Chapter 2

Issues

Introduction

2.1 The Independent Hospital Pricing Authority (IHPA) is central to a new approach to activity based funding of public hospitals. It also heralds a fundamental change in the nature of Commonwealth and state and territory arrangements for public hospital funding. Since 1984, the Australian Government has provided block funding to state and territory governments to support the delivery of free public hospital services.[1]

2.2 Despite periodic agreements, tensions between the Commonwealth and states and territories in relation to funding of hospitals have been ongoing. States and territories have disputed the adequacy of the Commonwealth contribution. The Commonwealth, in turn, has found it difficult to determine if states are maintaining levels of service provision appropriate to the population level, and have been concerned that states have shifted public hospital provided services to private practice arrangements that draw subsidies from Commonwealth programs. This new approach addresses these issues through a shift to primarily activity based funding (ABF) and the setting of a national efficient price, while maintaining a provision for block funding where required.[2]

2.3 There was broad support for the establishment of the IHPA from submitters.[3] Mr Martin Laverty, Catholic Health Australia (CHA), stated that:

> ...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.[4]

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1 Department of Health and Ageing, *Submission 13*, p. 8.

2 Department of Health and Ageing, *Submission 13*, pp 8–9.

3 Consumers Health Forum of Australia, *Submission 1*, p. 1; Australian Institute of Health and Welfare, *Submission 4*, [p. 1]; Victorian Healthcare Association, *Submission 8* p.1; Australian Medical Association, *Submission 9*, p. 3; Women's and Children's Hospitals Australasia, *Submission 10*, p. 1; Dr Kathryn Antioch, *Submission 14*, [p. 5]; Catholic Health Australia, *Submission 6*, p. 2; Australian College of Rural and Remote Medicine, *Submission 15*, p. 1.

4 Mr Martin Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 7 September 2011, p. 6.

2.4 Ms Carol Bennett, Consumers Health Forum of Australia (CHF), also expressed support for the IHPA and stated:

> 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.[5]

2.5 Submitters, however, raised some matters in relation to specific provisions of the Bill.

Proposed Part 4.2 – IHPA establishment, functions, powers and liabilities

Proposed section 131 – Functions of the Pricing Authority

2.6 Proposed subsection 131(1) provides for the functions of the IHPA, something that occasioned much interest from submitters, in particular proposed paragraphs 131(1)(a)-(e). Submitters also commented on proposed subsection 131(3) which pertains to the matters that the IHPA must have regard to in performing its functions. A number of submitters proposed additional matters they believed the IHPA should also have regard to.

Proposed section 131(1) – National efficient price for activity based funding (ABF)

2.7 Proposed paragraph 131(1)(a) provides for the IHPA to determine the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis. The Department of Health and Ageing (DoHA) stated that ABF will:

> ...provide incentives for most hospitals to treat more patients more efficiently, while still ensuring the viability of smaller hospitals and some particular kinds of services for which ABF is not appropriate.[6]

2.8 Many submitters supported moving to a national activity based funding system.[7] CHA, for example, commented that proposed paragraph 131(1)(a), together with proposed paragraph 131(1)(d) (provision for adjustments), provide reasons that 'the Bill should be supported as benefiting the future planning of resource allocation across the Nation's public hospital system'.[8]

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5 Ms Carol Bennett, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, 7 September 2011, p. 1.

6 Department of Health and Ageing, *Submission 13*, p. 4.

7 Dr Kathryn Antioch, *Submission 14*, [p. 5]; Catholic Health Australia, *Submission 6*, p. 2.

8 Catholic Health Australia, *Submission 6*, p. 2.

2.9 However, a number of concerns were raised by submitters. CHA observed that whereas the Bill provides a mechanism to determine a national efficient price, 'it does not set a nationally agreed public hospital payment'. CHA noted that, through the Council of Australian Governments (COAG) agreement, there will be certainty as to how much the Commonwealth will contribute, but it is not certain how much the states or territories will contribute.[9]

2.10 Similar concerns were raised by the Australian Medical Association (AMA), which noted that the National Health Reform Agreement (NHRA) allows state and territory governments to pay public hospitals less than the full efficient price determined by the IHPA (clause A65). The AMA submitted that this information should be included in the report the IHPA must make to Parliament each year, pursuant to proposed section 210, and should also be provided to the National Health Performance Authority (NHPA), so that it is clear when poor performance is linked to insufficient funding.[10]

2.11 In responding to these concerns, Mr Peter Broadhead, DoHA, told the committee that 'under the agreement reached in early August there is a role for a national health fund administrator and the national health funding pool', and that these may be established by legislation later in the year.[11] He explained further:

> 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.[12]

2.12 In relation to the contribution of states and territories to the national efficient price, Mr Broadhead, DoHA, stated that there is an underlying efficient basis for providing funding to hospitals. However, states have a capacity to adjust their contribution so they are not bound to simply pay exactly the balance of the national efficient price, and that in some areas it may be more and, in some, less.[13]

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9 Catholic Health Australia, *Submission 6*, pp 2–3.

10 Australian Medical Association, *Submission 9*, p. 3.

11 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 29.

12 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 28.

13 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 29.

2.13 Mr Broadhead also noted that government does not generally cover 100 per cent of costs as hospitals have their own revenue sources, particularly in metropolitan areas. He also noted that the states' contribution will undoubtedly take into consideration other factors that may vary locally for that hospital, in terms of both costs and revenue.[14]

2.14 The Victorian Healthcare Association (VHA), while supporting the standardisation of ABF across Australia, drew on their experience of ABF in Victoria over the last 18 years – in the form of casemix funding – to sound a note of caution. VHA noted that in Victoria, grants have been introduced to cover various shortfalls due to differential pricing. These grants, however, are not transparent as not all agencies receive them.[15]

2.15 Dr Kathryn Antioch, drawing on her experience leading the reform of ABF in Victoria, also noted that extra 'risk adjusted' funding was required in the Victorian situation, 'given hospitals incurred significant funding deficits under the ABF arrangements because funding does not meet the health need in the absence of such adjustments'.[16]

2.16 Dr Anthony Sherbon, Acting Chief Executive Officer, interim Independent Hospital Pricing Authority, responded to these comments and stated that 'most definitely we will take into account the Victorian experience'.[17] Dr Sherbon explained further:

> 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.
>
> But there are other systems all around the world as well, of course, some of which have been operating for some time. So 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.[18]

2.17 The Australian Healthcare and Hospitals Association (AHHA) argued that there is a risk that introduction of ABF could reinforce existing models of care, with 'the potential for skewing of incentives resulting in some patients being treated inappropriately as inpatients'. AHHA advocated an innovative use of ABF, including 'developing comprehensive understanding of how ABF systems for non-admitted

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14 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 30.

15 Victorian Healthcare Association, *Submission 8*, p. 1.

16 Dr Kathryn Antioch, *Submission 14*, [p. 1].

17 Dr Anthony Sherbon, Acting Chief Executive Officer, interim Independent Hospital Pricing Authority, *Committee Hansard*, p. 36.

18 Dr Anthony Sherbon, Acting Chief Executive Officer, interim Independent Hospital Pricing Authority, *Committee Hansard*, pp 36–37.

patients are constructed in order to fund care delivery in the setting most appropriate to the patient needs'.[19]

2.18 Mr Broadhead described at length to the committee the preparatory work that is currently being carried out in the Health Reform Transition Office and the Health Reform Implementation Group. This includes work on what are known as tier 2 clinics. He explained:

> 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.[20]

Proposed section 131(1) – Efficient cost for health care services provided by public hospitals where the services are block funded

2.19 Proposed paragraph 131(1)(b) provides for the IHPA to determine the efficient cost for health services provided by public hospitals where the services are block funded. The National Rural Health Alliance (NRHA) emphasised the importance of the IHPA taking into account the full price of care through the provision of block funded hospitals in rural and remote areas. The NRHA noted that the cost of providing care in these circumstances includes:

> the costs of travel and accommodation for locum and agency staff to cover shortages, staff leave and continuing professional development, higher operational and infrastructure costs due to the higher costs relating to location and more limited services, and the need for local capacity building and training for management and administrative staff.[21]

2.20 The VHA advocated that maternity services be funded as a strategy, rather than on the basis of an activity, as otherwise low-volume maternity services will become less viable.[22]

2.21 Dr Sherbon, interim IHPA, explained to the committee that the interim authority is currently analysing 'what is an appropriate scope of activity based funding in accordance with the agreement...as well as some criteria for the application of activity based funding versus block funding in various situations'. He went on to explain that 'no decisions will be made until the authority proper is established'.[23]

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19 Australian Healthcare and Hospitals Association, *Submission 12*, p. 5.

20 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, p. 30.

21 National Rural Health Alliance, *Submission 11*, [p. 1].

22 Victorian Healthcare Association, *Submission 8*, p. 3.

23 Dr Anthony Sherbon, Acting Chief Executive Officer, interim Independent Hospital Pricing Authority, *Committee Hansard*, 7 September 2011, p. 33.

Proposed section 131(1) – Classification systems and data collection

2.22 Proposed paragraphs 131(1)(c) and 131(1)(e) provide for the development of classification systems for health care and other services and to determine data requirements. In general submitters were supportive of a move to national consistency in data management. The Australian Institute of Health and Welfare (AIHW) observed that they view the data related functions of the IHPA as providing:

> ...a valuable opportunity to improve the quality of statistical information on Australia's hospitals. It is anticipated that the Authority's work will result in better information becoming available over time on the nature of public hospital services, the costs of the services, and the efficiency with which they are provided. The information is not only likely to be more comprehensive and accurate than is currently available, it is also likely to allow better comparability between the states and territories and over time than is currently the case.[24]

2.23 AIHW went on to make a strong case for the IHPA to draw upon the current sets of nationally agreed data definitions and standards for the national hospital collection which have been 'developed and agreed by the jurisdictions and AIHW through multijurisdictional processes auspiced by Health Ministers through the National Health Information Agreement'.[25] AIHW argued that this would ensure:

> ...that the definitions, classifications and data collections used by the Authority were consistent with those in the current national collections, allowing the total national hospital information resource to expand in a way that would be most useful for a wide range of data users. It would also contribute to greater efficiencies in the national processes to collect and report data, with the objective to collect one consistent set of data on each aspect of hospital activity. This should be suitable for multiple uses, including those of the Authority (and others involved in the establishment of activity based funding) and the wider purposes for which national hospitals data are required. [26]

2.24 However, a number of submitters expressed concerns about how the IHPA will classify, collect and manage data. Concerns included the challenges in aligning the differences in how health services are delivered and counted between and within the states and territories, the need to link patient-centric data sets, the burden of compliance on hospitals and the timeframe to resolve data issues. Ms Prue Power, AHHA, commented:

> 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

24 Australian Institute for Health and Welfare, *Submission 4*, [p. 1].

25 Australian Institute for Health and Welfare, *Submission 4*, [pp 1–2].

26 Australian Institute for Health and Welfare, *Submission 4*, [p. 2].

> consistent nature before it can be properly analysed. At the moment, it is inconsistent between states and territories.[27]

2.25 The Australian Private Hospitals Association (APHA) sought clarification as to whether the Government intended that the IHPA would develop a separate or replacement system to that of the Australian Refined Diagnosis Related Groups (AR-DRG's), believing that the Bill implies a new system. The APHA argued that the development of a new system 'would be an unnecessary and costly duplication of resources'. APHA explained further:

> DRGs are a patient classification system that provides a clinically meaningful way of relating the types of patients treated in a hospital to the resources required by the hospital. AR-DRGs are used in the public and private sectors and have been under development for many years in collaborative work amongst the Commonwealth, States, Territories and the private sector through the Clinical Casemix Classification Committee of Australia and its various coding and clinical groups.[28]

2.26 Women's and Children's Hospitals Australasia (WCHA), however, raised concerns that 'the current classification used to fund acute inpatient care (AR-DRGs) in general do not differentiate adult from paediatric care and yet there are significantly higher costs in paediatric care compared to adults'. WCHA went on to observe that a published study it had commissioned in 2008 into healthcare costs in Australian Specialist Paediatric Hospitals found that the AR-DRG system:

> ...fails to account for a large number of complications and comorbidities that materially affect the cost of care of children particularly those cared for by specialist paediatric hospitals, because the Australian DRG does not include almost 1,500 diagnosis codes included in the international ICD-10-AM [International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification].[29]

2.27 The AHHA argued that there is significant work to be done to 'ensure consistency in classifications and linkages between data sets held by various jurisdictional bodies' and that this will be essential to enabling 'meaningful analysis of the performance and cost of the public hospital system across Australia'.[30] AHHA went on to note that currently the disparate data sets cannot be linked.[31]

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27 Ms Prue Power, Australian Healthcare and Hospitals Association, *Committee Hansard*, 7 September 2011, p. 10.

28 Australian Private Hospitals Association, *Submission 2*, [p. 2].

29 Women's and Children's Hospitals Australasia, *Submission 10*, p. 6.

30 Australian Healthcare and Hospitals Association, *Submission 12*, p. 8.

31 Australian Healthcare and Hospitals Association, *Submission 12*, p. 9.

2.28 The AHHA also observed that 'there are still major gaps in the measurement tools available', making particular note of the absence of nationally acceptable measures for out-patients and mental health.[32]

2.29 The AMA submitted that the IHPA must have regard to any, and all, performance indicators that hospitals are required to achieve as mandated by COAG.[33] The AMA explained that the NHPA will be required to report on the performance of public hospitals against performance indicators contained in a Performance and Accountability Framework as mandated by COAG. The AMA argued that this also has an impact on the IHPA:

> If hospitals are expected to perform to a certain standard, the national efficient price and the efficient cost must provide sufficient funding to achieve those standards. The AMA considers this to be the 'effective' cost.[34]

2.30 Mr Broadhead, DoHA, told the committee that significant work over many years has been undertaken on standardisation of hospital data, with less work on non-admitted data or outpatient data being undertaken. He further explained that ahead of the arrival of the pricing authority, further work has been undertaken on what standards will apply and what data will be collected. Mr Broadhead provided further details:

> 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.[35]

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32 Australian Healthcare and Hospitals Association, *Submission 12*, p. 8, fn 1.

33 Australian Medical Association, *Submission 9*, p. 5.

34 Australian Medical Association, *Submission 9*, p. 1.

35 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 30.

2.31 Mr Broadhead, DoHA, also clarified that once the legislation is passed, this work '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'.[36]

2.32 In relation to the burden on hospitals of complying with additional data collection, classification and reporting, the AHHA noted that hospitals currently are required to submit data to a plethora of Commonwealth agencies and state/territory departments of health/human services.[37] These comments were echoed by the AMA, which submitted that 'every effort should be made to minimise data collection duplication and therefore unnecessary administrative burden on health care providers'. The AMA went on to argue that:

> Clarity on the relationship between the three agencies will assist in achieving this. The Bill should require that the Authority, the National Health Performance Authority and the Commission collaborate with each other and other relevant bodies to ensure that data collection requirements are consistent, synchronised and streamlined.[38]

2.33 Dr Sherbon, interim IHPA, explained to the committee that the interim IHPA 'will be an active partner in attempting to streamline as much as possible any data requests on states and territories'. He noted that at the Australian Health Ministers Conference held in Darwin in early August, health ministers had resolved to 'seek to rationalise the data impact on states, territories and the Commonwealth...and other data providers'.[39]

2.34 The AMA noted that the NHRA addressed the funding of teaching, training and research within the public hospital system. Yet the AMA observed that the funding of these functions and the role of the IHPA in calculating costs is not made explicit in the Bill.[40] The AMA was of the view that proposed paragraph 131(3)(c) should be amended to have regard to:

> ...the need to ensure that public hospitals are able to fulfil their role and function to provide teaching and training and to undertake clinical research.[41]

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36 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 30.

37 Australian Healthcare and Hospitals Association, *Submission 12*, p. 9; see also Ms Prue Power, Australian Healthcare and Hospitals Association, *Committee Hansard*, 7 September 2011, p. 10.

38 Australian Medical Association, *Submission 9*, p. 3.

39 Dr Anthony Sherbon, Acting Chief Executive Officer, interim Independent Hospital Pricing Authority, *Committee Hansard*, 7 September 2011, p. 34.

40 Australian Medical Association, *Submission 9*, p. 1.

41 Australian Medical Association, *Submission 9*, p. 5.

2.35 Mr Broadhead, DoHA, addressed the committee at length on the issue of teaching, training and research. He observed:

> 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.[42]

Proposed section 131(1) – Advice and public submissions

2.36 Proposed paragraphs 131(1)(h) and 131(1)(i) go to advice in relation to the funding model for public hospitals and confidential advice on costs for health care services to be provided to the Commonwealth and states and territories. Proposed paragraph 131(1)(l) provides for the IHPA to call for and accept, on an annual basis, public submissions. Concerns raised in relation to proposed paragraphs 131(1)(h) and (i) were also raised by other submitters in relation to Part 4.13 on the reporting obligations of the IHPA. These are discussed below.

2.37 The AHHA sought clarification on whether the advice provided pursuant to paragraph 131(1)(h) will also be made available to the public and the public hospital sector. The AHHA argued that 'the acute sector will be responsible for implementing decisions and hence informed stakeholder involvement will be critical to the success of the program'. [43]

2.38 Some submitters took issue with proposed paragraph 131(1)(i) which gives the IHPA a power to make confidential advice to government on future cost as it was argued that the provision of confidential advice is at odds with proposed subsection

42 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 27; see also p. 28.

43 Australian Healthcare and Hospitals Association, *Submission 12*, p. 6.

129(2) which provides a commitment to transparency. It was argued that the workings of the IHPA should be public and transparent.[44]

2.39 Mr Graeme Head, Deputy Secretary, Health Reform Transition Office, DoHA, told the committee that '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'. He explained further that this provision simply provides that one of its functions can be to provide confidential advice.[45]

2.40 Mr Broadhead, DoHA, also added that the confidentiality provision is the same as the usual practice on the part of the Commonwealth in not publishing the parameters that underpin Commonwealth indexation: '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'.[46] He emphasised that confidentiality pertains to:

> ...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...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.[47]

Proposed subsection 131(3) – Matters which the IHPA must have regard to in performance of its functions

2.41 Pursuant to subsection 131(3) there are a range of matters that the IHPA, in performing its functions, must have regard to, including relevant expertise and best practice within Australia and internationally, as well as the range of public hospitals and the variable affecting the actual cost of providing health care services in each of these hospitals.

2.42 Dr Antioch argued that adequate risk adjustment must also be taken into account in order to 'enable reasonable access, quality, predictability of costs and effectiveness, efficiency and financial sustainability given the price could more accurately reflect the costs required to meet health need'. Dr Antioch cited the experience of ABF in Victoria and stated that:

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44 Catholic Health Australia *Submission 6*, p. 3;Australian Healthcare and Hospitals Association, *Submission* 12, p. 3; see also Mr Martin Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 7 September 2011, p. 9.

45 Mr Graeme Head, Deputy Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 25.

46 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 25.

47 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, pp 25–26.

> This is a serious matter and should not be taken lightly given the experience where ABF has been implemented in Victoria. ABF in the absence of adequate risk adjustment has been associated with underfunding of hospital networks and would have further implications for patient safety (in the absence of adequate EBM [evidence based medicine] initiatives) and stretches the capacity of dedicated staff.[48]

2.43 Dr Antioch went on to submit that:

> The legislation could be amended to include reference to the need for adequate risk adjustment in the deliberations of the Independent Hospital Pricing Authority to avoid reductions in quality that may result from underfunding if the funds do not adequately match health need.[49]

2.44 As previously stated Dr Sherbon, interim IHPA, noted to the committee the intention to heed the Victorian experience.[50]

2.45 The CHF observed that proposed subsection 131(3)(a) of the Bill requires that the IHPA 'must have regard for relevant expertise and best practice within Australia and internationally'. The CHF advocated that in this case relevant expertise 'must include the expertise of health consumers, as the users, and ultimately the funders, of the health system'.[51]

2.46 The CHF submitted that the views of consumers 'provide an important balance to the views of other stakeholders, including clinicians, health economists and state and territory bureaucrats' and argued that:

> There is increasing recognition, both within Australia and internationally, that involving consumers in healthcare policy and decision-making leads to better outcomes for both health consumers and the health system as a whole.[52]

2.47 Dr Sherbon, interim IHPA, responded to concerns about consumer engagement with the IHPA noting that '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'. He explained:

> 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

48 Dr Kathryn Antioch, *Submission 14*, [pp 3–4].

49 Dr Kathryn Antioch, *Submission 14*, [p. 4].

50 Dr Anthony Sherbon, Acting Chief Executive Officer, interim Independent Hospital Pricing Authority, *Committee Hansard*, 7 September 2011, p. 36.

51 Consumers Health Forum of Australia, *Submission 1*, p. 2.

52 Consumers Health Forum of Australia, *Submission 1*, p. 2.

> very important, and we will be seeking participation of the Consumers Health Forum in that process.[53]

2.48 Medibank raised the issue of the need to take account of the significant differences in the comparability of cost data across public and private hospitals, with a number of factors making a direct comparison of technical efficiency between public and private hospitals complicated.[54]

2.49 CHA voiced similar concerns and noted that there is a lack of recognition of the unique position of some Catholic hospitals which are defined as private by statute, yet maintain a public service orientation and deliver public health services. CHA argued that:

> If the intent of the Bill is to empower the Authority to determine an efficient price for every Australian hospital identified in practice as being public, the Bill should require the Authority to have regard to the different efficient price components that operate in (at least) the 21 public hospitals operated by Catholic services.[55]

2.50 For this reason CHA recommended that proposed subsection 131(3)(d) be amended to require the IHPA to have regard to the cost components of delivering public hospital services by non-government hospitals, such that it reads:

> ...the range of public hospitals and non-government hospitals providing public health services and the variables affecting the actual cost of providing health care services in each of those hospitals.[56]

2.51 In responding to these concerns about the non-government provision of public hospital services Mr Broadhead, DoHA, told the committee that:

> ...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.[57]

2.52 Dr Sherbon, interim IHPA, also commented on this matter:

> ...the interim authority will establish a preparatory pathway for the receipt of public submissions and it will gather the evidence around the world of

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53 Dr Anthony Sherbon, Acting Chief Executive Officer, interim Independent Hospital Pricing Authority, *Committee Hansard*, 7 September 2011, p. 36.

54 Medibank, *Submission 7*, pp 4–5.

55 Catholic Health Australia, *Submission 6*, p. 3; see also Mr Martin Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 7 September 2011, p. 7.

56 Catholic Health Australia, *Submission 6*, pp 3–4.

57 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 26.

> 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.[58]

Proposed section 134 – Constitutional limits

2.53 Proposed section 134 sets out the Constitutional limits of the IHPA. Pursuant to proposed subsection 134(a) the IHPA may perform its functions only for purposes related to (i) the provision of pharmaceutical, sickness or hospital benefits; or (ii) the provision of medical or dental services.

2.54 The AMA submitted that there is nothing in the NHRA to support the involvement of the IHPA in determining an efficient price or efficient cost related to the provision of pharmaceutical, sickness or hospital benefits. The AMA also commented that the intended purpose of this provision is not clear and should be removed. The AMA concluded that 'if the government has a particular role in mind for the Authority in this regard, it should undertake full and proper consultation with the health sector'.[59]

2.55 Mr Broadhead, DoHA, explained that this is standard drafting procedure to set out the Constitutional limits. Rather than extending the functions of the IHPA or the powers of the IHPA into the areas listed, this provision sets out that, in performing its functions and exercising its powers, the IHPA cannot go beyond things for which the Commonwealth has a head of power under the Constitution.[60]

Proposed Part 4.3 – Cost-shifting disputes and cross-border disputes

2.56 Proposed section 139 provides for assessment of cost-shifting disputes, with a Health Minister able to request the IHPA to make an assessment about a cost-shifting dispute between his or her jurisdiction and another jurisdiction.

2.57 The AMA noted that 'AMA members working in public hospitals have experienced many examples of activities that could be interpreted as a state or territory government cost-shifting to the Commonwealth'. Consequently, the AMA submitted that the Bill should also allow for individuals or non-government organisations, in addition to jurisdictions, to report cost-shifting to the IHPA.[61]

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58 Dr Anthony Sherbon, Acting Chief Executive Officer, interim Independent Hospital Pricing Authority, *Committee Hansard*, 7 September 2011, p. 33.

59 Australian Medical Association, *Submission 9*, p. 2.

60 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 27.

61 Australian Medical Association, *Submission 9*, p. 2.

2.58 Dr Sherbon, interim IHPA, explained that in the past there have been references to voluntary arbitration in previous healthcare agreements. However, for the first time there is now a clear legislative mechanism for resolving cross-border and cost-shifting disputes, with the legislation outlining a process and an authority 'whose job it is to take those complaints, examine them, assess them and make a recommendation'.[62]

Proposed Part 4.4 – Constitution and membership of the IHPA

2.59 Proposed section 144 provides for the appointment of members of the IHPA. Pursuant to proposed subsection 144(4) the Minister must ensure that at least one member of the IHPA has substantial experience or knowledge and significant standing in regional or rural health care.

2.60 A number of submitters proposed greater specificity regarding membership of the IHPA. By way of example, WCHA submitted that section 144(4) be amended to require inclusion of at least one person with substantial experience and knowledge, and significant standing in children's and young people's healthcare.[63]

2.61 Similarly, the CHF proposed a requirement for the IHPA to include a member with expertise or knowledge in consumer experiences of health care. This proposal was also supported by WCHA and Dr Antioch.[64]

2.62 Dr Antioch noted that the Senate Community Affairs Legislation Committee inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011 recommended 'that COAG should consider a broader range of mandated representation on the Authority and in particular should consider representation of consumers and indigenous health stakeholders'.[65] Dr Antioch went on to note that the current Bill has not addressed this issue in the context of the IHPA for either indigenous health stakeholders or consumers. Dr Antioch submitted that subsection 144(4) be amended to address the issue of indigenous inclusion. She concluded that 'this will enable consistency with all Federal-State financing agreements which include indigenous health as an overarching top priority for Australian Governments'.[66]

2.63 CHA submitted that the Bill would be enhanced by requiring the appointment of members skilled and experienced in non-government hospital service provision on the IHPA. CHA noted that it operated 21 public hospitals, in some cases large, iconic

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62 Dr Anthony Sherbon, Acting Chief Executive Officer, interim Independent Hospital Pricing Authority, *Committee Hansard*, 7 September 2011, p. 35.

63 Women's and Children's Hospitals Australasia, *Submission 10*, pp 2 and 3.

64 Consumers Health Forum of Australia, *Submission 1*, p. 1; Women's and Children's Hospitals Australasia, *Submission 10*, pp 3 and 5; Dr Kathryn Antioch, *Submission 14*, [p. 4].

65 Dr Kathryn Antioch, *Submission 14*, [pp 4–5].

66 Dr Kathryn Antioch, *Submission 14*, [pp 4–5].

and well-known hospitals, which provided 2 700 public beds. Mr Laverty stated the Bill ignores the requirements of how these beds are operated by CHA. Although this oversight was not seen as intentional, CHA assert that it is important that these considerations be taken into account. It stated:

> Over time, government purchasers of hospital services will be able to make informed decisions as to where the most efficient service can be obtained from. In order for the Authority to enable a genuine comparison of costs between government-owned hospitals and non-government owned hospitals, the definition of what a national efficient price comprises will need to be informed not just by practices of government owned hospitals, but also by non-government owned hospitals.[67]

2.64 Mr Laverty concluded:

> 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.[68]

2.65 The APHA also expressed disappointment that there is no reference in the Bill to the need to draw on the knowledge held by the private sector. They observe that the 'private hospital sector should be an integral part of developing reform solutions' and that:

> ...the new Authority would be well advised to draw some of its membership and some of its staffing as well, from the ranks of people who have appropriate experience in the private hospital sector.[69]

2.66 In support of their case, the APHA cited the 2009 Productivity Commission Research Study into Public and Private Hospitals. The APHA noted that the Commission found that:

- on average treatment in Private Hospitals costs $130 per case-mix adjusted separation less than in public hospitals;
- when analysing the costs that private hospitals can control they cost 32% or $1,089 less than public hospitals;
- private hospitals have a more complex casemix than public hospitals;

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67 Catholic Health Australia, *Submission 6*, p. 3.

68 Mr Martin Laverty, Chief Executive Officer, Catholic Hospitals Australia, *Committee Hansard*, 7 September 2011, p. 7.

69 Australian Private Hospitals Association, *Submission 2*, [p. 3].

- where comparable safety and quality data exists in the report private hospitals are shown to be safer than public hospitals;
- private hospitals offer more timely access to elective surgery; and
- analysis by the Commission shows that private hospitals carry out more elective surgery with patients from disadvantaged socioeconomic backgrounds than public hospitals.[70]

2.67 Mr Head, DoHA, explained to the committee that there are many different kinds of opportunities for inputs to the processes of the IHPA:

> 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...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.[71]

Proposed Part 4.10 – Clinical Advisory Committee (CAC)

2.68 Proposed Part 4.10 provides for the establishment (section 176), functions (section 177), and membership (sections 178–190) of the CAC. The Explanatory Memorandum states that the CAC advises the IHPA on the formulation of casemix classifications for healthcare and other services provided by public hospitals, provides advice on matters referred to it by the IHPA and is empowered to do anything incidental to, or conducive to, the performance of those functions.[72]

Proposed section 179 – Appointment of CAC members

2.69 Pursuant to proposed subsection 179(3), for a person to be eligible for appointment to the CAC, they must be a clinician. A clinician is defined under the *National Health and Hospitals Network Act 2011* (Cth) to mean 'an individual who provides diagnosis, or treatment, as a professional: (a) medical practitioner; or (b) nurse; or (c) allied health practitioner; or (d) health practitioner not covered by paragraph (a), (b) or (c)'.[73]

2.70 The AMA supported the requirement to establish a CAC comprised of clinicians to provide advice to the IHPA. However, it noted that the Bill does not specify the process for selecting members, apart from the fact that membership is a Ministerial appointment. The AMA submitted that at a minimum, the Bill should

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70 Australian Private Hospitals Association, *Submission 2*, [p. 3].

71 Mr Graeme Head, Deputy Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 24.

72 Explanatory Memorandum, p. 12.

73 Australian Institute for Primary Care and Ageing, *Submission 5*, pp 1–2.

require that the process should be 'transparent and apolitical'. In addition, at least one member of the CAC should be appointed from nominations provided by the AMA.[74] Mr Francis Sullivan, AMA, stated in relation to the CAC:

> ...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.[75]

2.71 The Australian Institute for Primary Care and Ageing (AIPCA) submitted that the definition of clinician should be narrowed so that appointment to the CAC be only open to health professionals registered under the national law, and only to those who have practice experience in public hospitals. They further suggested that in order to provide a minimum core of health professionals possessing a broad range of expertise there could be further specification 'for example that there must be a minimum of one medical practitioner, one nurse, one pharmacist and one other allied health professional (e.g. podiatrist, psychologist)'.[76]

2.72 The WCHA welcomed the commitment to establish a CAC. However, WCHA submit that proposed section 179 be amended to allow the Minister to appoint individuals to the CAC with coding and classifications expertise in addition to clinicians.[77]

2.73 Mr Broadhead, DoHA, responded to these matters and stated that in the legislation establishing the ACSQHC, the term clinician was not defined, but it was later defined in a subsequent amendment to mean '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'. He went on to explain that as the Bill is amending legislation, that same definition of clinician will also apply.[78]

Proposed Part 4.12 – Other Committees

2.74 Proposed section 205 provides for the IHPA to establish committees to advise or assist it in the performance of its functions. The CHF proposed the establishment of

74 Australian Medical Association, *Submission 9*, pp 2 and 5.

75 Mr Francis Sullivan, Secretary-General, Australian Medical Association, *Committee Hansard*, 7 September 2011, p. 17.

76 Australian Institute for Primary Care and Ageing, *Submission 5*, p. 2.

77 Women's and Children's Hospitals Australasia, *Submission 10*, p. 5.

78 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 31.

a Consumer Advisory Committee under this section to enable 'genuine consumer engagement and involvement in the work of the Pricing Authority'.[79]

Proposed Part 4.13 – Reporting obligations of the IHPA

2.75 Pursuant to proposed Part 4.13 of the Bill, which provides for reporting obligations of the IHPA, there is provision for the Minister or state/territory Minister to require the IHPA to prepare reports or give information (section 208), for the IHPA to keep the Minister informed (section 209), for the IHPA to report to Parliament (section 210), for the Minister or state/territory Minister to provide comment before public reports (section 211) and for the IHPA to prepare and give to the Minister an annual report for presentation to Parliament (section 212). Reporting obligations are also provided for in sections 131 and 193.

2.76 A number of submitters raised issues of transparency and access in relation to these provisions. The AMA submitted that all reports should be made available on the internet.[80] The APHA noted that the Minister stated in the second reading speech on the Bill that:

> The authority will have strong independent powers: it will be for public hospitals what the independent Reserve Bank is for monetary policy. This is unprecedented for the public hospital system. The result will be a thorough and rigorous determination without fear or favour to governments. The government is confident that the authority will provide the health system with the stability and robustness that the Reserve Bank has provided for monetary policy for decades.[81]

2.77 However, the APHA argued that the provisions contained in sections 208, 211 and 212 'fall a long way short of the practise of the Board of the Reserve Bank of releasing its decisions and monthly minutes publicly with no prior comment by the Executive'. The APHA went on to observe:

> If the Authority is to truly 'be to public hospitals what the Reserve bank is for monetary policy' then its governing legislation should require the Authority to publish on its website the minutes of its meetings and the reasons for its decision in regard to pricing. This would be in the best interests of hospitals, health consumers and the broader community. We urge the Committee to look closely at the disclosure and reporting regime of the Authority as specified in the Bill, as we believe there is room for significant improvement in terms of transparency and accountability.[82]

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79 Consumers Health Forum of Australia, *Submission 1*, p. 1

80 Australian Medical Association, *Submission 9*, p. 3.

81 Australian Private Hospitals Association, *Submission 2*, [p. 3] citing The Hon. Nicola Roxon, Minister for Health and Ageing, Second Reading Speech, National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011, *House of Representatives Hansard*, 24 August 2011, p. 9.

82 Australian Private Hospitals Association, *Submission 2*, [p. 4].

2.78 Pursuant to section 211, the IHPA 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. This does not apply, however, to a report under section 212.

2.79 The CHF submitted that 'in the interests of transparency, it is important that health consumers have access to complete and uncensored information on hospital pricing and any jurisdictional disputes that have arisen'. Further, the CHF sought clarification on:

> ...whether the comments of Ministers will influence the final report that is released to the public, and whether the comments of Ministers on the report will also be made public.[83]

2.80 DoHA provided evidence on transparency issues. Mr Head noted in relation to section 131 that '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'.[84] In responding to questions about the provisions of section 211, Mr Broadhead confirmed that it does not cover changing or varying a negative report.[85] He explained further that section 211:

> 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 [86]

Proposed Part 4.14 – Secrecy

Proposed sections 221, 222 and 228 – Disclosure to researchers, disclosure with consent and protection of patient confidentiality

2.81 The Office of the Australian Information Commissioner (OAIC) noted that in addition to the IHPA's obligations under the Privacy Act, proposed sections 221 and 228 prevent the disclosure of indentifying information. The OAIC concluded that 'it appears to the OAIC that appropriate privacy safeguards will be built into the regulatory framework governing the IHPA'.[87] Similarly, Dr Antioch

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83 Consumers Health Forum of Australia, *Submission 1*, p. 3.

84 Mr Graeme Head, Deputy Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 25.

85 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 26.

86 Mr Peter Broadhead, Acting First Assistant Secretary, Health Reform Transition Office, Department of Health and Ageing, *Committee Hansard*, 7 September 2011, p. 26.

87 Office of the Australian Information Commissioner, *Submission 3*, [pp 1–2].

considered that 'these privacy inclusions are an excellent development and clarify the privacy issues in the NHRA (July 2011)'.[88]

2.82 Pursuant to section 222, an official of the IHPA may disclose protected IHPA information that relates to the affairs of a person if (a) the person has consented to the disclosure; and (b) the disclosure is in accordance with that consent.[89]

2.83 Pursuant to section 228, the IHPA, NHPA and the ACSQHC must protect patient confidentiality with some provision for consent. The CHF argued that the legislation should specify that this must be informed consent, so that the consumer or another person who is able to give consent is fully aware of the implications of providing consent.[90]

2.84 The CHF noted that the National Health and Hospitals Network Bill 2010 was amended in the Senate to include reference to informed consent in the relevant provisions of that Bill and submitted that it is appropriate that this is reflected in the current Bill.[91]

Other matters raised in submissions

2.85 Principal among the reasons for referral of this Bill to the committee was consideration of the relationship of the IHPA and the ACSQHC, and the relationship of the IHPA with the NHPA.[92]

2.86 The AIPCA observed that the current/proposed legislative scheme contains no real obligation for the three statutory bodies to work together to avoid duplication when collecting similar and related data.[93] The AIPCA further noted that:

> The only real legislative connection between the Pricing Authority, the Performance Authority and the Commission is found in the secrecy provisions of the Bill, enabling disclosure of protected information by the Pricing Authority to assist the other two statutory bodies. [94]

2.87 Similarly, the AMA argued that more detail needs to be provided by governments on the circumstances in which information would be shared between the three agencies.[95]

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88 Dr Kathryn Antioch, *Submission 14*, [pp 2–3].

89 Consumers Health Forum of Australia, *Submission 1*, p. 3.

90 Consumers Health Forum of Australia, *Submission 1*, p. 3.

91 Consumers Health Forum of Australia, *Submission 1*, p. 3.

92 Selection of Bills Committee, *Report No. 11 of 2011*, Appendix 1.

93 Australian Institute for Primary Care and Ageing, *Submission 5*, p. 3.

94 Australian Institute for Primary Care and Ageing, *Submission 5*, p. 2.

95 Australian Medical Association, *Submission 9*, p. 3.

2.88 The AIPCA suggested that consideration could be given to recommending an amendment to the Bill to establish a duty of cooperation between the three bodies. The AIPCA explained that such a provision is contained in the United Kingdom's *Health and Social Care Act 2008.*[96]

2.89 However, DoHA submitted that the IHPA will have a legislative requirement to have a strong consideration of how its functions will interact with the safety and quality of health services. They also note that disclosures of information between the IHPA and the ACSQHC in regard to ensuring safety and quality in healthcare services are provided for by proposed section 220. DoHA also submitted that the NHPA reports and its performance framework will play a vital role in ensuring that the IHPA can drive improvements and efficiencies within the health sector.[97]

Conclusion

2.90 The establishment of the IHPA represents a key part of the Government's health reforms. The Bill reflects the historic agreement concluded by the Council of Australian Governments on 2 August 2011. The IHPA will have a pivotal role in increasing the efficiency of hospital services through determining a national efficient price for activity based funding and determining amounts for block funding. Critically, it will do this in an independent manner. This provides a guarantee of Commonwealth funding for hospital services based on an efficient price for each kind of service. In addition, the IHPA will, for the first time, provide a legislative mechanism for resolving cost-shifting and cross-border disputes. The Government's health reforms provide a different, and more transparent, approach to funding hospital services in the future.

2.91 The committee notes the broad support for both the IHPA and the national activity based funding system. The IHPA will be drawing on experience from many other jurisdictions, including Victoria which has had activity based funding for 18 years.

2.92 The committee considers that the measures set out in the Bill will ensure that the unique features of Australia's hospital sector will be adequately addressed. There is provision for block funding where circumstances are such that activity based funding is not appropriate. A further feature of the provision of hospital services in Australia is the engagement of non-government organisations in the provision of public hospital beds. In particular, Catholic Health Australia pointed to the large part its hospital network plays. The committee has considered the concerns of Catholic Health Australia that due consideration be given to the difference in provision of public beds by a non-government organisation. Catholic Health Australia recommended that a member of the IHPA have experience in the operation of non-government public hospital services.

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96 Australian Institute for Primary Care and Ageing, *Submission 5*, p. 3.

97 Department of Health and Ageing, *Submission 13*, p. 7.

2.93 The committee is satisfied that the Bill provides adequate recognition of the diversity of the hospital sector. In particular, the committee notes that in determining the national efficient price, the IHPA must 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. In addition, the IHPA will call for public submissions. Finally, the committee notes that it is open to COAG in determining membership of the pricing authority to choose people from a wide range of backgrounds.

2.94 The committee is also satisfied with information provided by both the Department of Health and Ageing and Dr Sherbon, of the interim IHPA, that there are many opportunities provided by the provisions of the Bill for meaningful consumer input, including the establishment of specific committees if required.

2.95 In relation to concerns about funding of teaching, training and research, the committee notes that the Government has indicated that initially this will be funded on a block basis.

Recommendation 1

2.96 The committee recommends that the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011 be passed.

Senator Helen Polley
Chair