



## National Health and Hospitals Network Bill 2011

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# National Health and Hospitals Network Bill 2011

**Date introduced:** 29 September 2010

**House:** House of Representatives

**Portfolio:** Health and Ageing

**Commencement:** 1 July 2011

**Links:** The links to the [Bill, its Explanatory Memorandum and second reading speech](#), can be found on the Bills home page, or through <http://www.aph.gov.au/bills/>. When bills have been passed they can be found at the ComLaw website, which is at <http://www.comlaw.gov.au/>.

## Purpose

The National Health and Hospitals Bill (the Bill) establishes the Australian Commission on Safety and Quality in Health Care as a Commonwealth statutory body.

## Background

This Bill was introduced in June 2010 but was not debated, and subsequently lapsed on the proroguing of Parliament in July 2010. It has been reintroduced without any changes.

## Basis of policy commitment

## History

The Australian Council for Safety and Quality in Health Care (the Council) was first established as a non-statutory body in 2000 in response to the Quality and Safety in Health Care study (1995) commissioned by the then Commonwealth Department of Human Services and Health. The study showed an adverse event rate of 16.6 per cent across public hospitals.<sup>1</sup> The Council was asked to lead national systemic approaches to improvements in the safety and quality in health care with an initial focus on reducing errors.<sup>2</sup> To begin with, the term of the Council was five years and this was extended for another year. The Council ceased in December 2005.

It was agreed by the Australian Health Ministers Conference that the Council should be succeeded by a national body, the Australian Commission for Safety and Quality in Health Care (the

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1. B Barraclough and J Birch. 'Quality and safety in health care: where have we been and where are we going?' *Medical Journal of Australia*, vol. 184, no. 10, 15 May 2006, supplement, S48-50, viewed 15 October 2010, [http://www.mja.com.au/public/issues/184\\_10\\_150506/bar11157\\_fm.html](http://www.mja.com.au/public/issues/184_10_150506/bar11157_fm.html)

2. Ibid.

Commission) to commence operation in January 2006.<sup>3</sup> The Commission was to report to Health Ministers and be linked with health departments, and other government and non-government bodies.<sup>4</sup> At the time, it was envisaged that a Commission would have clear mechanisms to 'link with, and have participation of, jurisdictions and key stakeholders'.<sup>5</sup> The Commission was to be responsible for providing 'robust advice' to the Commonwealth, state and territory health ministers and informing the development of national safety and quality strategies.<sup>6</sup>

The Commission is supported by the Department of Health and Ageing and has a five year work program with priority given to patient rights, accreditation of health services, medication safety and hygiene.<sup>7</sup> Activities of the Commission have included the Australian Charter of Healthcare Rights, the national patient wristband standard and the development of a national approach to surveillance of hospital acquired infection rates.<sup>8</sup> More recently, the Commission developed the National Falls Prevention Guidelines 2009 and adapted the World Health Organization's Surgical Safety Checklist for the Australian context. It also developed the Guide to Clinical Handover Improvement and the National Consensus Statement on Essential Elements for Recognising and Responding to Clinical Deterioration. These were all endorsed by Australian health ministers.<sup>9</sup>

As one of its recommendations for reform of the health care system, the National Health and Hospitals Reform Commission recommended that the Commission be established as a permanent body.<sup>10</sup>

## National Health and Hospitals Network

The National Health and Hospitals Network (NHHN) was agreed to by the Council of Australian Governments (COAG) in April 2010, with the exception of Western Australia. Under the Agreement, responsibility for hospital management would be transferred to Local Hospital Networks (LHN) and independent primary health care organisations, known as Medicare Locals, would also be created.

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3. Australian Health Minister's Conference, *Australian Health Ministers agree on new safety and quality measures*, joint communique, 28 July 2005, Alice Springs, viewed 18 November 2010, <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-mediarel-yr2005-jointcom-jc013.htm>
  4. Ibid.
  5. Op. cit., Barraclough and Birch
  6. Department of Health and Ageing (DoHA), *Annual report 2007-08*, Commonwealth of Australia, Canberra, 2008, p. 153
  7. DoHA, *Annual report 2008-09*, Commonwealth of Australia, Canberra, 2009, p. 276. The Commission is funded by all governments according to the Australian Health Ministers Conference formula. That is, 50% from the Commonwealth Department of Health and Aging and the balance from the state and territory departments proportionate to population.
  8. Ibid., p. 164
  9. DoHA, *Annual report 2009-10*, Commonwealth of Australia, Canberra, 2010, p. 276.
  10. National Health and Hospitals Reform Commission, *A healthier future for all Australians: final report*, Commonwealth of Australia, Canberra, 2009, Recommendation 111, p. 245.

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Changes were also made to the financing arrangements for health care with the Commonwealth government becoming the dominant funder through changes to the GST arrangements.<sup>11</sup>

## The Commission as a permanent body

As part of the NHHN, it was proposed that the Commission would be established as permanent body. The proposed Bill gives effect to this intention.

In her second reading speech, the Minister for Health, Nicola Roxon, noted that safe, high quality health care was imperative to the Government's health reform agenda.<sup>12</sup> This would be supported by the establishment of the Commission as a permanent body with an expanded remit to:

Drive safe, high quality health care and to ensure the appropriateness of services delivered in particular healthcare settings, including primary care and mental health<sup>13</sup>

It will have a focus on reducing the harm from preventable errors, reducing healthcare costs from unnecessary or ineffective treatments, as well as formulating safety and quality standards, guidelines and indicators. These standards, guidelines and indicators will be developed in conjunction with clinicians, professional bodies and consumers. The Commission will continue its role in advising Commonwealth, state and territory health ministers. It will also provide advice about what standards would be suitable as national clinical standards to be implemented by LHNs. It should be noted, however, that the Commission is not a regulatory body (this will be discussed later in the Digest).

## Responsibilities of the Commission

One of the features of the NHHN is its Performance and Accountability Framework. The Framework aims to provide Australians with greater information about the performance of health and hospital services and will include standards developed by the Commission.<sup>14</sup>

The Commission would also be responsible for: developing and monitoring quality and safety standards; working with clinicians to identify best practice care; and ensuring the appropriateness of health care. The Commission will then provide advice to Commonwealth, State and Territory government about standards which could be implemented on a national level. National standards will only be implemented if all States and Territories are in agreement. This may delay implementation of a nationally consistent approach. Compromise may also be required to reach agreement on national standards.

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11. The Federal Financial Relations Amendment (National Health and Hospitals Network) Bill 2010 gives effect to the proposed funding arrangements of the NHHN and retains around a third of GST revenue from State and Territory governments.

12. N Roxon (Minister for Health and Ageing), 'Second reading speech: National Health and Hospitals Network Bill 2010', House of Representatives, *Debates*, 29 September 2010, p. 75.

13. *Ibid.*

14. Explanatory Memorandum, National Health and Hospitals Network Bill 2010, p. 3.

Agreement on national standards may be facilitated by the approach to be adopted by the Commission which the Minister noted would be a collaborative approach, underpinned by an agreement.<sup>15</sup> This agreement is not included in the Bill, however, the Bill does prescribe consultation with State and Territory governments in the development of national standards, guidelines and indicators (see, for example, **proposed section 10 and 11**). The details of the agreement have not yet been finalised.<sup>16</sup> Consultation with clinicians, lead clinicians and key stakeholders is also prescribed in the legislation.

The Commission has a monitoring role and does not have a regulatory function. This may limit the extent to which standards – compliance with which will be voluntary - are implemented in a nationally consistent manner and the extent to which the Commission can improve the safety and quality agenda in health care. However, as noted later in this Digest, the Commonwealth will have the ability to require compliance with a standard as a condition of a grant or other legally enforceable agreement.

In the absence of any regulatory function, the Commission's capacity to directly influence change may be limited. The proposed Bill notes that the Commission has the power to:<sup>17</sup>

... do all things necessary or convenient to be done for or in connection with the performance of its functions.

Although this could be considered a broad remit it remains to be seen whether this is sufficient power to ensure a national approach to quality and safety in health care. The framework for implementation of national standards may further compound matters as this will be the responsibility of the LHN rather than State and Territory health departments. As yet, the accountability frameworks between LHNs and State and Territory health department have not yet been defined and will vary by State. Furthermore, the role of private hospitals under the LHN is yet to be defined and will be resolved on a State by State basis. This may further limit the extent to which a national approach can be implemented.

## Sentinel event reporting

The limitations of the establishing the Commission without regulatory power is also demonstrated by sentinel event<sup>18</sup> reporting.

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15. N Roxon, op. cit., p. 75.

16. N Roxon, op. cit., p. 75.

17. See **proposed Section 13**.

18. There are multiple definitions of sentinel events. [Sentinel events in Australian public hospitals 2004-05](#) published by the AIHW describes a sentinel event as an instance where a patient suffers harm that is unexpected and unintentional.

A national list of core sentinel events was agreed with all jurisdictions at the Australian Health Ministers Conference (AHMC) in 2003. Jurisdictions also agreed that sentinel events would be publicly reported by the end of 2005.<sup>19</sup> A report about sentinel events in Australia during 2004/05 was published by the Australian Institute of Health and Welfare (in conjunction with the Safety and Quality Council) in 2007. This information is now published as part of the Commission's report, *Windows into Safety and Quality in Health Care*.

However, it is important to note that reporting rates for sentinel events vary and there is no single national methodology for reporting of sentinel events.<sup>20</sup> This is demonstrated by a review of jurisdictions' health department websites. The timeliness of reporting also varies as does the inclusion of data from private hospitals.<sup>21</sup> This is despite agreement on the public reporting of sentinel events by Health Ministers at AHMC in 2003. Questions could be asked about the accountability for decisions made by Health Ministers through the AHMC. Further questions could also be asked about the appropriate framework to ensure consistency. The proposed legislation does not appear to address these concerns or establish a framework that might facilitate greater accountability. This perhaps is a lost opportunity to ensure a national approach to quality and safety in health care. Considerations about the accountability of AHMC decisions, and COAG processes more broadly, are outside the scope of this Digest. Information about sentinel events across Australian public hospitals is also included in the Report on Government Services (ROGS) (published by the Productivity Commission on a yearly basis). ROGS also notes that definitions about sentinel events vary across jurisdictions and definitions have been revised to only include death or major permanent loss of function. This potentially could lead to under-reporting of sentinel events.

## Establishment of new agencies

Notes to clause 3 of the Bill state that it is intended that the Act (as the Bill will be if passed and receives Royal Assent) will be subsequently amended by Parliament to establish two new statutory agencies: the Independent Hospital Pricing Authority (IHPA) and the National Performance Authority (NPA). However, the Bill is silent on how these agencies will work together. This will be an important issue as the three agencies will likely be collectively responsible for improving the performance of the health care system and, more broadly, governance arrangements for health reform.

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19. Safety and Quality Council, *Sentinel events*, fact sheet, not dated, viewed 18 October 2010, [http://www.health.gov.au/internet/safety/publishing.nsf/content/6a2ab719d72945a4ca2571c5001e5610/\\$file/sentnlevnt31305.pdf](http://www.health.gov.au/internet/safety/publishing.nsf/content/6a2ab719d72945a4ca2571c5001e5610/$file/sentnlevnt31305.pdf)
  20. Australian Commission on Safety and Quality, *Windows into Safety and Quality in Health Care 2009*, ACSQHC, Sydney, p. 60.
  21. WA requires private hospitals to report sentinel events and this is included in public reporting.

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## Committee consideration

The Bill has been referred to the Senate Community Affairs Legislation Committee (the Committee) for inquiry and report by 18 November 2011. Details of the inquiry are at the [inquiry webpage](#).

The Committee noted the previous version of the Bill (identical to the current Bill) was referred the Committee by the 42nd Parliament. Submissions made to that inquiry were considered by the Committee, and this Digest draws on them as appropriate.

It should also be noted that the Federal Financial Relations Amendment (National Health and Hospitals Network Bill) Bill 2010 has been referred to the Senate Economics Legislation Committee for [inquiry](#) and report by 31 January 2011.<sup>22</sup>

This Digest was cleared for publication prior to the Report of the Committee being [tabled](#) in Parliament on 22 November 2010. It does not take into account the Committee's Report.

## Policy position of non-government parties/independents

The Opposition has signalled its intention to oppose the Bill in the House and the Senate on the grounds that it creates additional bureaucracy without real reform.<sup>23</sup> This was reflected in the vote on the legislation in the House of Representatives on 27 October 2010.

One of the Independents, Rob Oakeshott, indicated his support for the legislation but noted his concern about the lack of bipartisan support for health reform. He also argued that the reform process should improve 'equity and efficiency' of health care and that, to date, this was not adequately reflected in the Government's broader health reform proposals.<sup>24</sup>

The other Independents, Messrs Crook<sup>25</sup>, Katter, Wilkie and Windsor all voted in support of the legislation. The member for the Greens, Mr Adam Bandt, also voted in support of the legislation.<sup>26</sup>

## Position of major interest groups

A number of submissions have been made to the Senate Inquiry and, overall, provided qualified support for the Commission. Several key themes emerged from the submissions including:

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22. Senate, Selection of Bills Committee Report, *Chamber*, Hansard, 27 October 2011, p. 55
  23. P Dutton (Shadow Minister for Health and Ageing), *Health 'reform' begins with bureaucracy*, media release, 27 October 2010, <http://www.peterdutton.com.au/MediaHub/MediaReleases/tabid/75/articleType/ArticleView/articleId/139/Health-reform-begins-with-Bureaucracy.aspx>
  24. R Oakeshott, *Bipartisan support needed on health reform – Oakeshott*, media release, 27 October 2010, viewed 29 October 2010, <http://www.roboakeshott.com/node/790>
  25. It should be noted that the WA State Government has not signed up to the COAG Agreement.
  26. House of Representatives, *Votes and proceedings*, 27 October 2010, p. 140-141, <http://www.aph.gov.au/house/info/votes/rvpf010.pdf>

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representation of certain groups on the Board of the Commission, governance and accountability mechanisms and the lack of detail about how the Commission will interact with other agencies proposed under the NHHN.

## Representation on the Commission

Four groups are claiming not be adequately represented on the Board of the Commission: consumers, primary health care professionals, allied health professionals and the Aboriginal community-controlled health sector. Each of these groups argued that there should be a designated position on the Board to represent them. The proposed membership of the Board is a maximum of 10 members and a minimum of eight, including the Chair. The proposed legislation prescribes the relevant expertise (**proposed Division 2, section 20**) to be considered by the Minister when appointing the Board. Although consumers are mentioned in general terms, some consumer groups did not consider this to be sufficient.<sup>27</sup> Primary care and allied health professionals are also not specifically mentioned in the list proposed in the Bill. It is possible, however, for the Minister to specify a field or profession by legislative instrument.<sup>28</sup>

It could be suggested that the absence of an explicit requirement for Board representation from allied health, mental health and primary care professionals is an issue that deserves reconsideration. There is a growing awareness that patient care and chronic disease management requires a multidisciplinary approach across a range of health sectors. One of the reform objectives of the NHHN is to improve access to, and coordination of, primary care. This is reflected in Minister's second reading speech, as the Minister notes that Commission has an expanded remit to influence high quality care and ensure appropriateness of services delivered in primary care and mental health settings.<sup>29</sup> It could be argued that appropriate representation on the Board would be integral to this.

Representation of Aboriginal Australians, with specific expertise in primary care, on the Board of the Commission was considered by Aboriginal Medical Services Alliance Northern Territory to be fundamental to 'closing the gap' and improving the provision health care.<sup>30</sup> It was also argued that the work plan of the Commission should include specific measures in relation to 'closing the gap' and the provision of primary health care for Aboriginal Australians.

It should be noted, however, the Bill prescribes the consultation processes to be undertaken by the Commission and consultation with consumers is required in the development of any guidelines or standards (see **proposed clause 11(2)**). This may alleviate some of the concerns about representation on the Board.

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27. See, for example, the [submission](#) from the Consumers Health Forum and the [submission](#) from La Trobe University.

28. Legislative instruments are disallowable under the *Legislative Instruments Act*.

29. N Roxon, op. cit., p. 75.

30. Aboriginal Medical Services Alliance Northern Territory, Submission to the Senate Committee on Community Affairs, *Inquiry into the National Health and Hospitals Network Bill 2010*, October 2010, viewed 29 October 2010, <https://senate.aph.gov.au/submissions/committees/viewdocument.aspx?id=7c39783f-bd9a-4b59-8564-a949647a7c8f>.

## Governance and accountability mechanisms

Stakeholders expressed concerns about governance and accountability mechanisms for the Commission. The lack of detail about these mechanisms was noted, as was the voluntary compliance with the guidelines, standards and indicators developed by the Commission. It was also argued that the work plan of the Commission should be a publicly available document.

Catholic Health Australia (CHA) supported greater transparency and accountability across all health care services yet noted that national reporting on performance should lead to improvements rather than duplication of effort.<sup>31</sup> Most State and Territory health departments already have reporting requirements and additional reporting requirements could increase the administrative burden on hospitals. CHA also sought clarification about the relationship between private hospitals, the Commission and the NHNN more broadly.<sup>32</sup> CHA also argued that Catholic hospitals should be involved in the governance arrangements for the Commission as Catholic hospitals account for a significant number of hospital procedures in Australia and have formed their own LHNs in some States.<sup>33</sup>

The Business Council of Australia (BCA) considered the COAG reforms to be a 'good first step' yet argued that the Commission would be unable to drive improvement without appropriate powers.<sup>34</sup> This was also noted by the Australian Nursing Foundation (ANF), who also argued that the lack of incentives to implement the proposed standards would lead to inconsistency and would not ensure improvements in quality.<sup>35</sup> The Australian Medical Association (AMA) also noted the lack of obligations for State and Territory governments to comply with guidelines and standards from the Commission.<sup>36</sup>

Reflecting on the first six years of the Council prior to the commencement of the Commission, Bruce Barraclough suggested that 'powerful levers' would be required to change the nature and delivery of health care across public and private settings.<sup>37</sup> Similarly, Professor Smallwood noted that the

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31. Catholic Health Australia (CHA), Submission to the Senate Committee on Community Affairs, *Inquiry into the National Health and Hospitals Network Bill 2010*, October 2010, viewed 29 October 2010,

<https://senate.aph.gov.au/submissions/committees/viewdocument.aspx?id=04af6b11-f211-4e2b-bee2-0b7fa3d3ccba>

32. Ibid.

33. Ibid.

34. Business Council of Australia (BCA), Submission to the Senate Committee on Community Affairs, *Inquiry into the National Health and Hospitals Network Bill 2010*, October 2010, viewed 29 October 2010,

<https://senate.aph.gov.au/submissions/committees/viewdocument.aspx?id=ee6dfb87-842e-4258-b3a7-ed8f9ed154c7>

35. Australian Nursing Foundation (ANF), Submission to the Senate Committee on Community Affairs, *Inquiry into the National Health and Hospitals Network Bill 2010*, October 2010, viewed 29 October 2010,

<https://senate.aph.gov.au/submissions/committees/viewdocument.aspx?id=e63fcd4d-6931-4de3-8ebc-75f1e72dd6a1>

36. Australian Medical Association (AMA), Submission to the Senate Committee on Community Affairs, *Inquiry into the National Health and Hospitals Network Bill 2010*, October 2010, viewed 29 October 2010,

<https://senate.aph.gov.au/submissions/committees/viewdocument.aspx?id=d0efa496-39d4-49ca-ae07-1543c862b43f>

37. Op. cit., Barraclough and Birch.

Commission is 'expected to make things happen in a way its predecessor could not.'<sup>38</sup> He suggested that this could be achieved through high quality data on safety and quality on a national level to be used for national benchmarking purposes. Despite the Commission being in operation for four years, it appears that this remains an elusive goal. Australia still does not have a nationally consistent data set for hospitals. The proposed legislation does not give the Commission any additional powers to collect data or compel State and Territory governments to participate in national data collection. Although outside the scope of the Digest, this raises questions about the most appropriate mechanisms to achieve this objective.

## Relationships with other agencies

The Bill is silent on the proposed relationships with the other agencies to be established under the NHHN. This was noted by a number of submissions. Other submissions argued that due consideration could not be given to the Bill as these relationships had not been articulated;<sup>39</sup> and that it would have been appropriate and useful for the Parliament to consider this Bill concurrently together with the Bills for establishing the Independent Hospital Pricing Authority and the National Performance Authority.<sup>40</sup>

The AMA highlighted the advice that was included in Treasury's Red Book:<sup>41</sup>

To maximise the benefits of the NHHN reforms, implementation should ensure that mechanisms are put in place that allow the new national governance authorities to work together effectively. Effective links between authorities are needed to ensure the right balance between efficiency, safety and equity in the health system.

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38. R A Smallwood, The safety and quality of health care: from Council to Commission, *Medical Journal of Australia*, vol. 184, no 10, 15 May 2006, supplement, S48-50, viewed 1 November 2010, [http://www.mja.com.au/public/issues/184\\_10\\_150506/sma10326\\_fm.html](http://www.mja.com.au/public/issues/184_10_150506/sma10326_fm.html)
39. See for example, Aboriginal Medical Services Alliance Northern Territory, Submission to the Senate Committee on Community Affairs, *Inquiry into the National Health and Hospitals Network Bill 2010*, October 2010, viewed 29 October 2010, <https://senate.aph.gov.au/submissions/comitees/viewdocument.aspx?id=7c39783f-bd9a-4b59-8564-a949647a7c8f>.
40. AMA, supplementary submission to the Senate Committee on Community Affairs, *Inquiry into the National Health and Hospitals Network Bill 2010*, 15 October 2010, viewed 20 October 2010, <https://senate.aph.gov.au/submissions/comitees/viewdocument.aspx?id=277923f5-e100-4f7d-92c9-0d524c91e3e6>; Royal Australian and New Zealand College of Psychiatrists, Submission to the Senate Committee on Community Affairs, *Inquiry into the National Health and Hospitals Network Bill 2010*, 20 October 2010, viewed 9 November 2010, <https://senate.aph.gov.au/submissions/comitees/viewdocument.aspx?id=2064bdc9-dfe7-4339-bd36-40d82bcd0c5c> However as noted previously in this Digest, it appears this Bill (or Act, as it potentially may become) will be subsequently be amended to establish these bodies.
41. The Treasury, *Treasury Incoming Government Brief - Red Book – Redacted - Part 4*, Commonwealth of Australia, Canberra, 2010, p.16, viewed 29 October 2010, [http://www.treasury.gov.au/documents/1875/PDF/Red\\_Book\\_Part\\_4\\_Redacted.pdf](http://www.treasury.gov.au/documents/1875/PDF/Red_Book_Part_4_Redacted.pdf) and AMA, supplementary submission, <https://senate.aph.gov.au/submissions/comitees/viewdocument.aspx?id=277923f5-e100-4f7d-92c9-0d524c91e3e6>

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The lack of clarity about these relationships was also noted by CHA.<sup>42</sup> An overarching criticism of the NHHN has been the lack of detail about the linkages between the proposed authorities and the governance arrangements more broadly. The Commission is one of the new governance authorities for the health care system under the NHHN and the lack of detail about proposed coordination arrangements may hinder the implementation effort.

## Financial implications

The funding and work plan of the Commission is also subject to an agreement with the State and Territory governments, namely Health Ministers.<sup>43</sup> This agreement is yet to be finalised.

The Explanatory Memorandum notes that the Commonwealth Government will provide \$35.2 million over four years to jointly fund, with States and Territories, the Commission.<sup>44</sup>

## Key provisions

### Part 1—Preliminary

**Clause 1** provides that the Act may be cited as the *National Health and Hospital Networks Act 2010*.

In its submission, the Royal Australia and New Zealand College of Psychiatrists reflected on the title of the proposed Act:

The title of the Bill is not descriptive of the contents may, over time, cause confusion as separate bills for the establishment of the Hospital Pricing Authority and the National Performance Authority are introduced. These Authorities are core components of the National Health and Hospitals Network structure, while the ACSQHC is an aligned structure. The Bill could be re-titled *Australian Commission on Safety and Quality in Health Care Bill 2010*.<sup>45</sup>

Their suggestion and underpinning logic appears worthy of further consideration.

**Clause 3** states the object of the Act is to implement the NHHN in so far as it involves the establishment of the Commission which has functions relating to health care safety and quality matters.

The Mental Health Council of Australia made the following observation:

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42. CHA, op. cit.

43. Department of Health and Ageing, Submission to the inquiry into the National Health and Hospitals Network Bill 2010, *Inquiry into the National Health and Hospitals Network Bill 2010*, October 2010, viewed 27 October 2010, [http://www.aph.gov.au/Senate/committee/clac\\_ctte/Nat\\_hlth\\_hospital\\_network\\_43/submissions.htm](http://www.aph.gov.au/Senate/committee/clac_ctte/Nat_hlth_hospital_network_43/submissions.htm)

44. Explanatory Memorandum, op. cit., p. 4.

45. Royal Australian and New Zealand College of Psychiatrists, Submission to the Senate Inquiry into the National Health and Hospitals Network Bill 2010, *Inquiry into the National Health and Hospitals Network Bill 2010*, 20 October 2010, viewed 9 November 2010, [http://www.aph.gov.au/Senate/committee/clac\\_ctte/Nat\\_hlth\\_hospital\\_network\\_43/submissions.htm](http://www.aph.gov.au/Senate/committee/clac_ctte/Nat_hlth_hospital_network_43/submissions.htm)

A specific focus by the Commission on the special needs of the safety and quality issues in the mental health sector and a closer engagement between the Commission and mental health consumers and carers would be welcomed and would improve the influence of the Commission on practice in this sector. However provision for this focus is not covered by the Bill.<sup>46</sup>

**Clause 5** provides definitions for the purposes of key provisions contained in this Bill including:

**Health care safety and quality matter**, means:

- a matter relating to the safety of health care services, or
- a matter relating to the quality of health care services, or
- a matter specified in the regulations.

**Partner** of a person means, the person's spouse; or the person's de facto partner (within the meaning of the *Acts Interpretation Act 1901*).

It also provides definitions for 'National Health and Hospitals Network Agreement' and 'participating State/Territory Health Minister'.

**Clause 7** provides that the Crown (encompassing the Commonwealth, State and Territory governments) is bound by the Act, however the Crown (but not an authority thereof) will not be liable to pecuniary penalty (a monetary fine imposed by a civil court) or prosecution for the offence.

## Part 2—Commission's Establishment, Functions and Powers

**Clause 8** establishes the Commission and provides that the Commission is a body corporate which must have a seal; may acquire, hold and dispose of real; and personal property and may sue and be sued in its corporate name.

**Clause 9** lists the range of functions given to the Commission. These are:

- to promote, support and encourage the implementation of arrangements, programs and initiatives relating to health care safety and quality matters
- to collect, analyse, interpret and disseminate information relating to health care safety and quality matters
- to advise the Minister about health care safety and quality matters
- to publish (whether on the internet or otherwise) reports and papers relating to health care safety and quality matters
- to formulate, in writing, standards, guidelines and indicators (which are not legislative instruments) relating to health care safety and quality matters and to promote, support and

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46. Mental Health Council of Australia, Submission to the Senate Inquiry into the National Health and Hospitals Network Bill 2010, *Inquiry into the National Health and Hospitals Network Bill 2010*, July 2010, viewed 9 November 2010, <https://senate.aph.gov.au/submissions/committees/viewdocument.aspx?id=bd83351-6db7-40f9-9206-fbbfed8ecd39>

encourage their implementation. (**Clause 10** provides additional provisions relating to the formulation of these standards, guidelines and indicators).

- to advise the Minister, and each participating State/Territory Health Minister; about which standards formulated are suitable for implementation as national clinical standards
- to formulate model national schemes (which are not legislative instruments) which provide for the accreditation of organisations that provide health care services, and relate to health care safety and quality matters
- to consult and co-operate with other persons, organisations and governments on health care safety and quality matters
- such functions (if any) as are specified in a written instrument (which is not a legislative instrument) given by the Minister to the Chair, although the Minister must first consult with each participating State/Territory Health Minister
- to promote, support, encourage, conduct and evaluate training programs for purposes in connection with the performance of any of the Commission's functions
- to promote, support, encourage, conduct and evaluate research for purposes in connection with the performance of any of the Commission's functions, and
- to do anything incidental to or conducive to the performance of any of the above functions.

**Clause 10** provides **additional provisions relating to the process for formulating standards, guidelines and indicators** referred to in clause 9. Before any such formulation takes place, the Commission must consult with: clinicians; lead clinician groups; heads of health departments of participating States or Territories, any other persons or bodies, who in the Commission's opinion, are stakeholders in relation to the formulation of standards, guidelines and indicators, and the public.

The term '**clinician**' has not been defined in the legislation. This could be considered an omission from the legislation and arguably this requires clarification. Allied health professionals should also be explicitly included in any such definition, because, the term clinician is not yet defined, it potentially could result in some health professionals not being consulted in formulating standards, guidelines and indicators. This concern was a common theme in the submissions to the Senate Inquiry into this Bill. As the Australian Psychological Society noted:

The National Health and Hospital Commission Report made many recommendations to improve multidisciplinary practice through improved engagement with allied health clinicians. Unfortunately current practice is that allied health clinicians and their relevant representative organisations are often not invited to comment or participate in discussions regarding safety and quality.<sup>47</sup>

Perhaps a useful definition of the term '**clinician**' for the purposes of this legislation, would be that provided by the Consultation Paper on the Draft National Safety and Quality Health Service Standards:

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47. Australian Psychological Society Ltd, Submission to the inquiry into the National Health and Hospitals Network Bill 2010, *Inquiry into the National Health and Hospitals Network Bill 2010*, 19 October 2010, viewed 10 November 2010, [http://www.aph.gov.au/Senate/committee/clac\\_ctte/Nat\\_hlth\\_hospital\\_network\\_43/submissions.htm](http://www.aph.gov.au/Senate/committee/clac_ctte/Nat_hlth_hospital_network_43/submissions.htm)

**Clinician:** a healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners, or a team of health professionals providing health care who spend the majority of their time providing direct clinical care.<sup>48</sup>

In terms of securing appropriate ‘public consultation’, the Royal Australian and New Zealand College of Psychiatrists raised a subtle, yet important amendment that may be worthy of consideration. They argued that while consultation with the public is mentioned in **clause 10** and other provisions in the Bill, it would be very useful to specifically also include ‘carers and consumers’. This would facilitate the improvement in outcomes and possibly address deficiencies in current practices.<sup>49</sup>

In the Senate Inquiry into the Bill, the Department of Health and Ageing stated that:

In making specific provision for consultation the NHHN Bill sets an expectation that the Commission will consult widely and will comply with international best practice standards. While each stakeholder is not explicitly listed in the NHHN Bill, it is anticipated that the Commission will regularly consult with consumers, carers, health service organisations – both public and private, clinicians and peak bodies, including Catholic Health Australia.<sup>50</sup>

However, this verbal response of what would be anticipated by the Department, is perhaps better secured in explicit drafting in the legislation, hence the proposal by the Royal Australian and New Zealand College of Psychiatrists remains pertinent.

**Clause 10** also provides that if the Commission is of the opinion that there is an urgent need to formulate particular standards, guidelines or indicators, and it is not reasonably practicable to engage in the aforementioned consultation, then the Commission does not have to engage in such consultation.

Also, before formulating standards, guidelines or indicators, the Commission must collect, analyse and interpret such information as the Commission considers relevant.

There is also provision for the Minister to make rules (by legislative instrument) to be complied with by the Commission, in formulating standards, guidelines or indicators. However, the Minister must first consult with each participating State and Territory Health Minister, before making such rules.

**Clause 11** provides **additional provisions relating to the process for formulating model national accreditation schemes** that provide accreditation of organisations providing health care services,

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48. Consultation Paper on the Draft National Safety and Quality Health Service Standards, August 2010, p. 21, viewed 16 November 2010, [http://www.wagpnetwork.com.au/client\\_images/316887.pdf](http://www.wagpnetwork.com.au/client_images/316887.pdf)

49. Royal Australian and New Zealand College of Psychiatrists, Submission to the inquiry into the National Health and Hospitals Network Bill 2010, *Inquiry into the National Health and Hospitals Network Bill 2010*, 20 October 2010, viewed 9 November 2010, [http://www.apf.gov.au/Senate/committee/clac\\_ctte/Nat\\_hlth\\_hospital\\_network\\_43/submissions.htm](http://www.apf.gov.au/Senate/committee/clac_ctte/Nat_hlth_hospital_network_43/submissions.htm)

50. Answers to Questions on notice, Senate Inquiry into the National Health and Hospitals Network Bill 2010, Outcome 10: Health System Capacity and Quality, Question 2, 9 November 2010, viewed 16 November 2010.

and relate to health care safety quality matters. The provisions in clause 11 largely mirror those in clause 10.

**Clause 12** basically explains and confirms that the Commission's functions are to be performed within the Commonwealth's constitutional powers.

**Clause 14** allows the Commission to charge fees for things done in performing its functions, as long as the requisite rules for doing so (which are legislative instruments) are in force and complied with. Before making such rules, the Minister must consult each participating State/Territory Health Minister.

**Clause 15** gives the Commission privileges and immunities of the Crown in right of the Commonwealth.

**Clause 16** enables the Minister to give directions to the Commission in relation to performance of its functions and exercise of powers, with which the Commission must comply. These directions must be of a general nature only. The Minister must also consult with each participating State/Territory Health Minister before giving any direction to the Commission.

### Part 3—The Board of the Commission

**Clause 18** sets out the role of the Board of the Commission.

The Board is responsible for ensuring the proper and efficient performance of the Commission's functions, and is given the power to do all things necessary and convenient to be done for or in connection with the performance of its duties.

**Clause 19** provides that the Board shall consist of a Chair, and not fewer than seven but no more than nine other Board Members.

**Clause 20** deals with the appointment of Board Members by the Minister and their 'qualifications'. A person is not eligible for appointment as a Board Member unless the Minister is satisfied that the person has substantial experience or knowledge and significant standing in at least one of the following fields:

- public administration in relation to health care
- provision of professional health care services
- management of companies, or other organisations, that are involved in the provision of health care services outside the hospital system
- general management of public hospitals
- general management of private hospitals
- financial management
- corporate governance
- improvement of safety and quality
- representation of the interests of consumers

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- law, and
- a field that is specified in a legislative instrument made by the Minister.

While the Minister must ensure that the Board members collectively possess an appropriate balance of experience and knowledge in each of the fields mentioned above, it is unclear that the list above will necessarily yield the most appropriate membership. For example, experience in the field of 'law' seems too broad. Perhaps it would be better to confine it to 'health law'. Also, the other fields seem too weighted in favour of administrators and bureaucrats with emphasis on substantial experience *or* knowledge, which does not necessarily equate with substantive experience *and* knowledge. The list provided seems to unquestioningly continue a tradition of appointing bureaucrats or administrators to roles, where it would make sense to also demand appropriate tertiary qualifications, including at least some Board members possessing degrees in medicine.

The Australian Medical Association has argued that:

One of the platforms of the Government's health reform agenda is to increase clinician engagement in decisions about health care delivery. Accordingly, clause 20 of the NHHN Bill should be amended to require that a practising medical practitioner is included on the Board of the Australian Commission on Safety and Quality Health Care. This will ensure medical input is provided to important safety and quality initiatives.<sup>51</sup>

An extension of the point above, the Australian General Practice Network has pointed out that:

while the fields of expertise specified in the Bill include the management of health care services that operate outside the hospital system, the Bill does not specifically call for expertise related to the management of general practice and primary health care provider services. AGPN is concerned this will support a greater emphasis on acute and tertiary health care services with less consideration given to primary health care. As the scope of the Commission's activity includes primary health care we recommend that the Bill also specifies management of primary health care services as a field of expertise that must be represented on the Commission's Board or otherwise seeks to ensure a more balanced representation of skills and expertise related to the provision of primary health care services, on the board.<sup>52</sup>

**Clause 21** provides that Board members are to be appointed for maximum period of 5 years.

**Clause 22** deals with the Minister appointing an Acting Chair of the Board and an Acting Board Member.

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51. AMA, Supplementary submission to the Senate Committee on Community Affairs, *Inquiry into the National Health and Hospitals Network Bill 2010*, viewed 16 November, 2010, <https://senate.aph.gov.au/submissions/committees/viewdocument.aspx?id=277923f5-e100-4f7d-92c9-0d524c91e3e6>
  52. Australian General Practice Network, Supplementary submission to the Senate Committee on Community Affairs, *Inquiry into the National Health and Hospitals Network Bill 2010*, 20 October 2010, viewed 16 November 2010, <https://senate.aph.gov.au/submissions/committees/viewdocument.aspx?id=8a2fbb59-715b-45da-84bb-80ccc9bf3199>

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**Clause 26** provides that the Minister *must* terminate the appointment of a Board member if:

(a) the Board member:

- (i) becomes bankrupt, or
- (ii) applies to take the benefit of any law for the relief of bankrupt or insolvent debtors, or
- (iii) compounds with his or her creditors, or
- (iv) makes an assignment of his or her remuneration for the benefit of his or her creditors, or

(b) the Board member is absent, except on leave of absence, from 3 consecutive meetings of the Board;  
or

(c) the Board member fails, without reasonable excuse, to comply with an obligation imposed on him or her by section 27F or 27J of the *Commonwealth Authorities and Companies Act 1997*.

However, the Minister also has *discretionary* power to terminate for misbehaviour, or physical or mental incapacity.

The Minister must consult each participating State/Territory Health Minister prior to terminating the appointment of a Board member under their discretionary power.

**Clause 28** provides that the Chair must convene three meetings of the Board in each calendar year, and may convene additional meetings if he or she deems it necessary. The Chair must also convene a meeting of the Board if so directed by the Minister.

**Clauses 30** and **31** deals with quorum and voting at meetings respectively. **Clause 32** provides for a process for taking decisions without meetings. Clause 33 deals with conduct of meetings.

**Clause 34** provides that the Board must keep minutes of its meetings.

**Clause 35** allows the Board to delegate any or all of its functions and powers to:

a Board member, or

the CEO, or

a person who is:

a member of the staff of the Commission; and

an SES employee or acting SES employee. Part 4—Chief Executive Officer, staff and consultants.

## Part 4 – The Chief Executive Officer (CEO)

**Clause 37** provides that the role of the CEO is to be responsible for the day-to-day administration of the Commission, and would have the power to do all things necessary or convenient to be done for or in connection with the performance of his or her duties. It is also provided that the CEO is to act in accordance with the policies determined, and any directions given, by the Board.

**Clause 38** deals with the appointment of a CEO for a period of not more than five years. The CEO must not be a Board member.

**Clause 40** provides that the CEO must not engage in paid employment outside the duties of his or her office without the Chair's approval, and, that Chair must notify the Minister of any such approval.

**Clause 43** provides that the CEO must give written notice to the Board of all material personal interests that the CEO has or acquires; and that conflict or could conflict with the proper performance of the CEO's duties.

**Clause 45** deals with the termination of appointment of the CEO. The Board *may* terminate the appointment of the CEO for: misbehaviour, physical or mental incapacity, and if the Board is satisfied that the CEO's performance has been unsatisfactory.

However, the Board *must* terminate the appointment of the CEO if the CEO:

- becomes bankrupt; or
- applies to take the benefit of any law for the relief of bankrupt or insolvent debtors, or
- compounds with his or her creditors; or
- makes an assignment of his or her remuneration for the benefit of his or her creditors, or
- the CEO is absent, except on leave of absence, for 14 consecutive days or for 28 days in any 12 months, or
- the CEO fails, without reasonable excuse, to comply with clause 43, or the CEO engages, except with the Chair's approval, in paid employment outside the duties of his or her office.

Prior to terminating the appointment of a CEO using its discretionary capability, the Board must first consult the Minister; and the Minister must consult each participating State/Territory Health Minister.

**Clauses 47-49** deal with basic matters relating to the employment and conditions of staff, consultants and persons assisting the Commission in its work.

## Part 5—Committees

**Clause 50** enables the Commission to establish committees to advise or assist it in the performance of its functions. Membership of these committees may include Commission Board Members and, or non-Commission Board Members.

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## Part 6—Reporting and planning obligations of the Commission

**Clause 52** provides that the Minister may, by written notice, require the Commission to prepare reports or give information (or provide copies thereof) within a period of time specified by the Minister, about one or more specified matters relating to the performance of the Commission's functions. The Commission must comply with such a request. The Minister may also ask for such reports or information to be published.

**Clause 53** requires the Commission to publish an annual report which includes the following information:

- (a) an assessment of the performance of each of the Commission's functions during the financial year, and
- (b) an assessment of the impact of the performance of each of the Commission's functions during the financial year, and
- (c) an assessment of:
  - the safety of health care services provided during the financial year, and
  - the quality of health care services provided during the financial year.

**Clause 54** provides that the Commission must provide to the Minister a work plan each financial year, which covers work to be undertaken for the next three financial years. As soon as practicable, after receiving such work plan, the Minister must give a copy of that work plan each participating State/Territory Health Minister. The Minister must give a copy of the draft work plan to each participating State/Territory Health Minister and invite submissions to be given about the draft work plan. A work plan is not a legislative instrument.

## Part 7—Miscellaneous

**Clause 57** deals with compliance with standards and guidelines formulated under clause 9 of the Bill. It is proposed that such compliance be voluntary. However, this does not prevent compliance with a standard or guideline formulated under **clause 9** from being a term or condition of either a grant, or a contract or other legally enforceable agreement.

The Australian Nursing Federation has raised the concern that 'compliance with any standards and guidelines developed by the Commission is voluntary', and that 'that without an incentive or requirement in place, consistency in safety and quality of care for consumers of health and aged care services will not be achieved':

The ANF therefore supports a mechanism which would either provide an incentive - such as additional funding; or a requirement - such as those suggested in the Explanatory notes to the Bill

*...compliance with those standards or guidelines may be made a term or condition of a grant or under a contract or other legally enforceable agreement. They may also be applied or adopted by a State or Territory law or a law of the Commonwealth.*

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National registration for health professionals was implemented in part to achieve greater consistency across the country in standards of care. It would seem that, unless there is a mechanism to enforce the clinical standards produced by the Commission, as nationally consistent standards, the push for improvement to safety and quality of care will be compromised.<sup>53</sup>

**Clause 58** seeks to protect patient confidentiality and provides that in the performance of the Commission's functions, the Commission must not publish or disseminate information that is likely to enable the identification of a particular patient. This does not apply where consent has been given in specified circumstances.

## Concluding comments

There are a number of outstanding issues that the Bill fails to address. As noted in submissions to the Senate Inquiry, the title of the Bill fails to accord with what the Bill proposes. Further, the proposed membership of the Board of the Commission does not currently stipulate that a person with medical qualifications is required on the Board. Dependent on who is eventually appointed to the Board (if indeed the Bill passes Parliament), this may raise serious questions about the extent to which the Board can appropriately direct the Commission in its functions. The Commission may also be further limited in its perspective as the legislation fails to define 'clinician'. This may mean that allied health professional and other health professions will not adequately be consulted in the development of any guidelines, standards and indicators.

Improvements in safety and quality in health care are a laudable, if not essential, aim of the health care system. This legislation sets up a permanent Commission with responsibility for promoting safety and quality in health care. A notable omission, however, is the lack of power given to the Commission to implement system wide improvements in health care. It should be noted, however, that reporting against the new national clinical quality and safety standards is a feature of the National Partnership Agreement on Improving Public Hospital Services.<sup>54</sup> The legislation is also silent on the proposed linkages between the various governance authorities to be established under the NHHN. This combined with the lack of power of the Commission could potentially hamper the Commission's important role in improving in improving the safety and quality of Australia's health care system.

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53. Australian Nursing Federation, Submission to Senate Standing Committee on Community Affairs, 30 July 2010, viewed 13 November 2010,

[http://www.aph.gov.au/Senate/committee/clac\\_ctte/Nat\\_hlth\\_hospital\\_network\\_43/submissions.htm](http://www.aph.gov.au/Senate/committee/clac_ctte/Nat_hlth_hospital_network_43/submissions.htm)

54. Although the States agreed in principle to this Agreement, none have formally signed the National Partnership Agreement on Improving Public Hospital Services. For details of the reporting against safety and quality standards, see p. 7 of the [National Partnership Agreement on Improving Public Hospital Services](#).

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