank you. The AHHA is the independent peak membership body and advocate for the Australian public and not-for-profit health sectors. My short statement will be set out under the headings that we put in our

submission. All of these headings relate to the legislation and the intent of the legislation in the context of the national health reform agenda.

First of all, I will talk about independence and transparency. The establishment of the Independent Hospital Pricing Authority is critical to the success of the national health reform agenda. We commend that IHPA will be able to provide independent advice to governments on the funding of public hospitals. We believe that is essential for the benefit of the community and for the public hospital sector generally and that IHPA must be informed by the evidence, both nationally and internationally, rather than being impacted by political or parochial influences.

However, there are a couple of areas where we raise some concerns in the legislation. IHPA's advice to governments about funding models for hospitals, in clause 131(1)(h), may or may not be made available—it is unclear—to the public or the public hospital sector. We seek clarification on that. We believe that the acute sector will be responsible for implementing the decisions and hence informed stakeholder involvement will be critical to the success of the program.

There is another concern which is probably a greater concern—that is, the commitment to transparency is not reflected in the provision for IHPA to give confidential advice to governments on future healthcare services. That is clause 131(1)(i). We cannot support that provision. We would like to see the requirement for confidentiality removed from that provision. Here again the community and the health sector, the key vehicle for service delivery, are best served if full transparency in the deliberations of the IHPA is preserved. However, we do believe that this legislation will improve the level of transparency between Commonwealth and state funding arrangements. That will be of great benefit both for the Commonwealth and for the states in being able to see where the funding comes from and how it is delivered.

On public hospital functions, I would like to emphasise that IHPA needs to be provided with the necessary tools to gear incentives for care in the most appropriate setting. The meaning of 'hospital care' is very important in this context, and it must be flexibly defined so that it can encompass all the services delivered or contracted out by local hospital networks. To this end, we recommend that the meaning of 'hospital care' explicitly include community health services incentives. This will require the Commonwealth to fund growth in alternative models of care better delivered outside traditional hospital settings, and we believe it will also require the states and territories to commit to appropriate funding for community care services.

Under the heading of 'activity based funding', we note that it is recommended in the terms of reference for both the clinical and the jurisdictional committees that they be required to advise IHPA on emerging models of care that should be classified and priced prior to their widespread introduction. We hope that this will minimise the serious risk that activity based funding has where it may just reinforce existing models of care, and this relates to my previous comment. So, although we actually do support activity based funding and we certainly support a level of consistency across all states and territories, which we have not had in the past, we need to make sure that activity based funding is sufficiently flexible to allow for new models of care coming through and to ensure that we do not get stuck with caring for people in inappropriate settings—traditional hospital settings, for instance.

We also believe that IHPA, in performing its functions, must have regard to the relevant expertise and best practice within Australia and internationally. In fact, that is part of its requirement. We believe that this expertise may not be available in Canberra and the level of independence may also not be readily apparent in Canberra, and we recommend that this authority be based elsewhere, perhaps in Sydney or Melbourne.

The IHPA will have a key role in determining new classifications and data requirements. This will be a significant challenge to overcome because we need to make sure that the costing and clinical data across Australia is of a consistent nature before it can be properly analysed. At the moment, it is inconsistent between states and territories. In this context, the AHHA supports the provision for the Clinical Advisory Committee to be formed to inform IHPA's work, and it has an important role there. Linking patient-centric activity data sets will be essential. At the moment we have data sets on patient activity held by the Commonwealth Department of Health and Ageing and the Australian Institute of Health and Welfare. They are not necessarily linked, which would make it very difficult then to follow up patients' activity through the various stages of their treatments. We do warn against burden of compliance on hospitals and healthcare services in providing data. There is probably an argument there for making sure that there is rationalisation of the roles of data collection agencies. I think national efficient price is a good move in creating a consistency of approach across the whole of Australia. At the moment there is a lack of clarity about how the value of the efficient price will be set. We did not expect anything else at this stage. However, we have to make sure that the price is set in order to value innovation and substitutability, which are the same points that I have already made about making sure that new models of care are valued. There is also a lack of information about how the efficient price will be indexed in order to calculate annual rises in

hospital costs as distinct from rises in volume, and that needs to be taken into account by IHPA, if not necessarily incorporated into the legislation.

As far as public hospital access, sustainability and continuity are concerned, there are requirements of IHPA to make sure that access, sustainability, continuity and so on are preserved. This will require a very deep understanding of how activity based funding systems for not only admitted patients but non-admitted patients are constructed in order to fund care delivery in a setting most appropriate to patient needs. Also, maintaining appropriate standards of training and sufficient opportunities for research cannot be underestimated in preserving sustainability for our public healthcare sector and public hospital sector in particular. We understand that IHPA will be responsible for assessing the value of training and research not so much within the efficient price but within the block funding. However, this is not explicit in the legislation, and we are seeking clarification. We suggest that it may need to be explicit in the legislation.

A final point on safety and quality: determining how price is linked to quality is a critical issue and requires significant clinical advice. While the draft legislation uses the term 'efficient' throughout, this term is never defined. An efficient price which does not adequately take account of investment in access, quality, innovation, research and teaching will risk taking hospital services backwards in terms of patients being able to access the most effective treatments and technologies to support efficient and high-quality care, so we recommend that a definition of the term 'efficient' be included in the legislation to take account of the sorts of things I have just outlined and that this definition include concepts of both technical and allocative efficiency.

We note that, under clause 220, the IHPA is required to disclose to other agencies. Under this clause, we anticipate that IHPA's liaison with the National Health Performance Authority, the Australian Institute of Health and Welfare and other national bodies will take place. I think the Australian Institute of Health and Welfare is very important in this context.

CHAIR: Thank you very much for those remarks.

Senator FIERRAVANTI-WELLS: I will start with the point about confidentiality. You are advocating the removal of clause 131(1)(i), deleting that clause?

Ms Power: I think our concerns could be alleviated if there were no requirement for confidentiality in that clause, so that the deliberations on the future costs of health services could be made transparent and public. I think it is a very, very important aspect of IHPA's role. It is also very important that all the stakeholders and the public understand their deliberations at least on the future costs of public health services.

Senator FIERRAVANTI-WELLS: Of course, that is the same basic theme in clauses like 211. The transparency point seems to go throughout—

Ms Power: It does.

Senator FIERRAVANTI-WELLS: where there is the reporting. Basically the concept is that it should be transparent and open rather than open to being in some way varied, manipulated or suppressed—

Ms Power: Yes, we agree that—

Senator FIERRAVANTI-WELLS: by a government, whether it be state or Commonwealth?

Ms Power: Yes, so that all advice that the IHPA provides to the Commonwealth and states, and possibly vice versa, should be in the public domain.

Senator FIERRAVANTI-WELLS: Yes, but, going specifically to my point about clause 211, that is the one which says:

The Pricing Authority must not report publicly … unless the report—

and it sets out a framework there—

has been given to the Minister …

Concerns were raised earlier about how that will stifle—if you want to—and afford the opportunity for amendment, vetting, alteration—

Ms Power: Yes, our comments would relate to 211 as well.

Senator FIERRAVANTI-WELLS: You talk about activity based funding at page 2.3 saying that it will simply reinforce existing models of care:

The proposed legislation does not sufficiently recognise and minimise this risk.

Where specifically would you like to see amendments or what amendments are you proposing there?

Ms Power: A number of our comments we have put in here in relation to the context. I was writing this as information—on which to base your decisions—and some things might not necessarily need to be included in the legislation. However, perhaps under the terms of reference for the clinical and jurisdictional committees they should be explicitly required to advise everyone on emerging models of care that should be classified and priced prior to their widespread introduction. If we were going to include this in the legislation, that would be the point at which it should be included.

Senator FIERRAVANTI-WELLS: In relation to new classifications and data, there are provisions at section 131 to determine data requirements and data standards. This has been a perennial problem in terms of data across the states and the Commonwealth. The Australian Institute of Health and Welfare also make comments about the quality and comprehensiveness of the data, that it could be improved. Do you have any views in relation to how that could be improved?

Ms Power: I think it will be absolutely necessary for the success of this legislation and for the success of the reforms that states and territories are able to provide data in a consistent fashion. I do not think it will be able to perform its role sufficiently well if that does not happen. The states and territories have been funded for quite some time now to develop case mix activity based funding and some are more ahead than others. There is a very short time frame between now and 1 July next year in which some of this needs to be under way. In that time frame, however, it will have to require the states and territories to provide data in a consistent fashion so that they are able to develop consistent data encoding standards across Australia.

Senator FIERRAVANTI-WELLS: It is reminiscent of evidence we heard at the last estimates when I asked about the definition of a bed. I understand that still has not been resolved. So I think we have a way to go, Ms Power.

Ms Power: As I said earlier, it has a very important and crucial role in the success of the reforms. Their role is crucial in the implementation of the reforms. Hence our comment earlier that it will need a very high level of skills internally to work on this and they have a very short time frame to do it in.

Senator FIERRAVANTI-WELLS: Can I go to the definition of an efficient price. You are saying that an efficient price should be defined in the legislation right up front. Is that what you are—

Ms Power: Yes. It is very important that the efficient price takes account of quality in particular. There is a lack of clarity at the moment about what the efficient price really means. It will be up to IHPA to determine this. We think that it would be good to have a definition in the legislation.

Senator FIERRAVANTI-WELLS: I think on page 5 of your submission you are suggesting it be recommended that the indices you give for the national efficient price should be applied quarterly in the first few years of operation. So do you see those as influencing it? How would you word that? Would you simply say 'the efficient price is this and should take account of that'?

Ms Power: At the bottom of page 5, under 'Safety and quality', we have a recommendation about the definition for the term 'efficient' being included in the legislation and say that this definition should include concepts of both technical and allocative efficiency. We make a separate point that there is lack of information about how the efficient price would be indexed in order to calculate annual rises in hospital costs, as distinct from increases in volume. The association would like to see in the legislation some reference to indexing of the efficient price in relation to hospital costs. We know that in a sense it is automatically indexed in relation to volume because the Commonwealth, in applying the efficient price, will take account of volume. There are a number of ways that the efficient price could be indexed. We have set out some examples of how it could be indexed.

Senator RYAN: I want to explore this issue of indexation. Doesn't indexation in some way run counter to the idea of an efficient price as we get more technology and as, for example, medicines might come off patent and become cheaper and as the requirement for labour may change in certain procedures. I thought this was partly to get around a flat sort of indexation approach to hospital costs.

Ms Power: We believe that the hospital costs will rise. For instance, infrastructure and technology costs might not be taken into account when the efficient price is calculated. If the efficient price is calculated in order to take account of infrastructure and costs including technology, then perhaps an indexation would be automatically included, but this is unclear.

Senator RYAN: I suppose this is one of the problems that I have. If we include an indexation arrangement, don't we get the problem where we are sort of rewarding existing behaviour and treatments rather than potentially looking at alternatives? An indexation approach merely applies at a cost-plus level; it will always grow faster than inflation in the health system, and I do not think anyone is challenging that. What, for example, if we want to

steer people to other forms of care that might be different ways that they are treated inside hospitals? It just strikes me that a flat indexation rate runs counter to the whole notion of coming up with an efficient price which is calculated based on inputs.

Ms Power: The efficient price is going to be calculated on the basis of inputs, certainly, and some of those inputs will be included in a case-mix price and a DRG price. However, we are concerned that there will be unrealistic expectations. On page 11 of our submission we have warned that there are unreal expectations of savings to be made out of public hospital activities. As you can see there, Australian public hospitals have already achieved pretty remarkable efficiency gains over the last several decades, and we have set out some data to prove that. For instance, overall demand on emergency departments increased 17 per cent during the period 2005-06 to 2009-10 and it is likely to continue at this rate. As for overnight separations, the average length of stay was 5.9 days in 2009-10, down from 6.2 days in 2005-2006. So we do not believe there is a lot of efficiency gain to be made out of public hospitals. We do not believe that they are actually underperforming.

Senator RYAN: Looking at the Productivity Commission's analysis of private versus public hospital costs, for example, they did point to the fact that labour costs were higher in public hospitals and in the private hospitals there was a higher utilisation of technology but that overall it was a bit of a wash and they were actually relatively comparable. I am just trying to get to this point that it is a bit like, in a broader sense, wage indexation. In fact, some people argue there is substantial room for efficiency gains in public hospitals through work practices. An indexation approach would hide that and merely allow existing work practices to continue and not potentially challenge managers to explore that as a potential efficiency gain.

Ms Power: Perhaps this comes down to the fact that the value of the efficient price is yet to be set and we are unclear about what the components will be and how it will be set. Perhaps this association needs to be confident that the efficient price is set in such a way that the underlying costs of infrastructure, technologies and so on will be realised in the efficient price. Otherwise, we believe that, if it is going to be set as an average price, as we have it right now around the states—and it may be set as an average price in the beginning—then we do not want to just include the difficulties that the public hospitals have at the moment in maintaining good care.

Senator RYAN: The point I am making is that we do not want to similarly include the inefficiencies in the cost base. I am not a medico, so excuse me if this is too simple. There is the way we used to operate on stomach ulcers. If we still need to operate it is done arthroscopically, so there is a higher technological cost but a much lower cost to the system overall because there are fewer bed days and the procedure itself is much simpler with fewer complications. By including technology can lead to an overall lower cost because there are other efficiency gains that can be made. I do not want to lock in the existing cost base and assume it is the most efficient it could be.

Ms Power: The DRGs that are being revised again at the moment should take into account some of those efficiency gains that have been made. In fact, I suspect that the case-mix system in Australia takes account of those sorts of efficiencies in a much better way than the Medicare system takes account of some of the efficiency gains that might have been made in some of the treatments that specialists carry out. However, unless we can be confident that the efficient price is taken into account, with all the costs involved in the efficient and quality care of patients in public hospitals, we would want to see some indexing.

Senator RYAN: Regarding your concern about the ability for the authority to give confidential advice to governments on future health care costs, you assert that the system is best served if full transparency in the deliberations is preserved. I do not necessarily think that precludes the ability for the Commonwealth or the states to seek confidential advice. If they did not seek confidential advice from this authority, potentially, on future health care costs they are probably going to get it from state and federal treasuries or health departments, which is probably going to lead to, shall we say, not as good information around the table when they have a discussion about future health costs. Why is it that, when there are other transparency mechanisms in place, if you are happy with those—I do not assert that—this particular power is a problem? It strikes me that being able to seek advice for deliberation is not always a bad thing.

Ms Power: It just seems inconsistent with the clauses up-front in the legislation.

Senator RYAN: I appreciate that. You do mention the transparency clauses.

Ms Power: Yes. When we are in deliberations about future health costs, it is extremely important. As an association we would like to be involved in some of those discussions and we think it would be useful for the public.

Senator RYAN: I appreciate that. I do not think this clause precludes that. It is an additional clause that might say: the Productivity Commission might have done a report into public and private hospitals; can we get the

authority to analyse that for a discussion at COAG when it is not going to be a public document, or for a ministerial council of some variety?

Ms Power: Yes, that makes sense, as long as independence and public reporting in the other sections of the legislation are thoroughly carried out.

Senator FIERRAVANTI-WELLS: On page 7 of your submission you talk about the public hospital functions, which is the terminology of the legislation in 131(1)(f). You then go on to talk about the meaning of hospital care. Are you suggesting that public hospital functions should be defined or a new definition called 'hospital care' should be inserted? I am not quite sure what you mean.

Ms Power: It goes back to the original statements that I made that we need to make sure that, whether we call it 'public hospital functions' or 'public hospital care', there is flexibility in the definition so that we are not seeing public hospital care, as one might traditionally have seen it, as being a bed in a room, but that public hospital care can be provided in a number of settings. Hospital in the home is one fairly well known setting. But as technologies improve we might find that there are a number of other ways to provide care that are more cost effective and we would not want to see that, as a result of this legislation, IHPA is restrained in calculating in the efficient price of hospital care to more traditional settings. What we might find then is that treatments could be skewed inadvertently to a more high-cost setting than they otherwise might be able to achieve.

CHAIR: Thank you for your submission and for your evidence.

SULLIVAN, Mr Francis, Secretary General, Australian Medical Association

[11:16]

CHAIR: Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has your submission. I invite you to make some short opening statements after which the committee will put questions to you.

Mr Sullivan: Thank you for the opportunity to appear. I would like to send an apology from our president, Dr Steve Hambleton, who, due to time constraints for him and the shortness of the hearing, could not make it. You have me instead.

CHAIR: You are very welcome.

Mr Sullivan: As you know the AMA membership comprises medical practitioners who work in public hospitals, those who provide services as visiting medical officers and those in private practice. These members experience the difficulty of providing safe, quality care in under-resourced hospitals. Evidence shows that where doctors are involved in the management of hospitals results improve and morale is better. We therefore fully support the establishment of the clinical advisory committee to provide advice to the pricing authority. This will help to ensure the calculation of prices for public hospital services is informed by the practical and immediate experience of practising doctors.

It is important that the price the authority arrives at is not just the cheapest price. From the medical profession's perspective the cheapest price could lead to clinical decisions being compromised and a reduction in the quality of care. For that reason there needs to be absolute clarity about the relationship between the clinical advisory committee and the jurisdictional advisory committee. The success of the authority and its decisions will be strongly influenced by the advice it receives. There is no detail about how the authority will deal with any conflicting advice from these committees. Clearly there is potential for very different views given that the committees will represent very different interests. In our submission we have suggested how collaboration between the two committees could be maximised and conflict minimised. We would also like to be certain that the relationship between the committees is not hierarchical—that is, the advice of the jurisdictional advisory committee should not take precedence over the advice of the clinical advisory committee.

We would like to see more certainty in the bill that the authority must take into account the costs of teaching, training and research. We have seen a significant increase in the number of medical student places in Australia, and this is a very welcome measure. But this must be matched by increased pre-vocational training places. In setting prices for public hospital services the authority must take into account not only current costs of teaching and training but the increased places that will be needed in public hospitals into the future to ensure Australia maintains its enviable reputation for medical workforce training. We also have concerns clause section 134, which defines constitutional limits. Subclause 134(a) appears to provide for the authority to have a possible future function in determining an efficient price for pharmaceutical, sickness and hospital benefits and medical and dental services. There is nothing in the National Health Reform Agreement to support the authority's involvement in any of these functions in any form. If the government has a particular role in mind for the authority in these areas, it should undertake full and proper consultation with the health sector. In the meantime, the clause should be removed.

Senator FIERRAVANTI-WELLS: I will take you through a summary of the amendments proposed, to get a bit of a handle on those. Let's start with clause 131(3). You suggest that another clause be inserted. You have obviously heard the evidence that was given by both Ms Bennett and Mr Laverty, one from the consumer perspective and the other from the non-government hospitals perspective. Can you elaborate on the nature of the words you would see inserted in that section?

Mr Sullivan: As you can tell from our submission, I did not hear the other two submissions but I am sure they were eloquent. The point that we are trying to make is that the hospital system was, even before the COAG agreement, a system out of which data was drawn excessively, and hospitals are already required to achieve many performance indicators. This goes to this issue about the efficient price. In other words: what is going to be the bucket of money that is given to a particular hospital to perform its service agreement? Remember that it is a service agreement that it has to meet. The service agreement is struck between the hospital network, of which the hospital is a part, and the state government.

Senator FIERRAVANTI-WELLS: Yes—going back to whatever iteration it was of the hospital plan, because the services are bought by the local hospital network from the state government.

Mr Sullivan: The key to this structural issue for us is as follows. The agreement is struck at one end, on volume of services to provide, and the payment for the service is determined at the other. In the structure of the

bill, the payment is considered to be an efficient price not for that hospital, not for that set of services, but for a more generic set of services in a broader area. In other words, the local costs of a service delivery are relative to the actual cost calculation. Our concern is that hospitals are required to report on a number of performance areas apart from that.

Yesterday, when we heard ministers all around the country complaining about how the results came out on hospital performance, did you notice how many of the ministers said, 'The trouble is we're not being given enough funding to perform,' and that they are being asked to be assessed in areas of performance which some ministers said was not the main game. I heard one minister say they were more concerned about getting people off waiting lists—good idea—than having to perform in some other specific areas. So our point in the first instance is this: COAG is asking hospitals to perform in specific areas, and the state governments will be asking the hospitals to perform in other areas as well.

Senator FIERRAVANTI-WELLS: And directing the volume of services that they purchase from that hospital network.

Mr Sullivan: Correct. So our point is: we do not think section 131(3) adequately addresses what we think is a broader, if you like, obligation on demand. This goes to the fundamentals—and you have been hearing it, I am sure, from others—and the notion of efficient price. I notice Senator Ryan was making comments here, and it would be good to have a discussion. The notion of an efficient price technically makes sense. It does not make sense if the price leads to gaming on services, and it does not make sense if the price shifts services to other places beyond hospitals inappropriately as opposed to appropriately. I think that was a point you were trying to make at one point. There is always going to be a redesign of services. There is always going to be an improvement in how they are undertaken and possibly at times less expensively. But an efficient price wrongly restructured will also have a dysfunctional approach.

Senator FIERRAVANTI-WELLS: Taking that further, the efficient price, when you look at it from that perspective, would vary from local hospital network to local hospital network.

Mr Sullivan: Agreed.

Senator FIERRAVANTI-WELLS: In effect this legislation seems to impose from above an efficient price—and taking into account the various criticisms that have been made about a lack of definition of an efficient price—which really is arbitrary in the sense that it is there in the ether and in some cases will absolutely bear no resemblance to what the actual efficient price will be, taking into account the exigencies of a particular area and efficiencies, picking up Senator Ryan's point, of workforce and all sorts of different issues.

Mr Sullivan: Sure.

Senator FIERRAVANTI-WELLS: It starts from the concept itself, does it not, Mr Sullivan? The concept itself as deficiencies. This is really where the coalition was coming from.

Mr Sullivan: It goes to our broader points. The first thing is that we have concern about the concept of an efficient price. We introduce the concept of an effective price. An effective price in reality is a negotiated price, and it is a negotiated price as close to the service as possible. That is a principle we have worked on through the health reform debate—the idea of devolving a lot of the negotiation, a lot of the, if you like, effective control, as close to the services as possible; and in our case, of course, involving doctors as much is possible. The second point is that we know that labour prices shift across the country depending on geography, availability and so on. There is the basket of goods that goes to determine the foundation of a price. It is the debate you have in aged care, it is the debate you have in schools—it is the same debate. For years we have had this debate about the right inflator, the right basket of goods in healthcare. Both sides of the parliament have had to grapple with this. It is not a surprise, therefore, that it rears its head here, because the fundamental question still is: how are we going to base health services as a funding model?

Senator FIERRAVANTI-WELLS: Of course it then flows on to your next point on the insertion of the clause 131(3) about teaching, training and undertaking clinical research.

Mr Sullivan: Yes.

Senator FIERRAVANTI-WELLS: How do you value a hospital, say, in metropolitan Sydney that has not just a role as a public hospital but also a teaching hospital and also has medical research and a whole range of other things?

Mr Sullivan: Yes, we would love the committee to suggest that this is an area of work that really needs further development, particularly in regard to, when we talk teaching, these days we need to factor in appropriate time for teaching. It is anecdotal, but you will often hear people say now, 'You've got to be careful if you're a

patient at a public hospital because there might be this hoard of people coming along to watch you.' A lot of the medical interns and the like are eager to find another teaching experience and there are so many people needing to be taught. It is the prevocational years that are being squeezed out.

It is fantastic that there are medical students graduating; the difficulty will be the next couple of years when they need to find places to be taught. That relates to how the public hospitals are funded not only for the teaching places but for the people doing the teaching, making sure they have the appropriate time to do the teaching and, equally in some cases, the time to do appropriate supervision of the junior doctors. I know you have heard all these things before, but they are important factors in this.

Senator FIERRAVANTI-WELLS: You dealt with section 134, and basically at this point in time the legislation seems just to cover a possibility which really has not been flagged at all.

Mr Sullivan: No.

Senator FIERRAVANTI-WELLS: Your point being that it is not part of this, so why are you including it in the legislation?

Mr Sullivan: Correct.

Senator FIERRAVANTI-WELLS: In relation to section 139, we have not really talked a lot about the cost-shifting disputes. Can you elaborate a little bit? What you are saying is individuals and non-government organisations are reporting allegations of cost shifting—in other words, that the situation should be investigated. A member of the public could potentially be sent from a public hospital to a private provider—and we have seen it with radiology and other services—where they can get it off Medicare rather than getting it through the public hospital system. Is that the sort of thing that you are envisaging?

Mr Sullivan: Yes. I am sure you would have heard that this morning from the other groups—the big not-for-profit, non-government public hospitals, who are also caught up in this but often do not get as strong a say in the arrangements. Doctors themselves see this all the time in public hospitals. Sometimes we would even argue that they are put in situations of cost shifting that they do not particularly enjoy being participants in. We feel that the current legislation allows for some cost-shifting reporting, but only between governments. Clearly, if we are going to find out the full picture, there are other participants.

Senator FIERRAVANTI-WELLS: I want to pick up the next two points, about section 144 and section 179, on the transparency of the process. Can you elaborate on your particular concerns about that.

Mr Sullivan: It is pretty straightforward for us in the sense that we obviously support the establishment of this advisory committee and also the establishment of the authority's membership. Clearly we would like to make sure that the process is as transparent as possible and that individuals who believe they have something to contribute could possibly put their hand up.

Senator FIERRAVANTI-WELLS: In other words, people being appointed in their individual capacities rather than as representatives of a particular body—is that right?

Mr Sullivan: I would not go that far. Clearly the AMA would be quite keen to have a person on the authority, but I think the point is more that the processes of selection should be transparent.

CHAIR: I want to follow up on the make-up of these advisory committees. We have had other submissions where consumer representation has been sought and, further to that, there would be a separate consumer committee established as well so there is not a tokenism attached to having a consumer rep. I asked whether or not a clinician would suffice as a consumer rep, but that was not overly welcomed. I was just wondering, following on from your comments to Senator Fierravanti-Wells, whether you have anything to add now that you are seeking to have AMA representation on these committees.

Mr Sullivan: We have certainly made the point that we would be keen for an AMA nomination on the clinical advisory committee. Where governments believe that a consumer advisory committee is necessary, as their call, certainly in the clinical advisory area you would not need to have a specific consumer rep, simply because you will find plenty of people on the clinical advisory committee who have been consumers of the system. But what you are looking for, one assumes, is a specific set of advice to do with clinical practice inside the hospital. That clinical practice is obviously medical, but there are other clinical areas that would need to have a voice in a committee as such. That is why we have gone with the idea that, at least, an AMA nominee on the committee would ensure that there is a broader medical voice than, say, just a specific voice.

Senator RYAN: Can I just explore this. What percentage of doctors does the AMA represent?

Mr Sullivan: About 40 per cent.

Senator RYAN: You are saying the AMA, representing 40 per cent of doctors, should be able to effectively appoint someone to this board?

Mr Sullivan: Nominate, I think we said.

Senator RYAN: Nominate. Your words were 'should be appointed from nominations provided by the AMA'. Effectively, it is a bit like the way bishops of the Church of England are appointed: you get to nominate one or two people and they only get to choose from the one or two people you nominate. Is that what you are proposing?

Mr Sullivan: I am not familiar with the Anglicans.

Senator RYAN: I see your point about having clear criteria and clear processes but, surely, the interests of your members and the experience and expertise of your members could be represented by someone who shares their professional association and background, if not necessarily a membership of the AMA?

Mr Sullivan: You probably would not expect me to totally go there with you on that one. Our point is this. Interestingly, the AMA was the only medical organisation to put in a submission to you today. It is the only group that has taken the time to try to grapple with the bigger public policy issues and maybe the implications of the bill. That is because, generally speaking, the medical profession, diversified as it is, would say to you that when you are looking for a broad medical voice it will be found more in the AMA than anywhere else. That would be the justification for why we are putting forward our position.

Senator RYAN: I think the fact that you are one of the groups that have put forward a submission is more a reflection of the entire eight days that were made available for these submissions and the rapid speed of this inquiry. But I take your point. I am not denying the work the AMA has done and its expertise in this area, but I am far from convinced that you should effectively have an appointment power, which effectively that is what it is—by choosing two or three of your number and then constraining the ability of the minister to have to appoint one of those.

Mr Sullivan: I think the minister would probably be fine within the scope of individuals whom we could put forward. I think the minister would be pretty happy about finding someone they could work with.

Senator RYAN: I do not think we are going to agree on that.

Senator FIERRAVANTI-WELLS: Just continuing down that list, with respect to the requirement for the clinical advisory committee and the jurisdictional advisory committee to meet jointly once a year, can you elaborate on that perhaps in terms of practical issues that will overlap and why that would be advantageous?

Mr Sullivan: Throughout the whole health reform debate—and we go back to the end of 2007 and beyond—one of the consistent things which the AMA was asking for and which, I think, was reflected in former Prime Minister Rudd's commitment to the AMA was that doctors would be more engaged.

Senator FIERRAVANTI-WELLS: The local clinicians group! They seem to have fallen off the perch, don't they?

Mr Sullivan: I will stick with this one for now.

CHAIR: Senator Fierravanti-Wells, if you would just allow the witness to complete his results.

Mr Sullivan: But with these we are saying that here is another opportunity for engagement. What we were concerned about is that the jurisdictional advisory committee, by definition, has a whole separate set of interests from what clinicians will have. So, in order for there to be at least a conversation that is regularised, we have suggested at least this once-a-year joint meeting. How would it happen? I notice that in some parts of the country at the moment, from our members who are appointed to local clinician groups, they are trying to look at ways in which they will relate to even the establishment of the Medicare Locals and the like. So some of this is going to have to be a work in progress, but there should at least be some institutionalised regular meeting so that issues of common interest can be thrashed out, as opposed to the authority receiving separate bits of advice which we may at times find conflicting. We will go back to the whole issue about setting efficient prices and determining whether those prices are still relevant a year later.

Senator FIERRAVANTI-WELLS: I am conscious of the time, but I just wanted to ask something in relation to proposed section 210(2), inserting not as part of that reporting to the parliament. This, I think, goes back to the earlier point about the efficient price. In other words, what you are saying is, 'Okay, you might have set an efficient price up here, but just tell us what you actually paid the local hospital network—in other words, what was the efficient price determined there and what you actually paid?'

Mr Sullivan: Correct. We think there is a structural flaw here, and I would ask the committee to look at this very carefully. The point of establishing an efficient price, contestable though it may be, was that ultimately the Commonwealth would pay 50 per cent and the state would pay the other 50 per cent. That is the theory, but it is

interesting to note that in the agreements the states do not have to pay the 50 per cent. That is a worry to us, because it means that a state authority can turn around and say, 'Look, it's been established that the price is x, but we think we'll only pay you x minus y.' The question is why. If that is going to remain the structure, we need a reporting mechanism to determine why that was the case.

Senator FIERRAVANTI-WELLS: It undermines the whole—

Mr Sullivan: It undermines the whole point.

Senator FIERRAVANTI-WELLS: What is the point of having an efficient price?

Mr Sullivan: We think it is a structural problem here. We would prefer that it be addressed now rather than later.

Senator FIERRAVANTI-WELLS: In other words, the system should reflect both sides of the fence and the commitment by both to pay.

Mr Sullivan: Yes.

Senator FIERRAVANTI-WELLS: But it does raise the question of why one is—

Mr Sullivan: Why this has happened.

Senator FIERRAVANTI-WELLS: Why this has happened. I think we would certainly ask that of DoHA. Have you sought clarification of that through your networks?

Mr Sullivan: We have not yet. As has been said, it has been only a couple of days for us to put this together. It has been raised with us, and we would appreciate it if you could get something on the record.

Senator FIERRAVANTI-WELLS: In terms of assisting, what clause of the latest iteration of the agreement are you referring to? I have kind of lost track.

Mr Sullivan: I think that is in proposed section 210(2). Do we have any clauses? We can give it to you.

Senator FIERRAVANTI-WELLS: I have a copy of the legislation in front of me, but the clause of the latest Commonwealth-state agreement—

Mr Sullivan: Okay. I will have to get it to you today. We will send it up to the secretariat if we can.

Senator FIERRAVANTI-WELLS: Could you just let me know the particular clause.

Mr Sullivan: Yes, we will.

Senator FIERRAVANTI-WELLS: If you do have access to that, that would be very helpful. Of course, there is the usual problem of the synchronisation of the data at 220—

Mr Sullivan: Yes.

Senator FIERRAVANTI-WELLS: and data collection, consistency, synchronisation and streamlining, which was very much a feature when we looked at this back in June. It was certainly, from the coalition's perspective, one of the concerns that we had raised in relation to consistency and synchronisation.

Mr Sullivan: Correct.

Senator FIERRAVANTI-WELLS: The others, of course, pick up the points raised earlier about publishing on the internet—

Mr Sullivan: Yes.

Senator FIERRAVANTI-WELLS: and the points that were raised in relation to proposed section 211 and the minister commenting on public reports before they are made public and the point about the previous section in relation to 131(i). Do you have a particular view as to whether that section should be deleted or should be—

Mr Sullivan: Strengthened? I think so.

Senator FIERRAVANTI-WELLS: to remove the confidential component of it?

Mr Sullivan: I was listening to that earlier. We think the reporting processes are adequate. We have not made any particular comment on whether ministers can also receive other confidential advice—I think it is probably a long bow to draw to say that they cannot. More to the point is that we think the reporting is okay but it is a surprise that the states would have so much time to see draft results beforehand. Again, our public position on this has been quite clear. We think it undermines the strength of the agreement generally and how the pricing and accountability measures are meant to be structured, so we certainly think it should be strengthened in line with the original intentions.

Senator FIERRAVANTI-WELLS: We have a copy of the agreement. Point A65 says:

There will be no requirement for Local Hospital Networks to be paid the full national efficient price if the State considers that a lower payment is appropriate, having regard to the actual cost of service delivery and the Local Hospital Network's capacity to generate revenue from other sources.

It gets back to the first point we made. You might have an efficient price in one place, but it just varies area to area. That point strengthens your argument even further.

Mr Sullivan: I find it odd that we have an agreement thrashed out between the Commonwealth and the states which fundamentally agreed that there would be, if you like, a state efficient price, but inside that state governments can still argue that they do not have to pay it; they can pay less. That is the problem.

Senator FIERRAVANTI-WELLS: The Commonwealth cannot pay less, but—

Mr Sullivan: But a state can, and this is the issue we have. The Commonwealth will always have to pay 50 per cent of the efficient price. I know that some state governments were concerned that they may have to pay more than the efficient price for their side of things, and I think that has to be looked at as well. They will clearly want to report on that, but the flip side is that, if they are going to pay less, it needs to be clear why. The hospitals are under enough hammer as it is. If they are going to receive less money, somewhat arbitrarily, at a state level, we would not accept that.

CHAIR: We touched on how we take into consideration teaching, research and professional development. That does not happen just in major cities; it also happens in regional hospitals. I want to give you the opportunity to add to that. Should we be looking at incentives to ensure that those opportunities are enhanced?

Mr Sullivan: When this was first mooted, the reason we talked about an efficient price is that it is widely recognised that the casemix models have come a long way—and that was mentioned previously. They are under review and that is a good thing. There are areas of acute services that casemix is not appropriate for. Teaching is one of those areas. We know there is a capacity for what they call block funding in the area, say, of capital, particularly for the regional hospitals. Block funding around the areas of teaching and research will be essential and governments at both levels will need to have the discretion to do that. One size does not fit all within a jurisdiction. We know, for example, in rural Australia there will need to be separate ways of supporting and compensating the particulars of those hospitals. That is basically our point. We would hope that that flexibility remains in the system and the pricing authority demonstrates that it is going to be flexible.

CHAIR: I thank you for your submission. There are always short time frames for inquiries into pieces of legislation, so we appreciate you making yourself available.

Mr Sullivan: Thank you, Senators.

LEEDER, Professor Stephen, Director, Menzies Centre for Health Policy, University of Sydney

[11:50]

Evidence was taken via teleconference—

CHAIR: Welcome. I understand that you have been provided with information on parliamentary privilege and the protection of witnesses in giving evidence. I now invite you to make a short opening statement and at the conclusion of your remarks I will invite members of the committee to put questions to you.

Prof. Leeder: While I appear in my capacity as Director of the Menzies Centre, I also have another position in that I chair one of the local health districts in the new configuration of health services in New South Wales, namely the Western Sydney Local Health District Board, which includes Parramatta, Blacktown, Holroyd and the Hills District, so I bring several perspectives to the conversation and make some observations that come from many years of involvement in the health system and also from the perspective of someone vitally interested in the theory and practice of health policy as it affects the lives of people.

I welcome the changes that we have been told about and are beginning to observe in the federal reform agenda which has certainly had a major impact on the states or at least the one in which I operate. We are looking at more change in the way in which activity is supported through activity based funding for clinical services. My interest also is in the way in which we would wish the health system to evolve in terms of being efficient and effective. In that setting I advance the view that the best evidence we have about the way in which health services operate suggests that ultimately having one single payer for health services makes enormous sense. One only has to look at what has been the outcome of single payer arrangements in, say, the Kaiser Permanente health maintenance organisation in California to see how much easier it is to add in substantial primary care and preventive activities to those of hospitals if the same people are paying for all of them. I hope that the process of evolution in that direction which was represented somewhat figuratively I suppose in the Commonwealth assuming a greater responsibility for the funding of community based services of primary care and also taking on a more substantial payment arrangement for public hospital services would move us in that direction.

The other point that I think is worth observing especially in the more effective North American models—I know we are often very critical of what happens in health care in America, it may have the worst of systems but it also has some fine examples of the best—is that when those systems are operating well as they are in California and in other parts of America the private sector finds a congenial to make their contribution and not be in a state of antagonism with the public system. So the whole business of unifying the source of payment for health care requires a system that is based on an annual premium paid by several million members of that organisation and enables the integration of preventive, caring, palliative services in a way that I saw when I visited there a year ago but really inspires me to think that, if we can keep going on the same track we are going down in Australia, the destination is a good place. I just wanted to underline the importance of moving to a point where we have one agency that is responsible for paying for health services and hope that we can make progress in that direction.

CHAIR: Thank you, Professor.

Senator FIERRAVANTI-WELLS: Professor, we are here basically to look at this legislation. Where do you see the deficiencies in this legislation? From your perspective, are there any deficiencies or would you like to point us to particular areas of the bill which you think should be strengthened, deleted, improved or augmented?

Prof. Leeder: I can say from the New South Wales perspective that I would be happier—I happened to overhear the tail end of the last person presenting to you although I do not know who they were. There is concern that by focusing very largely on payment for activity in public hospitals we are not doing justice to the various other things that such hospitals do. I know that in New South Wales there is a lively debate about how the research activities that are critical to making both medical progress and to ensuring that health services are effective and efficient will be funded in the new arrangements and this is, in a way, symptomatic of the fact that we have different payers for different things. How that relates to clinical activity is not clear to me. The point was made before about the importance of so-called block funding, which is not necessarily the only way of doing it but certainly is the way in which we might move for those services that extend beyond the simple provision of a clinical service. For example, teaching—and I am not referring exclusively to medical student teaching but to all of the professions who depend on practical exposure of their students, both graduate and undergraduate to clinical settings—and some further clarity about the way in which hospital services and Medicare Local services will operate. I grant you that the legislation is certainly not going to provide chapter and verse of the details of these things and let me be clear, I have no particular concern about the legislation. My concern is that it be located within a political context which has the aspiration of achieving for Australia the most efficient and effective way of preventing what is preventable and treating effectively and humanely then what needs to be treated. It must be

espoused at a national level, at a state level and also, of course, at the local health network level. If that can be remembered, it seems to me that that will inform a lot of the activity that goes on in the light of the legislation. I am not discomforted by the legislation per se. I am really keen to ensure, though, that we have a shared view about what the politics of health in Australia is seeking to achieve.

CHAIR: Professor, could you give us your opinion on whether the efficient price should be based on input and output, or outcome, or a combination of both? Do you have a view?

Prof. Leeder: Yes, I have a view. I think it must be both, largely because of the immense variety of services that are provided. It might sound laughable to people from other countries when I say that Australia is not a homogenous nation, but, frankly, the health care arrangements in remote and rural places are very different to those that you find in the large tertiary care hospitals. There is the severity of illness and the complexity of it, not only regarding the problem that the person is being treated for, but, increasingly, when we are dealing with older populations we find that they have five, six, seven or eight different health problems and that will have a bearing on the episode for which the person is being treated at the time. If you go into hospital to have a hernia fixed and you also have heart failure and emphysema, it is going to be a very different pilgrimage to one where you went in and just had it done. If you are otherwise whole and hearty, you would be out in two days. I do not think that you can have an absolutely uniform pricing mechanism. Having said that, you could respond to that and say, 'Get real,' because if you buy a car in Broken Hill you pay roughly the same price as you do in Sydney, although the conditions under which it operates are very different. I have some sympathy for that view.

The pricing authority clearly has to strike a compromise between those two things. It needs to be generous enough to allow quality of care to occur, and then that is fine, but I would be concerned if too many things were loaded into the efficient price. For example, there may be some allowance that we would wish to make for rurality and we may wish to make some allowance for disease complexity and whatever else a large teaching hospital is doing. If they are doing clinical research, it is not totally clear to me where the support for that would come unless there is some recognition of it in the pricing authority's determinations, unless we then decide what clinical services we are going to make money available for in the larger hospitals to cover their costs. My understanding of the Victorian experience with case-mix funding is that such allowances ended up having to be made because the larger hospitals simply could not stay afloat with reimbursements only for the clinical activity that they were providing. So, yes, I do think it is important that the reward structures for clinical activity take account of where that activity is occurring and the severity of the patient's condition.

You also need to be clear that activity based funding does not include in its calculus, as far as I can see, any estimate of what is actually achieved in terms of improved health or a patient's satisfaction. I presume that has to be the next step, but we are still some distance away from it if we are simply rewarding activity. It says nothing about the appropriateness of that activity either, I might say. You can imagine—and, indeed, this occurs—that there is a lot of gaming in the system where activity based funding applies. India has some totally spectacular and almost unimaginable examples of clinical overactivity that have followed the introduction of that form of funding in a couple of the states. But that is of limited relevance to Australia, I think.

CHAIR: In relation to the risk adjustment, how do you see this working? Have you got a view that you can share with the committee?

Prof. Leeder: Yes. I think it is a good method to take account of that patient complexity component which I was speaking about before. A patient with very severe coronary disease might be referred to, let us say, the Alfred hospital in Melbourne, whereas someone with coronary disease that is not complex and can be straightforwardly handled might be done at a small hospital, and the costs incurred would be very substantially different because of the staffing structures, the backup technologies, the treatment given and so on. Taking into account as best one can, not exhaustively but say on five or six measures of risk or disease severity, I think in the experience of casemix funding has proved to be a useful method of calculation. That, as I understand it, would feature in the new system. My point about context certainly includes that, but it goes a bit beyond it in the sense of taking account at some point—maybe more generally, rather than related to a specific clinical activity—of the fact that running things in less centralised circumstances, which applies in a lot of Australia, may end up being paradoxically more expensive than it would be in the big city, where the technology is greater but the tyrannies of distance do not apply. I just think it has got to be done intelligently and sympathetically and openly. I am sure there will be an iterative process while the authority gets things sorted out, just to make sure that we maintain a commitment to equity in that interim period while things are adjusting. I would say that it will probably take two or three years for that to bed down.

CHAIR: There has been some discussion and evidence this morning in relation to the definition of efficient pricing. What is your interpretation?

Prof. Leeder: I think that it would be defined as, where we can observe high-quality care in Australia, the price of that—what that costs. There is an immense amount of variation, of course, in clinical practice in Australia, but we know that there are some ways of doing things that are more efficient than others. I would hope that it is an incentive to all health services to adopt the evidence, in terms of both effectiveness and cost of services, and apply their minds to how they can operate within that constraint. I think there will be internal incentives within the major institutions. I am thinking about Western Sydney, for example. In our local health district, we have a budget of around $1 billion a year. Let us suppose that, against the criteria of efficient prices, there are one or two services that are obviously costing us more than we are getting back. It is not necessarily a problem with the efficient pricing; it may well be a problem in the way that we are providing the services. So we would be having a very good look at those to see what the problem is—is the staffing ratio wrong or something like that? I could give you examples of that that apply now, where, when we benchmark what goes on in one clinical activity against the Australian norms, we find that we are top-heavy with highly qualified nursing staff and light-on in terms of nursing aides and the rest of it. That is an adjustment that we may well be able to encourage within that service which would bring it more into line with what would be judged to be an efficient notional price.

I see no justification for continuing with those services that may be a matter of professional pleasure. But the opposite is true too: if the market for the provision of a particular service becomes totally unprofitable to everybody, then you are going to be in trouble because no-one will bother doing it. That is not true, of course, because state politics would mandate that the service still be provided. But it would then begin rattling the whole business of activity based funding in a way that would not be in anyone's interests.

I think the authority will have a good look at what the best practice is in Australia for certain key budget items—I cannot imagine they would do it for everything but they would for the big ticket ones in relation to major things like heart disease, stroke, cancer, orthopaedic problems and the like—and then declare what it is prepared to pay. There may be some which are initially too generous, and I am sure people will be alert to that. I suppose the precedent really is the Medicare Benefits Schedule, where there is always ongoing debate about whether the rebate actually covers best practice; sometimes extended rebates are provided, and there is a lot of to-ing and fro-ing about whether we have the best arrangement for the care of people with mental health problems. I cannot imagine that the pricing authority will be any less controversial than that; I think that is the reality of it all. But I think most people would agree that efficient pricing should include an incentive for good-quality care that does not waste resources anywhere.

CHAIR: Thank you. Do you have a view to share with us in relation to IHPA being able to provide confidential advice to the government? Do you think they should be able to provide that confidential advice?

Prof. Leeder: Who? Sorry, I missed who it is that would be providing that advice.

CHAIR: IHPA, the pricing authority.

Prof. Leeder: The pricing authority—

CHAIR: Yes.

Prof. Leeder: providing confidential information to the government?

CHAIR: Confidential advice to the government in relation to pricing—should they be able to do that? We have had some discussion and evidence on that this morning. Do you have a view?

Prof. Leeder: I would have thought they should be able to do that. I do not think that one need be too precious about confidentiality, because the greater the visibility of these decisions the better for everybody. But from time to time there may be a need for a degree of confidentiality. I would not feel uncomfortable with that.

CHAIR: Okay. There are no further questions from the committee, so thank you very much, Professor Leeder, for giving us your time today.

Prof. Leeder: My pleasure. Thank you for listening.

CHAIR: The committee will break for lunch and then resume in approximately one hour.

Proceedings suspended from 12:13 to 13:17

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

HEAD, Mr Graeme, Deputy Secretary, Health Reform Transition Office, Department of Health and Ageing

CHAIR: I welcome officers of the Department of Health and Ageing. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I remind witnesses that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to a superior officer or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policy or factual questions about when and how policies were adopted. Do you have any comments to make on the capacity in which you appear?

Mr Head: I am a deputy secretary in the Department of Health and Ageing and also the chief executive of the Health Reform Transition Office in the department.

CHAIR: Thank you. The committee has your submission. I now invite you to make a short opening statement, and at the conclusion of your remarks I will ask members of the committee to put any questions to you.

Mr Head: Thank you, Senators, for the opportunity. I will only make a couple of brief remarks by way of an opening statement. The bill you are currently considering, of course, is one of the key pieces of legislation to establish the machinery to give effect to the National Health Reform Agreement, which was agreed on 2 August this year. In large part it gives effect to schedules A and B of that agreement and, through the process of negotiating the agreement with the states and territories, there has been significant ongoing dialogue with the states and territories about the terms of the bill. I will not go through the matters addressed in our submission, which also covers off those matters that are set out in the explanatory memorandum, but I am happy to take questions.

CHAIR: Thank you very much. Mr Broadbent, you have nothing further?

Mr Broadhead: No.

Senator FIERRAVANTI-WELLS: You defer, Mr Broadhead?

Mr Broadhead: I do.

Senator FIERRAVANTI-WELLS: Mr Head, to use the time, I might just take you through some of the comments that have been made by various people who have given evidence. We have your submission, but I would like to pick up on those, in no particular order. I will just start with some comments by the Consumer Health Forum in relation to the inclusion of a consumer component. Mr Head, did you hear the previous evidence that other witnesses have given?

Mr Head: Most of it, and I have also seen the submissions that have been lodged.

Senator FIERRAVANTI-WELLS: Okay. It was in relation to the point about their framework and the inclusion of a consumer component either as part of the broad, overall, or as the establishment of a consumer advisory committee. Has that been considered, or do you have any comments in relation to that?

Mr Head: The comment I would make is that the arrangements agreed by governments in terms of both the functions for the authority and its governance structures do provide opportunities for consumer and a wide range of other inputs, not in a prescriptive way, but the functions for the authority will see it receiving submissions as part of the exercise of its determinative functions. The provisions that relate to the membership of the pricing authority, while they only prescribe two forms of specific expertise, of course leave it open to COAG in determining appointments to choose people from a wide range of backgrounds. There are also provisions in the bill that allow for the authority to establish committees other than those that it is required to establish. The two that it is required to establish are a Clinical Advisory Committee and a Jurisdictional Advisory Committee. Obviously the first relates to the complexity of clinical issues in operationalising the activity based funding system and the need for close engagement with the clinical community in that. Also the scale of the change process for states and territories in respect of those new arrangements suggests a formal structure for that, but it is open to the authority to establish other advisory bodies and it will call for public submissions, so there are a range of opportunities in the existing terms that do provide for the input of—

Senator FIERRAVANTI-WELLS: So at some point the authority will call for submissions in relation to what subcommittees should be established? Do I understand correctly?

Mr Head: I am sorry if I was not clear. The authority will call for submissions in respect of the setting of the national efficient price. There is through that process an opportunity for a wide range of interactions with the authority, and it can also establish, as it sees fit, other communities to either deal with issues or engage with particular sectors.

Senator FIERRAVANTI-WELLS: Mr Head, in terms of the framework, let us just take for example the Consumer Health Forum. Would it be up to the Consumer Health Forum to engage directly with the authority and say, 'We believe that you should be looking at this,' or if, say, this committee made a recommendation of that nature then there would be a process whereby that could happen? I am just looking at the logistics of how that could happen. Is that something that would have to be instigated by the authority, or is that something that the consumer health family could push?

Mr Head: The agreement and the bill following the agreement certainly anticipate a pricing authority that will engage extensively with those organisations and sectors that have an interest in its work. It is formally required to enter into two specific engagement processes with jurisdictions and with clinicians, as I have said, but the expectation on it is that it will have an open and transparent process, it will receive submissions from interested parties and it will publish reports on its determinative functions.

I expect—although obviously I cannot speak on behalf of such a structure—that the normal processes would apply where submissions are called for and are advertised and that there are other modes of interaction for stakeholder groups. Indeed, it is probably worth reinforcing the point that while the bill does not prescribe, beyond a couple of specific examples, types of expertise that are required to be on the authority itself it is open to COAG to draw membership from a wide range of fields of expertise and perspective to actually constitute the authority itself.

Senator FIERRAVANTI-WELLS: Another point that the consumers raised specifically—and this was also raised in other evidence given this morning—was clause 131 and the issue of confidential advice to the Commonwealth. Do you have a view, Mr Head, as to the comments made that that provision should be deleted—that it should be providing advice and that advice should be open and transparent, that being the government's intention in relation to this authority?

Mr Head: The observation I would make is that, taken in context with other provisions, the intention is, and the relevant section requires, that the pricing authority publish a report setting out the national efficient price and associated matters. This simply provides that one of its functions can be to provide confidential advice. There are a range of other provisions in the bill that clearly reinforce the intention of governments to increase greatly the transparency in respect of these financing arrangements. My colleague may wish to comment further.

Mr Broadhead: I think that the confidentiality here is particularly about parameters, if you like, or estimates of growth in particular parts of costs that may be used to underpin advice to governments about what hospital costs may be doing in the future. I think the reason for the confidentiality here is the same as the usual practice on the part of the Commonwealth in not publishing, as I understand it, the parameters that underpin Commonwealth indexation—that is, we put out forward estimates of future expenditure but some of the bases on which those are estimated we do not publish because it is sensitive information.

For example, labour costs are a major part of hospital costs. In projecting future costs of hospital services the pricing authority would have to make some assumptions about growth in labour costs. It is entirely likely that, were those to be published, they would then be fed into bargaining arrangements, as between employees and employers, pointing to the authority having, in a sense, blessed a particular number in its assumptions. Therefore, for the same reasons that the bases for future values and parameters in Commonwealth indexation are not generally published, there is also the opportunity here for that advice to remain confidential.

Senator FIERRAVANTI-WELLS: Is that the sort of thing that you would put in guidelines? It is quite open-ended, and you would appreciate why some of the people submitting have questioned it. This is supposed to be an authority that is about transparency and openness, yet dotted throughout this legislation there are these confidential type clauses. For example, there have been some comments in relation to clause 211, which states:

… must not report publicly … unless the report, and a period of 45 days in which to comment on the report, has been given to the Minister and each State/Territory Health Minister.

Implicit in that seems to be some 'lack of transparency'. I am just trying to paraphrase a little of the sentiment. What are your views in relation to that, Mr Broadhead?

Mr Broadhead: Firstly, in relation to the one about future costs, it is only in relation to future costs that confidentiality applies—in other words, the advice it provides to governments about the costs of providing healthcare services in the future. It is not meant to be about the present or the past. For example, in putting

forward its national efficient price and related matters, it would be transparently publishing all the information that underpins that—or we would expect that that would be the case. It is only where it is venturing into territory which is in a sense speculation, if you like, or projections that it has the opportunity to remain confidential in advising governments about what it thinks might happen in the future. But it cannot have that then fed into other forms of negotiation.

In relation to 211, I suppose this is essentially about a 'no surprises' provision in terms of people who may be asked to respond to the things that are published, particularly state and federal ministers. There is nothing in this provision which prevents the publication of something, but it does give to people who will likely be called on as soon as such a report is published the opportunity to understand it and therefore respond in an informed way rather than in a—

Senator FIERRAVANTI-WELLS: Basically, Mr Broadhead, it does not afford the state minister or the Commonwealth minister the opportunity to vary the report. In other words, that is seemed to be the gist of the commentary this morning—the opportunity to change it, vary it or do that sort of stuff.

Mr Broadhead: I cannot rule out that a circumstance might arise, for example, where the pricing authority puts before a state or federal minister, or ministers collectively, a report and subsequently advice is given to the authority in respect of that that ministers think there was some basis of the report that was improperly founded or would bear further scrutiny or whatever, in which case the pricing authority would be at liberty to respond or not to that advice back from ministers. But there is nothing in this provision here that requires the pricing authority not to publish if it wishes to publish or anything; it just has to give a lead time to those people who will likely be asked to respond.

Senator FIERRAVANTI-WELLS: No, but in the end it does not cover changing or varying the report if there is negative new—

Mr Broadhead: No, it does not.

Senator FIERRAVANTI-WELLS: That is the point. I think that is really the assurance that people want: that it is simply a time mechanism rather than an ability to vary a report of the pricing authority that a state minister or a Commonwealth minister may not like. That is a genuine inference that can be drawn from that section.

Mr Head: What the bill provides for is simply an opportunity to examine the report within a specified time frame. It in no way fetters the authority's decision-making processes in respect of publication.

Senator FIERRAVANTI-WELLS: All right. I will take that and I might pursue that a little bit more with the minister during the second reading. I will just go to some other points which were picked up: the Catholic Health Australia point about the costs components—again we are on proposed section 131—and the suggestion about the uniqueness of the Catholic hospital system. I am not sure if you heard the evidence that Mr Laverty gave this morning. Can you, if you would not mind, comment on that and the suggestion that Mr Laverty has made about the costs components of delivery of public hospital services by non-government hospitals.

Mr Broadhead: The authority, in reaching its determination about the national efficient price, is required to have regard to the actual costs of service delivery in as wide a range of hospitals as practicable. It also has a function to produce adjustments or loadings to that price in respect of hospital characteristics, including type, size and location. So this reflects wording in the agreement but is also in the functions. It can, for example, say that the particular type, size or location of a hospital can affect the cost of delivery of services and therefore an adjustment should be made to the national efficient price to reflect those things. In the agreement in general terms—and I can look for the specific terms—it says that this is about taking into account things that affect costs that are essentially beyond the control of the hospital. So the aim here is not to hold hospitals to a price. It does not reflect things that do vary their costs but cannot be controlled by them.

In that respect, if for example it was apparent in the work the pricing authority did that there was a systematic difference in costs for reasons to do with size, type and location—and I do not think they are restricted to only those—that was beyond the control of the hospital or set of hospitals, a loading or adjustment could be made in respect of the price.

Mr Head: If I may add to that, the relevant part of the agreement, the principles for determining the national efficient price, are in clauses B11 to B14 inclusive. And, in addition to the points that Mr Broadhead has just made, there is an extra reassurance in the bill, in that section 132—

Senator FIERRAVANTI-WELLS: What clauses were those?

Mr Head: B11 to B14 inclusive are the principles for determining the national efficient price.

Senator FIERRAVANTI-WELLS: In response to Catholic Health you say that that is sufficient and you reject their suggested amendment, or words to that effect?

Mr Head: There is a wide range of matters that the pricing authority must have regard to in respect of those principles. The point I was going to make is that there is also an extra piece of reassurance in the bill itself, in that section 132, which deals with the intergovernmental agreement—subclause 3—makes it clear that where the agreement sets out processes to be followed or conditions or requirements to be met by the pricing authority. In performing a function it must follow those processes or meet the conditions or requirements. So, where the agreement indicates that it must have regard to the sorts of matters that are specified there, and which Mr Broadhead clarified, there is an extra reassurance in the bill relating to the pricing authority's adherence to that.

Senator FIERRAVANTI-WELLS: All right. I am sure Mr Laverty will take that on board. Going to the AMA submission and some of the comments they made and their summary of amendments proposed, I will take you to some of those. First, regarding section 134, what is your response to Mr Sullivan's evidence that there is nothing in the agreement in relation to pharmaceuticals or hospital benefits and medical or dental services and therefore that section ought not to be there?

Mr Broadhead: I need to first preface my remarks with the usual disclaimer that I am not a lawyer and particularly not a constitutional lawyer!

Senator FIERRAVANTI-WELLS: We all muddle through!

Mr Broadhead: My understanding of this is that this section actually sets out limits. So it does not extend the functions of the authority or the powers of the authority into the areas listed. Rather, it basically sets out that in performing its functions and exercising its powers it cannot go beyond things for which the Commonwealth has a head of power under the Constitution. So this clause essentially lists the constitutional limits that would apply to the bill and to the authority in pursuing—

Senator FIERRAVANTI-WELLS: Are you saying that it is doing it in the abstract and it is not, as Mr Sullivan envisaged, that there is nothing on the radar at the moment and therefore not to be included; it has just simply been put there as a statement of constitutional parameters. In the event that something happens in the future it could only go to those limits.

Mr Broadhead: Even more than that, it is actually limits that are applied to the operation of the legislation once it has passed the parliament. The basis of this is Commonwealth heads of power in the Constitution; therefore I cannot envisage a circumstance in which this would apply, but I understand it is standard drafting procedure to set out the constitutional limits. If it were to find itself attempting to exercise its functions or powers in a way that went beyond the constitutional limits then it could not do so. So it is for the sake of clarity. It is making clear that it can only operate within the parameters of the limits of constitutional power. For the Commonwealth, the actual functions and powers it has are set out in the legislation. Absent an amendment, they are what they are.

Senator FIERRAVANTI-WELLS: I take that point. I will just go through various other points that they pick up. Points have been made by various people who have given evidence about teaching, training and clinical research, those components and how they fit into the efficient price. Are you satisfied that those previous parameters that we discussed in terms of the combination of B11 through to B14 and what Mr Head said—those additional provisions in clause 132—will be sufficient to take those sorts of matters into account?

Mr Broadhead: There are a number of specific provisions in the reform agreement which deal with teaching, training and research. In particular, initially teaching, training and research are to be funded on a block basis. The amount in the first year is to be settled between the Commonwealth minister and the minister of each state and territory. This is because there is not at the moment a basis for funding teaching, training and research on an activity basis, if you like, although some may wish to put forward particular ways in which it might be done, but there is no agreement that it could be done at this juncture. There is a clause in the agreement which does say that the pricing authority should provide advice by, I think, 2018 on the feasibility of moving teaching, training and research funding to an activity basis, but the general view amongst all of the jurisdictions in the development of this agreement is that the particular costs of teaching, training and research are not currently well identified separately within the existing funding arrangements and so it is not possible at this juncture to try and move to a more particular or activity based approach. Indeed, given that 2018 is the come-back time for the pricing authority, it is not envisaged that it would move to an activity basis for some time, if ever, depending on the report.

The reason for funding it on a block basis is precisely to ensure that there is funding identified for teaching, training and research, because all jurisdictions want to see this funded and continuing. The view was taken that

one of the risks in funding things you can count is that you might squeeze out funding for things you cannot count, if I can put it that way, and therefore you need to separately identify funding for teaching, training and research in order to ensure that there is a focus on those activities. That is why, in the structure of the agreement and in the arrangements that the pricing authority has responsibility for, there is separate block funding for teaching, training and research envisaged in the agreement and in the pricing authority arrangements. It is not current—it is not expected to be part of activity based funding from the get go.

CHAIR: Just following on from that, in relation to recognition of the research and training that is happening, do you have a view that you can share with the committee about the universities' role?

Mr Broadhead: I do not think I am allowed to express a view, but I think I can say that—

CHAIR: Are there any provisions, then, for universities to share some of this cost? Are there any provisions in the bill?

Mr Broadhead: One of the complexities in funding of teaching and training, particularly teaching, is that it is currently funded from multiple sources in a variety of ways and a number of the costs are hidden. So, for example, you have conjoint appointments, where people have an appointment through a university while also having an appointment through the health system or the hospital, which may be jointly funded. There are multiple different sources of funding and arrangements that apply, and there is no single way of doing this, no standard method of doing it and no standard method of identifying what money has come from where in order to support the function. There is even—dare I suggest—not complete clarity about what teaching is and what a cost of teaching is and is not. For the purposes of illustration I point out that our larger teaching hospitals say that there are costs of treatment that are attributable to their teaching role that relate to the time taken for supervision and the role of students in being educated both in operating theatres and around the bedside and so on which impact on their costs of service delivery. They are not necessarily funded as a separate strand of teaching costs, but they do influence the overall cost of services provision.

My understanding of the way in which the agreement is constructed is that there is a wish to identify as well as is possible these costs, a wish to work overtime to better understand these costs and a wish to examine over time the feasibility of moving to a more specific, activity-related basis for doing that while recognising that there is quite a deal of work and complexity in unpacking how teaching and training research is funded and what the impacts both direct and indirect are on the costs of other things that hospitals do.

So it is a matter of hasten slowly: let us start and identify what we can about these costs, ensure that there is a stream of finding that relates to them and work overtime to better understand and even, potentially—subject to this feasibility report—move to an explicit form of funding the actual activity of teaching, training and research.

CHAIR: So you take it that the contribution of the universities will be part of that review and reporting back.

Mr Broadhead: Yes

Senator FIERRAVANTI-WELLS: There is an issue that the AMA raised in relation to the reporting to the parliament under section 210, and I want to go to that now. On their submission they make a reference to clause A65 of the agreement:

There will be no requirement for Local Hospital Networks to be paid the full national efficient price if the State considers that a lower payment is appropriate, having regard to the actual cost of service delivery and the Local Hospital Network's capacity to generate revenue from other sources.

What is your view in relation to that reporting? They say that if there is a lesser amount paid surely that should be reported on.

Mr Broadhead: The intention of the arrangements under the agreement is that all activity-based funding will be reported in terms of both the amounts and the activity to which the funding is related or upon which the funding is based. It is a very strong principle through the agreement that the aim here is to have the amount of funding, the source of funding, the destination of funding and the basis upon which the quantum was arrived at all publicly reported. This would mean that, to the extent that a state's contribution to activity-based funding for a particular local hospital network was less than or more than the national efficient price or the same as the national efficient price, it would be visible for people to see in the reporting that is required. That includes not only the reporting to parliament but also the public reporting that is required.

Senator FIERRAVANTI-WELLS: So you are satisfied that the point that the AMA make—that is, that where there is a local hospital network or a public hospital, there is a difference between the efficient price determined by the authority and the actual price paid to that local hospital network for the delivery of services as contracted with the state authority—and that that is sufficient? Will that be included in the reporting?

Mr Broadhead: Yes. Graeme is pointing out to me that the specific way in which this will be done is not actually the subject of this bill, because under the agreement reached in early August there is a role for a national health fund administrator and the national health funding pool. So we would expect that later this year there may be further legislation introduced to establish the role and the pool. But, under those arrangements, as set out in the agreement in quite some detail, that administrator is responsible for reporting on payments into the funding pool and on payments out of the funding pool in respect of ABF. All payments from governments in respect of activity-based funding into that pool and then out of that pool to LHMs is to be publicly reported—both the quantum and the basis—and that is the mechanism to ensure that there is transparency in activity-based funding.

Mr Head: If I could just briefly give a thumbnail sketch, state and territory health departments will strike a service agreement with local hospital networks which will specify the type and volume of services to be provided. The national efficient price will then calculate the Commonwealth's contribution to the jurisdiction fund for the purposes of that service agreement, and state moneys flow through the fund as well. As Mr Broadhead has indicated, the national funding body and its administrator are intended to have a series of public reporting functions in respect of how those moneys move.

Senator FIERRAVANTI-WELLS: So, Mr Head, this is the funding authority that was and then was not, and now is back on the agenda! I know that we have traversed this in other ways, but that is the legislation that you refer to at the top of page 6.

Mr Head: And the references in the agreement to the national funding body and its administrator relate to those arrangements.

Senator FIERRAVANTI-WELLS: I have been doing this for two years, so please allow me some degree of humour about these things at times! Mr Broadhead, that then picks up on what you are saying at the bottom of page 5 of the submission, doesn't it?

Mr Broadhead: I will need to quickly refer to the bottom of page 5 to make sure I do not misunderstand you.

Mr Head: That is correct.

Mr Broadhead: Yes.

Senator FIERRAVANTI-WELLS: Okay. This morning, Mr Sullivan made comments about the efficient price. It was a discussion about an efficient price in the abstract. Each of those local hospital networks have their variations, and that efficient price in one local hospital network will vary from that in another because of different circumstances. Mr Head, do I understand correctly from what you have just said that the efficient price will be determined for each of those local hospital networks?

Mr Head: I will ask Mr Broadhead to go through the detail of how it works. But, no, that is not what I just said. What I was saying was that the role of the Independent Hospital Pricing Authority, in that thumbnail sketch, is to exercise its functions to determine the national efficient price, that state and territory governments will enter into service agreements with local hospital networks that will specify the type and volume of services, and that the type and volume of services, combined with the national efficient price, will produce a calculation as to the Commonwealth's contribution to go through the national funding body to that LHN. Mr Broadhead may wish to address the matters that the pricing authority must—

Senator FIERRAVANTI-WELLS: Mr Sullivan this morning raised the issue of the differences at that local level, Mr Broadhead.

Mr Broadhead: Yes. So the national efficient price, as its name suggests, is a national efficient price rather than a price for each and every hospital, or each and every LHN. The exception to that, as I mentioned earlier, is that there will be adjustments to the national efficient price using loadings that are based on size, type and location of hospital, for example. Complexity of patients is another factor that can be used to adjust the national efficient price. The combination of those loadings and the way in which they are applied may mean that, in the end, if you go from one LHN to another, there are some differences in the price that applies to a particular LHN, including the loadings, as compared to another one. So there is not one single, fixed price; there is one that underpins everything, but then there are adjustments that the pricing authority also produces which can be made to that. However, it would not extend to there being an individual price, a price that was different, for each and every hospital.

The premise of this is that there is an underlying, efficient basis for providing funding for hospitals. The flexibility—and I think that term was used this morning in a number of the discussions—in a sense comes from the state's capacity to adjust their contribution so they are not bound to simply pay exactly the balance, if you like, of the national efficient price. They can vary their contribution. Now, in some areas, I expect they will end up paying more than the national efficient price and, in other areas, I expect they will end up paying less. For

example, we expect the national efficient price will be determined based on gross costs of delivery. In other words, never mind where the revenue came from; what are the total costs of delivering a service?

The government revenue to public hospitals is actually not generally 100 per cent of the cost, because hospitals have their own revenue sources, particularly in metropolitan areas. For example, things like car parking can raise a significant amount of revenue for hospitals.

Senator FIERRAVANTI-WELLS: Absolutely. I can think of some hospitals in metropolitan Sydney that do very, very well in that respect!

Mr Broadhead: That may be your view, Senator. Obviously, where hospitals have capacity to raise revenue in their own right, ordinarily public subsidies would not be extended that took no account of the fact that they also have revenue to meet the costs, apart from their own resources. It is entirely possible that, while the Commonwealth contribution is tied to the national efficient price, the state's contribution will undoubtedly take into consideration other factors that may vary locally for that hospital, in terms of both cost and revenue. That is where the flexibility is built into the agreement.

Senator FIERRAVANTI-WELLS: Senator Polley, I have tried to go through and canvass all the issues that were covered this morning. I think that is just about everything.

CHAIR: That is fine. I have some questions too. There was some evidence given this morning about collection of data and how that varies from state to state and territory. Can you outline to us the mechanism for resolving that and whether or not there is an adequate time frame that can be met?

Mr Broadhead: There are some hospital data which have been collected for many years and have been subject to much work in terms of standardisation. Data that relates to patients who are admitted to hospital has for many years been collected nationally and has been the subject of a deal of work to standardise those data collections. In other areas we have more recently commenced data collection. Particularly in larger hospitals, there has been for some years now—but not for nearly as long as for the admitted patients—a national collection of emergency department data. The area where arguably there has been the least standardisation is probably non-admitted data or outpatient data.

All of this is well recognised by the jurisdictions that have signed up to the agreement, and there has been a lot of work going on, even ahead of the arrival of the pricing authority, on what standards will apply and what data will be collected and used for this purpose. For example, there is a rather large group of all jurisdictions and three deputy secretary level representatives from each jurisdiction which oversees, under COAG, implementation of health reform. It gets spoken of by its acronym, HRIG, the Health Reform Implementation Group. That body agreed a set of initial classifications that would be used for activity based funding several months ago—in fact, from memory it was in 2010. So there has been work going on apace to further develop those classifications so they will be fit for purpose from 1 July next year and to implement data collections that will enable them to be used.

For example, in the Health Reform Transition Office there have been people working on a thing called urgency related groups. This is a particular classification that was originally developed in Western Australia which will be used for emergency department services. We have now got a detailed specification which has gone to states and territories for trialling. This is consistent with the agreement that HRIG reached on the classification that would be used initially. All states are aware of the data requirements to populate, if you like, or to meet that classification.

Similarly, as I speak, the finishing touches are being put on something that will be going out to a working group of that implementation group to ratify detailed definitions for what are known as tier 2 clinics. These are a list of a little over 100, I think, clients of non-admitted or outpatient clinics that will be used as the initial classification for non-admitted patients. Again, there has been a lot of work done with states and territories, and indeed with clinical input, to look at those as the initial basis for activity based funding and outpatients. So there has been a lot of work going on. With the arrival—last week, as it happens—of the Interim Independent Hospital Pricing Authority, in this bill the pricing authority will have responsibility for setting the classifications and the data standards. This work has been going on in anticipation of the arrival of the pricing authority. Now that we have an interim pricing authority, it will move to them. Ultimately, once this legislation is passed, if I can make that presumption, it will go to the statutory authority to then be the custodian of those standards that are used to count and classify hospital activity for the purposes of funding.

In terms of time frames, it is a time frame that concentrates the mind. There are many minds concentrating very hard on it as we speak. But everybody believes—and the evidence is the signatures on the agreement—that this can be done. I think it was 14 June that the health reform implementation group ratified again the scope of things

that would be subject to ABF from 1 July 2012. Again they have reiterated their commitment to that as recently as June this year.

Mr Head: To add to that: in addition to the functions related to data in section 131(e), throughout schedule B in the agreement there are explicit data arrangements, including an obligation on national bodies to develop rolling three-year data plans in line with a particular process and with advice on those first data plans to be provided to health ministers in early 2012. This is an intergovernmental agreement within the meaning of the bill, and of course the arrangements I spelled out before would require the pricing authority to observe those arrangements in managing its development of its processes for taking forward any issues relating to data.

CHAIR: Thank you; I think that helps clarify it. The pricing authority, the Clinical Advisory Committee and the Commission for Quality and Safety in Health Care are all independent bodies. How is it under the proposed legislation that these bodies are going to work together? Are there enough safeguards in place or should we be looking at some sort of definition of duty of cooperation?

Mr Head: I am happy to start. There are a range of checks and balances in the arrangements as they are already proposed. For instance, the pricing authority clearly must have regard to safety and quality in exercising its determinative functions, which therefore creates a connection between the work of the pricing authority and the work that comes out of the commission. The national health performance authority legislation, the underpinning concept for the performance authority, says it will have a performance and accountability framework agreed by COAG. That framework will, amongst other things, articulate the indicators that are to be reported against, and there will be an articulation back to, for instance in respect of safety and quality, those things that arise from the work of the commission.

CHAIR: Mr Broadhead, did you want to add anything to that?

Mr Broadhead: No, I think that was an excellent answer!

CHAIR: We will move on to the definition of a 'clinician'. There has been some evidence given to us, and I am concerned about whether or not the definition needs to be further defined. Can you inform the committee of your understanding of what is proposed?

Mr Broadhead: I think the definition of 'clinician' was dealt with when the bill was passed to establish the safety and quality commission. Originally in that bill I believe 'clinician' was used as a term but there was not a specification of what it meant. There was subsequently an amendment to make clearer that 'clinician' means—I do not have that legislation before me—essentially people who have a clinical role in respect of patients. It is not purely medical but includes nurses, allied health practitioners and so on. So, in other words, because this bill is amending that act, that definition of 'clinician' will apply in terms of the provisions of this legislation once it becomes legislation. So, throughout what will become, assuming the bills go through, the National Health Reform Act, there will be a definition which makes clear that 'clinician' is broadly defined, as in that act currently, and that would apply to the use of the word 'clinician' in this legislation.

CHAIR: I know Senator Fierravanti-Wells asked whether there could be an advisory committee of consumers and you said that, under the act now, the advisory committee can set up virtually any sort of committee to seek information and to be an advisory body to them. There has been concern, obviously, that there is not a consumer representative on the advisory authority.

Mr Head: I attempted to address this in my answer to Senator Fierravanti-Wells's first question, I think. It is true that the bill does not specify a member with that expertise. In fact, of the seven members separate from the chair and the deputy chair, there are two areas of expertise that are specified, allowing COAG in determining the membership to consider a mix of skills and expertise that are appropriate for the pricing authority at particular points in its life. But clause 205 under part 4 of the bill does give the authority to power to:

… establish committees to advise or assist it in the performance of its functions.

And, as I have said in respect of the pricing authority, the current terms of the bill in no way preclude somebody with that expertise being included on the board; they simply do not prescribe it.

Mr Broadhead: Also, in relation to the corporate public submissions that it must make annually, I would expect that there would be quite a deal of input to that process from a range of organisations representing consumers. So, for example, the Consumers Health Forum clearly has a remit as an organisation to broadly represent health service consumers. But I would imagine, for example, that you would get peak bodies in relation to people with particular conditions wanting to put forward submissions in relation to the pricing of services that are particular to those conditions. For example, I would be surprised if organisations representing people with cystic fibrosis or diabetes and so on would not be putting forward not general submissions about things to do with orthopaedics, say, but submissions specifically in relation to what they see as issues of pricing for services to the

people that they represent. So I think there is scope for a very wide range of consumer input and even input from individual consumers, of course, as well, in that mechanism.

Senator FIERRAVANTI-WELLS: In relation to evidence given by Ms Power from the Australian Healthcare and Hospitals Association I want to raise a couple of points. The first is on there being no definition of 'efficient price', and there were some comments made in relation to that. The second is on her suggestion of the need to define public hospital functions, and you may have seen some of that evidence. Do you wish to respond? They were the only other two things that I did not ask about earlier. Did you have a comment in relation to that evidence?

Mr Broadhead: I think that these are two areas where essentially the approach taken is to say that these are matters which require some sort of deliberation and judgment to be exercised because there are so many different factors that could influence people's views about and determination of both the scope of hospital services and efficient price. The heart of this is to establish a mechanism and some parameters around that for an independent body to provide determinations or advice on those things, but it is not something that can be boiled down to a 'This is what it is.' If you could boil it down to a 'This is what it is' that you could put in a sentence or a provision, then you would not need a body to do it for you. In the same way that bodies like the Grants Commission et cetera have parameters which govern the way in which they undertake the work, in the end there are judgment factors and things on which research will have to be done and so on and input sought from a wide range of people to form a view about this rather than something you can prescribe.

Senator FIERRAVANTI-WELLS: In their submission they also make reference to a series of indices which for the national efficient price should be applied quarterly. They set those out in their submission at page 5. Should I take it from previous evidence that you are satisfied that the principles for determining the national efficient price are sufficient to cover the sorts of comments that they are making here? Mr Head made a comment before to the effect that the principles for determining the national efficient price sufficient are delineating what needs to be taken into account. Would the need for those indices be covered under that same answer?

Mr Broadhead: In the end, this whole thing relies on the authority itself, which is made up of the nine members including the chair and the deputy chair, and the work that will be done to inform its decision making, so I expect that there is provision for things such as loadings and adjustments. I am afraid I do not have in front of me the specific reference to indices that the AHHA have made.

Senator FIERRAVANTI-WELLS: I will read what they were saying for completeness; we have a couple of minutes. They say that the AHHA recommends:

The following indices (or other replacement measures) should be applied quarterly in the first few years of operation, followed by annually:

- The AIHW health price index;
- The Productivity Commission index of technology growth;
- Projected increases in population by region adjusted for likely hospital utilisation (which will not be covered totally by volume growth);

Mr Broadhead: I think that is a different mechanism for adjusting for changes in costs over time than is contemplated in the mechanisms that are sought to be established by the legislation. The legislation does not specify a particular method of forecasting the future cost of services, and I would expect that the pricing authority would have regard to those indices just mentioned. For example, I think from memory that the Institute of Health and Welfare is the basis of indexation of the current national healthcare agreement, so I expect that the pricing authority would know, understand and have regard to those indices, but because of the way in which hospital costs are differently partitioned—in activity based funding particularly, but also in block funding—it is not clear to me exactly how those indices might apply. Therefore, it would be a matter for the pricing authority in its judgment to decide how to make adjustments in terms of, for example, forecasting future healthcare costs in its work.

CHAIR: There being no further questions, I thank you on behalf of the committee for the department's submission and for appearing before us today.

Mr Broadhead: Thank you.

Mr Head: Thank you.

SHERBON, Dr Anthony (Tony) Kenneth, Acting Chief Executive Officer, Interim Independent Hospital Pricing Authority

[14:14]

CHAIR: I now welcome Dr Sherbon of the Interim Independent Hospital Pricing Authority. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I now invite you to make a short opening statement, and I think it is fair to say that at the conclusion of your remarks there will be senators who will be putting questions to you.

Dr Sherbon: I do not have a detailed opening statement. I am more than happy to assist the senators with answers to questions where I can. The Interim Independent Hospital Pricing Authority was formed by way of an executive order of the Governor-General on 1 September so we have only just started operations. Nevertheless, I am certainly more than happy, should senators wish to ask questions, to assist the committee with its deliberations.

CHAIR: Thank you very much. We will start with questions.

Senator FIERRAVANTI-WELLS: Have you listened to today's evidence?

Dr Sherbon: Part thereof.

Senator FIERRAVANTI-WELLS: Can I take you through some of the questions that have been raised ? Perhaps if I could start from a threshold question. If I put similar questions to those I have put to the department are you or would you be in a position to comment on various other submissions that have been made to this inquiry? Would you be in a position to answer those? I suppose if I could set the scene from the beginning could you say what you are in a position to tell us and whether you are in a position to make comments in relation to those. I would not want to push and start asking a whole series of questions where you are simply going to say, 'I have only just got my feet under the desk and I am not able to assist you.'

Dr Sherbon: I can assist you with answers to questions in relation to the expected operation of the Independent Hospital Pricing Authority, IHPA, and its interim predecessor organisation which I have currently established. With respect to matters in the bill the department of course is the primary source of policy advice to the minister so the department will have hopefully dealt with all your questions with respect to the bill.

Senator FIERRAVANTI-WELLS: In that case then, in terms of logistics you have been in the chair from 1 September. What is your staffing numbers that you have at the moment and could you tell us a little bit about the logistics of where you are at?

Dr Sherbon: We are recruiting to a range of technical and senior executive positions within the interim authority. Those appointments will only be for a period of months until the authority proper is established pending, of course, the deliberations of the parliament. We are in a position in accordance with the National Health Reform Agreement to get things moving, to get things started and to get a series of pieces of work underway such that when the authority itself is established it will be in a position, if you like, to take a running start at the issues.

It will have a series of pieces of work available to it from its inception one of which will be a framework for establishing an efficient price that will take into account a range of strategic considerations in the establishment of an efficient price, including an international analysis of what is efficient around the world by way of healthcare service provision. There will be an analysis of what is an appropriate scope of activity based funding in accordance with the agreement and there is consideration of governance to take place after the authority has come to a view on that as well as some criteria for the application of activity based funding versus block funding in various situations. The pieces of work underway over the next three or four months will focus on those key elements. No decisions will be made until the authority proper is established and that of course as you know better than anyone is pending parliamentary approval.

Senator FIERRAVANTI-WELLS: Are the issues that, say, Catholic Health Australia were raising this morning about the peculiar circumstances of their public hospitals the sorts of issues that would come into the sort of work that you are now doing?

Dr Sherbon: Yes indeed, the interim authority will establish a preparatory pathway for the receipt of public submissions and it will gather the evidence around the world of efficient practice in preparation for the authority proper's commencement. That public process will include submissions from any interested organisation—no doubt, Catholic Health Australia will be an interested organisation—and it is appropriate that they express their view of what they think is an efficient price and an appropriate time. So, depending on the timing of the passage

of the legislation, should it be passed by the parliament, the interim authority will do as much preparatory work as possible.

Senator FIERRAVANTI-WELLS: There were some issues canvassed by the Consumers Health Forum of Australia in terms of the practical application, if I can put it that way, of some of the provisions of the bill—for example, the composition of the authority, potential appointments, and those sorts of things.

Dr Sherbon: The interim authority will not establish the authority itself. That is clearly a matter for the parliament and then, subsequently, for ministers to confer on and for COAG, in fact, to agree on a list of participants in the authority proper as members of the authority. But, as was pointed out to you in the earlier evidence from the Health Reform Transition Office of the Department of Health and Ageing, it is expected that both the interim authority and then the authority proper will consult widely to get the various views in the community as to what is an efficient price. There will be a particular emphasis on the consumer view, I would expect, and a particular interest in the views of Consumers Health Forum of Australia and other consumer organisations.

Senator FIERRAVANTI-WELLS: Dr Sherbon, do you have a view on the definition of 'efficient price'? You have heard some of the evidence today about the bill being amended to include a definition of it. What is your view in relation to that, if you can proffer one?

Dr Sherbon: The parameters for the efficient price will be set by the authority proper when it is established. But some of the key elements of efficiency will be explored in preparatory work for the establishment of the authority. My staff and I will progress a draft pricing framework for the consideration of the authority after it is established, and that will take into account some of the key elements of efficiency. That is not only technical efficiency—in other words, cost—but also elements around allocative efficiency: what is the most appropriate driver of health care in terms of models of care? You do not want to establish a regime that is excessively based on hospital versus community based care, and there will need to be a very careful calibration of incentives to ensure that there are no perverse incentives for hospital admission or, indeed, for early hospital discharge.

Some of the other key elements of efficiency are the need for safety and quality factors to be taken into account. As you know, Senator, if safety and quality factors are not appropriately considered, then there is an adverse impact not only on patients but also on cost, as an unsafe, poor-quality system is almost inherently inefficient. There are a range of other factors that are detailed in the bill. As you heard in earlier evidence, there are factors around continuity and predictability in the costs of care.

So, yes, there will be a range of factors for the authority to consider, and we will do so in a pricing framework, a document that will be subject to extensive public consultation prior to the establishment of the authority, and then the authority itself will decide whether or not to adopt that framework when it is constituted.

Senator FIERRAVANTI-WELLS: For example, we heard just before about the sorts of indices and you may have heard the question. Is that the exploratory work saying, 'These are the sorts of things that are out there that can help us and could be taken into account in determining the efficient price'?

Dr Sherbon: Yes, definitely. I will be seeking to gather as much information from around the world as possible as to what is efficient practice and effective practice in terms of healthcare management and healthcare service delivery. Some jurisdictions around the world already have activity based funding systems. Some of them have toyed with the concept of an efficient price, but Australia will be the first nation to transparently consult and discuss and set an efficient price, as far as I can tell. This will be a major advancement that will be observed around the world—not only domestically but also internationally. So yes, indexation, cost increases or indeed cost trends, whether they be increases or decreases, will be an important consideration for the authority.

Senator FIERRAVANTI-WELLS: As will consideration of mechanisms relating to the cost of providing healthcare services in the future.

Dr Sherbon: Yes. Anticipated costs will be an important factor to take into account. You are quite correct.

Senator FIERRAVANTI-WELLS: Anticipated costs, yes. In terms of the standardisation, I think Senator Polley asked some questions before and I asked some questions before in relation to data and standardisation. Is that the sort of stuff you are also going to consider?

Dr Sherbon: Yes, we will attempt to reduce the data impact as much as possible on the states and other data sources in the spirit of the recent discussion that took place at the Australian Health Ministers Conference in Darwin in early August—I think it was 4 and 5 August—where health ministers resolved to seek to rationalise the data impact on states, territories and the Commonwealth, for that matter, and other data providers. The Interim IHPA, which I will manage for the foreseeable months, will be an active partner in attempting to streamline as much as possible any data requests on states and territories.

Senator FIERRAVANTI-WELLS: For the foreseeable future, how many staff do you have and what is your budget at the moment?

Dr Sherbon: We will be well within our expenditure in the forward estimates, but at full capacity we expect to be at around 42 FTE. But that will not be for some months yet because, as you are aware, some of our workload will be dependent on issues relating to cost shifting and cross-border cost disputes. We will not set up that function until those elements are in full swing, until the legislation is through. So my focus at the moment is to set up a team that will define the parameters of activity based funding and establish a pricing framework that can be considered by the authority. I estimate that in the course of the next two to three weeks I will be recruiting in the order of 18 to 20 full-time equivalent staff.

Senator FIERRAVANTI-WELLS: And your budget at the moment for this year?

Dr Sherbon: It is in the forward estimates. I did not bring it with me, sorry, but my memory of what was published in the 2010 federal budget is that in 2011-12 we have a budget of $31.8 million. But I will have to check that.

Senator FIERRAVANTI-WELLS: That is fine.

Dr Sherbon: It is approximately $92 million over four years, as published in the budget that I mentioned, the 2010 budget.

Senator FIERRAVANTI-WELLS: I have a couple of quick questions relating to the pricing authority, the Clinical Advisory Committee and the Commission on Safety and Quality in Health Care. You were in the room when I asked the department about how they are going to work in a collaborative way. Can you share with us your interpretation of what is set out in the legislation and how you see, going forward, that is going to work.

Dr Sherbon: My interpretation is probably better based on the national health reform agreement. As you say, there are pieces of legislation that follow on from that. This is the third bill in a series and another will soon follow to establish the national health funding pool and administrator, I understand. The way the authority has worked is probably summarised in a simple statement. It is slightly simplistic but, nevertheless, this is the way I describe it to the public when I am asked. The pricing authority sets the efficient price for the funding of hospitals. The performance authority monitors the performance of local healthcare organisations, be they LHNs, Medicare Locals or public or private hospitals. The national funding body is involved in the cash administration of funding and the distribution and transparent allocation of funding. The safety and quality commission sets standards and guidelines so that the system can be measured against safety and quality performance standards and guidelines. It also makes clear what is expected of the system as well.

They each perform distinct functions but, as you might perhaps have suggested in your question, there will be a lot of cooperation between all four, particularly, as I mentioned in an answer to an earlier question, on data request streamlining. Each of the national bodies will be carefully constituted so that they do not have a duplication in function. The interim independent hospital pricing authority is very careful to ensure that we do not drift into performance issues. That will be the preserve of the national performance authority when it is so established. As you know, there is legislation before the Senate as we speak. We will certainly not get into cash administration. That is the preserve of the national health funding pool and its administrator.

Senator FIERRAVANTI-WELLS: I have one final, quick question. In relation to the mechanisms for dealing with any disputes between the states and territories and the Commonwealth—and such disputes would be very unusual, I am sure—do you think the framework is adequate? From the public's point of view, they want to see a change from the continuing blame game and cost-shifting arrangements. Do you see that there are adequate provisions within the legislation?

Dr Sherbon: The legislation, for the first time in the Federation's history, in my understanding, outlines a process for cross-border disputes to be resolved between jurisdictions and also cost-shifting disputes between, as you suggested, usually the Commonwealth and a state or a territory. Whether that is adequate is not for me to say, but it is the first time that there is a clear legislated mechanism. There have been references to voluntary participation in arbitration in the previous healthcare agreements. Back when I used to manage ACT Health we used to regularly participate in a ritual arbitration with New South Wales about cross-border flows. But for the first time in legislation there is actually a process and also an authority whose job it is to take those complaints, examine them, assess them and make a recommendation.

Senator STEPHENS: I just wanted to go to an issue that was raised with us this morning by the Consumers Health Forum of Australia. I am not sure if you have seen their submission.

Dr Sherbon: I have seen their submission.

Senator STEPHENS: Their general concern is about the representation of the interests of consumers in all of these processes. They make the recommendation that:

… the legislation requires the establishment of a Consumer Advisory Committee, to supplement the role of the Clinical Advisory Committee.

I wonder if you have any comments you can make to the committee about that.

Dr Sherbon: I can only comment from the interim authority's point of view. The authority will make its own decisions. As you are aware, under the bill, the authority can establish committees as it sees fit. From the interim authority's point of view, the consumer input into the work that we are doing around the activity based funding technical systems and also the very important work on the strategic pricing framework will be very important, and we will be seeking participation of the Consumers Health Forum in that process. Whether we establish a committee for a short-term organisation, I cannot say, but we will seek their active participation in those documents.

Senator STEPHENS: How do you usually go about ensuring that you have got the voice of the consumer in the mix?

Dr Sherbon: Over the years in my practice leading healthcare organisations, usually one invites the peak body that is relevant to either the task in hand or the jurisdiction they are working in to participate in ongoing processes. It would be my expectation that we will have regular, frequent contact and seek regular input from Consumers Health Forum of Australia.

Senator STEPHENS: The CHF submission states:

CHF notes that Section 131 (3) of the Bill requires that:

In performing its functions, the Pricing Authority must have regard to the following:

(a) Relevant expertise and best practice within Australia and internationally […].

CHF argues that 'relevant expertise' must include the expertise of health consumers, as the users, and ultimately the funders, of the health system.

Senator Polley took this issue up with them in terms of whether or not they believed that the views and concerns of health consumers could be represented by the Clinical Advisory Committee, and there was a very strong feeling that it was a different perspective. Do you have any comment about that point of clarification that they argue about relevant expertise?

Dr Sherbon: Yes. Consumer advocacy expertise will be a key source of advice to certainly the interim authority and I would not mind betting the authority proper when it is established and, yes, I would agree with their submission that that is a very distinct stream of advice from clinical advice. Certainly my practice over the last 14 years that I have been managing healthcare services is to seek both streams of advice actively but separately.

Senator STEPHENS: The other concern that they have is about the difference between consenting to disclosure and informed consent. They expressed their concern that the legislation should specify that it must be informed consent so that the person is fully aware of the implications of providing consent. Is that an issue that has been raised with you?

Dr Sherbon: No, it has not been raised with me. I did note it in the submission. The department is probably better placed to assist you in a detailed discussion on the drafted provisions that you have before you. From my interaction with the department, I understand that the Consumers Health Forum's concern about informed consent should be satisfied by the drafted clauses given that consent does imply informed consent.

Senator STEPHENS: Thank you.

Senator FIERRAVANTI-WELLS: I have just one more question. You may have seen the submission from the Victorian Healthcare Association.

Dr Sherbon: Yes, I have.

Senator FIERRAVANTI-WELLS: They have said it has been in Victoria for 18 years as Casemix funding and they mention their experiences. I would assume that the process that you are now about to embark on will cover that possibility of them sharing their warts-and-all experiences in Victoria with you.

Dr Sherbon: Most definitely we will take into account the Victorian experience. As you know, South Australia also has an activity based funding system. It is not quite the same as the Victorian system, and some would argue that it is perhaps not as comprehensive as the Victorian system. There are other systems all around the world as well, some of which have been operating for some time. We will seek to draw from the experience of

many jurisdictions across the world, but the Victorian experience will be very much to the fore in our consideration.

CHAIR: Thank you very much for appearing before us. I am sure it is going to be an exciting and challenging time ahead for you.

Dr Sherbon: Thank you.

CARR, Mr Trevor, Chief Executive Officer, Victorian Healthcare Association

[14:41]

Evidence was taken via teleconference—

CHAIR: Welcome, Mr Carr. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has your submission, and I now invite you to make a short opening statement. At the conclusion of your remarks, I will invite members of the committee to put their questions to you.

Mr Carr: I am giving evidence from the point of view of heading up a peak body in Victoria that has the experience of 18 years of working with activity-based funding. I will not dwell on our submission, because you have received that and had the opportunity to read it.

On a macro level, we are reasonably supportive of the concept of having an independent hospital pricing authority and having some of the benefits that might be drawn nationally from the benchmarking power that can follow the evaluation that goes into setting prices. I think that has been a missing feature of the Australian health care system in the public sector, and I think that can certainly help us better understand the cost inputs that we are all trying to deal with.

The context of the VHA's response was mainly about some of the issues that have been drawn to our attention over the years of working with governments in setting price from an activity-based viewpoint and the experience that we have had with that—particularly with some of the traps that can be fallen into with regard to the delivery of maternity services and their pricing, considerations of pricing chronic care and some of the new, fairly significant cost drivers around ICT type initiatives and the impact that they might have prospectively in terms of cost considerations.

That is a very broad overview of the issues that we have highlighted in our submission. Rather than dwell on the detail of the submission, I am happy to take Q&A. As you understand, I am travelling at the moment, so it is not the easiest thing to dwell for too long on trying to make long statement.

Senator FIERRAVANTI-WELLS: We have just heard from the interim authority, and I am sure that they are looking forward to hearing about your experiences in Victoria. Where do you see the deficiencies in this legislation?

Mr Carr: Our response has not been so much a critical evaluation of every element of the legislation as it has been based on the practical experience of working with activity-based funding. We have not offered a critique of the relationships that are expressed and the real intent of the legislation as much as we have focused on the outcome of the concept of activity-based funding and looking for equitable pricing across the nation.

Senator FIERRAVANTI-WELLS: You make a comment in your submission about the weighted inlier equivalent separation funding model. You are suggesting that that could be the way to go in setting an efficient price—is that what you are saying?

Mr Carr: Yes. Generally the price is something that is set around a common denominator. The common denominator of one is based around experience of inputs and the time to treat. That is where the weighted inlier equivalent comes from. If you look at a routine maternity case in Victoria , that carries a cost weight of about 0.9 and then the baby itself carries a cost weight of 0.15 to 0.2 or something in that order. So overall you get a multiplier effect of 1.1 or thereabouts for that particular activity. The weighted inlier equivalent approach is really just an arithmetic application of the efficient price.

Senator FIERRAVANTI-WELLS: And you have found that it works well particularly with mental health and aged care.

Mr Carr: I think it could work in all sectors. The risks and the things to be aware of are the permutations around geography. That generally goes to scalability. If you are a regional service provider of obstetric services providing an important role towards sustainability in those communities, you are probably not going to enjoy the same cost benefits of a major metropolitan provider. I focus on obstetrics because it is the one that resonates and that we can understand most readily in using it as an example. But the example is the same no matter whether you are talking about surgical services for endoscopic procedures or mental health services or aged-care services. The input cost and the capacity to achieve efficiencies vary according to scale.

The example we put into our paper was about some of that early recognition in Victoria about scalable efficiencies, where there are a number of different price points for weighted inlier equivalent separations in Victoria that over time just moved in lockstep. We do not believe that that reflects the original premise that

differential pricing was intended to reflect. We are saying that these are the traps that we need to be very aware of as we enter this process of looking for the efficient price and the application of efficient price across Australia.

Senator FIERRAVANTI-WELLS: Hence your comment about the compounding of the failure of funding models to reflect increasing input costs. In effect, you are really saying that to determine—and this was the point that various others have picked up—the variations between local areas, local hospital networks, that needs to be reflected in some way in the differing costs at those levels in terms of how best to determine the efficient price there.

Mr Carr: Correct. It is a very difficult thing to get the right balance around because it opens up some of that qualitative assessment that can then be criticised as all sorts of other agendas. It is a very difficult area and one that I think is going to need to be very closely and carefully watched by Tony as the chief exec and by the board of the group.

CHAIR: If I could just follow that up. In terms of the experience in Victoria, we heard from Catholic Health this morning, who provide some public services in some of their hospitals throughout the country, particularly on the eastern border. Can you outline your experience dealing with the Catholic Health system in Victoria.

Mr Carr: There are three denominational providers in the public healthcare sector in Victoria—the St Vincent's Hospital, the Mercy Group and also Caritas Bethlehem. Each of those services, with the exception of Bethlehem, have worked with the activity based funding model for some time now and have experienced the same operational issues as the nondenominational providers. At times they have felt pressured under the different models and at times they have worked quite successfully with the models. I am not sure what more I can add or if I need to get a further explanation of the question.

CHAIR: It was just in terms of taking into consideration the public services provided for those hospitals. I am quite happy with your response there. If we can move on, the other issue we have canvassed throughout the evidence today is in relation to the data collection and the problems with it. I was wondering if you could outline for us your experience in Victoria and then some of the problems that we may incur by trying to do it Australia wide.

Mr Carr: Just before I move on to that, I am not sure whether you are aware but we also have a private provider of a public hospital in Victoria. It is the Mildura hospital where the Ramsay group have the administration of that hospital under contract with the Victorian government and are working within the activity based funding model in running that hospital and obviously trying to derive from the activity based funding model profit for that private enterprise of the Ramsay group. It is quite an interesting adjunct to the denominational question that there is also a private provider involved in public health care in Victoria.

To move to the data question, data is always a very difficult thing if you do not have the systems in place to accurately capture, evaluate and use the data in a benchmarking or useful way. We are still struggling with many of those elements in Victoria. We are all still fairly immature nationally in terms of capturing data electronically and deriving the best use of that data electronically. We have the first step towards an electronic health record starting in Australia from 1 July next year, although there are some challenges embedded within that approach. We have had attempts in Victoria to standardise record numbers of the unique identifier for a patient across the state. We have been unsuccessful in that to date. It is easier to imagine how you might like to use data than it is to consistently capture the data on a national footprint. The challenge will be to ensure that adequate investment goes into the systems that are designed to capture the data that we want for the evaluation that we are seeking on a national basis.

The challenge in terms of outcomes and performance in the past has been that you set up a range of performance measures and people then concentrate on those performance measures and might take their eye off some of the other aspects of the business. Then that becomes an issue publicly. It becomes a bit of a bouncing ball somehow. It is quite challenging to get the right context at the outset to fully understand how you want to use the data to make sure that you value add to any data capture by building understanding for the people who are actually submitting it so that you do create that benchmarking capacity and make sure that the systems at least have a consistent footprint nationally so that we know that we are capturing equal to match with equal.

CHAIR: I will turn to comments that you have made in your submission on page 3 which relate to technology and the impact changing technology has. Can you just elaborate on that for the committee.

Mr Carr: Sure. One of the issues that we currently have that our members are struggling with is the costs associated with trying to implement the previous government's HealthSMART strategy and the particular products that were prescribed under that strategy and the changed management costs associated with it. The point that we were making is that this is the leading cost, whereas the data that goes into determining the price in

Victoria generally has a two-year lag time. So a lot of the real costs associated with ICT implementation in Victoria is not currently reflected in that pricing evaluation because of that two-year lag. Our members are now experiencing the full reality of that impact. Therefore, they have a cost driver that is leading it in front of the reward mechanism that they are getting through activity based funding. The point we are trying to make is that where some of these new technologies are clearly gaining momentum, and there is an expectation from the basis of policy to implement that, we cannot always wait for the evaluation of pricing, which is always lagging, to determine what that fair price should be. Sometimes we actually have to look at other policy drivers to cost inputs and factor those elements into whatever we come up with as the supposed efficient price or the fair price.

CHAIR: Thank you for your submission and for joining us via teleconference this afternoon.

SHAY, Ms Cindy, Group Executive Provider Relations, Medibank Private

[14:55]

Evidence was taken via teleconference—

CHAIR: Welcome. These proceedings are being recorded by Hansard. Information on parliamentary privilege and protection of witnesses and evidence has been provided to you. The committee has your submission. I invite you to make a short opening statement after which the committee will put questions to you.

Ms Shay: Thank you for the invitation to give evidence to the inquiry today. Medibank and I very much appreciate the opportunity to provide input on this subject as it is an area about which we care deeply and invest heavily.

As Australia's largest health insurance company we are committed to delivering to our members the best possible services that are sustainable and represent value for money. We therefore support measures that deliver greater transparency and the efficient use of health resources, as long as they also serve to maintain people's confidence in the system.

As you are aware, the system is underpinned by a critical mix of inter-related public and private health care providers and funders, and both sectors are essential to the way the system works. The 2009 Productivity Commission report into public and private hospitals noted that there are many instances where similar services are provided. It also found that there were significant differences between the composition of costs between private and public hospitals, with almost 75 per cent of surgical diagnostic related groups having a lower cost in the private sector than in the public sector. Nearly half of all DRGs have a higher average cost in public hospitals of greater than 10 per cent—it also looked at infection rates—and this is one of the reasons we purchase a lot of services through the private sector. On average each year we purchase 670,000 overnight hospital procedures and 380,000 same-day hospital procedures at a cost of approximately $3.9 billion. That also involves the management of $1.1 million in hospital claims, 2.7 million medical claims and 8.3 million ancillary claims.

As part of ensuring that Medibank manages this expenditure effectively and in the best interests of our members, many years ago we embarked on a journey to ensure that we became a more efficient purchaser from providers. This involved the investment of substantial time and resources. Our experience would demonstrate that funding models drive behaviours, and incentives need to be designed so as to deliver the type of behaviour and service we want for our customers.

A key element for us in becoming a more effective purchaser has been the move to case weighted episodes of care. This provides a clinical link to patient care and means that you can assess the relativity of price points in addition to the case mix of a patient. It also provides a funding mechanism that is easy to change as new case weights are introduced or weights change as clinical care evolves. The recognition of the role of clinical care in a funding model is essential to effective patient outcomes. This pricing model, which is just for clinical casemix, allows comparators and reduces the impact of data noise. At the same time, we adopted a new quality and safety framework which, combined with the funding for quality program, has been critical in driving better clinical outcomes for our members.

Achieving sophistication in purchasing has required us to develop and employ an experienced and expert team with expertise in contracting for appropriate prices and services, negotiating price increases and promoting improved quality and safety. Our experience would indicate that any attempted changes to hospital pricing and purchasing arrangements require clarity of purpose, a significant investment of resources and an ongoing commitment of time and energy.

Funding models can be quite useful in the adoption of new modes of clinical care, and I would like to give an example of a couple that we introduced. There are certain clinical services—cataracts being one, for example—that a number of years ago all the clinical evidence said could be done as a same-day service, which is a better outcome for a patient and a better outcome for a hospital. However, hospitals in the private sector at that stage were reluctant to adopt the mechanism, one of the reasons being that their funding model did not appropriately support it. So one of the things that we did in this case was we priced it so that you would only receive a same-day fee irrespective of whether the patient stayed overnight. Within 12 months that led to the clinical adoption of same-day treatment for cataracts. So funding models, when used well, can be quite influential in driving changes in clinical outcomes.

We used similar approaches to readmission rules. We look at and fund readmission to hospital quite differently so that hospitals are encouraged (a) not to discharge too early but (b) to provide the right quality of care, because there is a financial penalty associated with readmission. The other area that we are now moving into is using funding models to encourage substitution of care—services that can be provided out of hospital. So a funding

model is more than simply a payment mechanism; it is essential that it sits within a framework that addresses patient need, clinical evidence and good quality outcomes.

In achieving an effective funding model, a key element is good datasets, not simply of pricing information but also of clinical usage and clinical outcomes. It is not currently clear how the pricing authority will collect data or how it will test its efficacy. Nor is it clear if the authority will be focused on encouraging enhancements, innovation or efficiency linked to good clinical outcomes. There are some areas we think the pricing authority will need to be mindful of. The Productivity Commission has highlighted the real risk that the authority may inadvertently drive inflation through uncertainty about the flow-on impact on private hospitals from price signals that will be set in the public system rather than improve efficient resource usage.

Price and performance in isolation should not be the sole factors used to make conclusions about hospital efficiency. In its broadest sense, healthcare efficiency is a measure of the relationship between healthcare outputs and inputs. Outputs include the healthcare services themselves and other healthcare system attributes such as access to care, choice and continuity of care. Inputs comprise the resources used to produce healthcare services such as labour and infrastructure. Misleading conclusions can be created by simply using cost measures when determining relative efficiency of hospitals. For example, a more costly hospital may be deemed a poor performer when it is actually performing better than other hospitals when measured against the quality of care delivered and the resulting health outcomes. Using a relative cost comparison to measure performance can bias decisions in favour of low-cost providers of hospital services, regardless of the cost-effectiveness of those services.

Conclusions derived from cost indicators and all performance indicators are complicated by variations in the severity of conditions and comorbidities within each procedure. It is therefore important that the pricing model addresses these issues. Health outcomes depend on a multitude of factors in addition to in-patient care, such as the demographic and case mix profile of the patient and their health behaviour after a hospital separation. These need to be considered when measuring the performance of a hospital. A hospital that is identified as high-cost while delivering below-average health outcomes may be performing well when proper account is taken of the complex case mix in that particular population, such as patients with a high number of chronic conditions or those that exhibit a number of comorbidities, such as diabetes or obesity.

CHAIR: Sorry to interrupt. Can I ask you to summarise and finish so that we can have some questions for you rather than going through your submission.

Ms Shay: Yes, and I was just at that point. From our perspective, we have long experience of purchasing health services and a long history of effective purchasing. It does require people to consider not just the pricing but the clinical usage, the clinical outcomes and patient and consumer satisfaction. So that is quality in its broadest sense. I am happy to further discuss our submission or take questions at this point.

Senator FIERRAVANTI-WELLS: Thank you. Where do you see the deficiencies in the legislation?

Ms Shay: I think that in the legislation it is about the linkages with other components of the legislation. So it is a pure pricing authority, and it is not yet clear how that will flow on to the hospital care. Funding behaviours provide perverse incentives and often drive perverse behaviours, so it is important that it show a coordinated approach to the patient journey.

Senator FIERRAVANTI-WELLS: I take that point, but my question to you is: where do you think that the legislation as it stands at the moment is deficient in that way, and what specific changes to the legislation do you think need to be made to achieve the objectives that you talk about?

Ms Shay: What we would like to see is better coordination among all of the new agencies, but we will have to see the detail that sits behind the legislation to be able to determine how that could most effectively be met.

Senator FIERRAVANTI-WELLS: You are basically saying that this bill does not contain sufficient reference to the interaction of the various different authorities that are going to be set up.

Ms Shay: That will come, we would hope, when the framework around the pricing mechanisms is established.

Senator FIERRAVANTI-WELLS: Okay. In other words, based on your submissions, you would probably be making suggestions to the new authority about ways that it could determine efficient price?

Ms Shay: Ways that it could determine efficient price and ways in which the framework needs to address the outcomes that they are seeking from the price. So it is that measuring of quality outcomes, clinical usage and patient satisfaction.

Senator FIERRAVANTI-WELLS: The department have said to us that, in the agreement between the states and the Commonwealth, there are delineated principles for determining the national efficient price. Are you saying that they are not adequate or—

Ms Shay: No, the detail is crucial here, and at the moment it is difficult to see how those links will be achieved.

Senator FIERRAVANTI-WELLS: All right. So it is really a general comment rather than a specific comment in relation to where deficiencies are, but you are basically saying that there is insufficient material in the various pieces of legislation—certainly in this bill—as to how it is all going to link together.

Ms Shay: It is difficult to see how it would all link together.

Senator FIERRAVANTI-WELLS: Thank you.

CHAIR: Thank you very much. It appears that your submission has covered everything that the committee needed at this point in time. There are no further questions, so we thank you and Medibank Private for the submission and for making yourself available this afternoon. I thank the Hansard people and of course, as always, our great secretariat.

Committee adjourned at 15:10