



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

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

Date introduced: 3 March 2011

House: House of Representatives

Portfolio: Health and Ageing

Commencement: The formal provisions commence on Royal Assent. Schedule 1 to the Bill commences on a single day to be fixed by proclamation but not before the commencement of section 3 of the National Health and Hospitals Network Act 2011.¹

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

Purpose

This Bill establishes a new statutory authority, the National Health Performance Authority (the Authority).

The Government first committed to establishing the National Health Performance Authority at the April 2010 Council of Australian Governments (COAG) meeting.² The commitment to establish the Authority was reconfirmed at the 13 February 2011 COAG meeting, details of which are summarised in the [Heads of Agreement – National Health Reform](#).

This Bill has implications for the [National Health and Hospitals Network Bill 2010](#) passed by the House (with Senate amendments) on 21 March 2011; the National Health and Hospitals Network Bill establishes the Australian Commission on Safety and Quality of Health Care (ACSQHC) as a permanent agency.³ If enacted, this Bill will amend the National Health and Hospitals Network Bill 2010 by changing its title to the *National Health Reform Act 2011*. It will divide the Act into several chapters and add additional chapters. It will make a number of technical amendments to existing chapters, including the preliminary chapter and the chapter on the ACSQHC. It will also introduce two new chapters: Chapter 3, which concerns the establishment of the National Health Performance

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1. This Act has passed both Houses but has not yet received Royal Assent.
 2. Explanatory Memorandum, National Health Reform Amendment (National Health Performance Authority) Bill 2011, p. 2. Note: in the original National Health and Hospitals Agreement, the Authority was called the National Performance Authority. In this Bill, its title has been amended to the National Health Performance Authority.
 3. This Bill, with amendments, was passed by Senate on 3 March 2011. The amendments were passed by the House of Representatives on 21 March 2011. The Bill has not yet received Royal Assent.

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Authority, and Chapter 4, which covers miscellaneous subjects such as privacy and confidentiality, relations between this Act and state laws, and regulation making power.

Background

Basis of policy commitment

Prime Minister Rudd first outlined plans to introduce national performance standards for health care providers in his [address](#) to the National Press Club on health reform on March 3, 2010.⁴ The subsequent [National Health and Hospitals Network Agreement](#) (NNHN Agreement) made in April 2010 between the Commonwealth and all state and territory governments, except Western Australia, committed governments to establishing an independent National Performance Authority that would be responsible for:

- monitoring the performance of health care providers from 1 July 2011
- reporting against clinical safety and quality performance standards developed by the ACSQHC, and
- producing reports on waiting times, adverse events, patient satisfaction and financial management in public and private hospitals.⁵

In the 2010-11 Commonwealth Budget, \$118.6 million was allocated over 4 years to establish the National Performance Authority.⁶

The Rudd Government's health reforms were renegotiated by Prime Minister Gillard at a subsequent COAG meeting on 13 February 2011. A new health reform deal was needed because Western Australia refused to sign up to the original NNHN Agreement, and some elements of the Agreement remained contentious: for example, the proposal requiring states and territories to dedicate a portion of GST to health care and the proposal to transfer policy and funding responsibility for primary health care from the states to the Commonwealth.⁷ The functions and purpose of the

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4. K Rudd, 'Better health, better hospitals: the National Health and Hospitals Network', speech to the National Press Club, Canberra, 3 March 2010, viewed 11 March 2011, http://parlinfo.aph.gov.au/parlInfo/download/media/pressrel/G22W6/upload_binary/g22w60.pdf;fileType=application%2Fpdf#search=%22health%20reform%20rudd%20%20|%20EBS%20CO%20AAP%20prime%20minister%20national%20health%20and%20hospitals%20network%22
 5. Council of Australian Governments, Communiqué, meeting 19 and 20 April, 2010, Canberra, viewed 11 March 2011, http://www.coag.gov.au/coag_meeting_outcomes/2010-04-19/docs/communique_20_April_2010.pdf
 6. Australian Government, *Budget measures: Budget paper No. 2: 2010-11*, Commonwealth of Australia, Canberra, 2010, viewed 11 March 2011, http://www.budget.gov.au/2010-11/content/bp2/html/bp2_expense-13.htm
 7. See for example: E Connors, 'Health plans may need life support', *Australian Financial Review*, 10 February 2011, p. 2, viewed 11 March 2011, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressclp%2F543323%22;>

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Authority outlined in the original NHHN Agreement are unchanged in the new Heads of Agreement – National Health Reform. They are discussed in the section below.

Performance monitoring in health care

There are a number of local, state and national performance monitoring schemes already operating in the health sector. At the local level, for example, hospital boards and area and district health services have established mechanisms for monitoring performance standards. There is, however, little nationally consistent and comparable publicly available information on providers' performance at this level.⁸ At the state level, some data on the performance of public hospitals and other public health services is made available, but it too varies from jurisdiction to jurisdiction (for examples, see [here](#)). According to the [MyHospitals](#) website, some areas where there are known to be differences in reporting at the state level include: elective surgery and emergency department waiting times, average length of stay and counts of available beds.⁹

At the national level, there are also a number of different performance monitoring mechanisms operating. They include:

- The COAG Reform Council (CRC) and its Performance Reports on the National Healthcare Agreement
 - The CRC is responsible for reporting on the performance of the Commonwealth and state and territory governments with respect to the National Healthcare Agreement and its eight associated national partnerships.¹⁰ Performance measures include data on: the prevalence of selected diseases and risk factors for ill health, health service utilisation, health outcomes (for example life expectancy and cancer survival rates), health care costs, and some measures of the quality of care (although many are only proxy measures for quality, such as waiting times for care).¹¹ A full list of indicators can be found [here](#).

M Metherell, 'Red book finds rub with Rudd', *Sydney Morning Herald*, 7 October 2010, p. 8, viewed 11 March 2011, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressclp%2F269571%22>

8. Australian Government, 'A National Health and Hospitals Network for Australia's future: delivering better health and better hospitals', Canberra, 2010, p. 45.

9. Australian Government, Australian Institute of Health and Welfare (AIHW), 'MyHospitals', AIHW website, viewed 11 March 2011, <http://www.myhospitals.gov.au/about-the-data>

10. Council of Australian Governments, COAG Reform Council, 'Healthcare', COAG Reform Council website, viewed 11 March 2011, <http://www.coagreformcouncil.gov.au/agenda/healthcare.cfm>

11. Council of Australian Governments (COAG), COAG Reform Council, 'National Healthcare Agreement Baseline Performance Report 2008-09', 30 April 2010, viewed 11 March 2011, http://www.coagreformcouncil.gov.au/reports/docs/healthcare_agreement_report_2008-09_exec_summary.pdf

- The Australian Institute of Health and Welfare (AIHW) and the [MyHospitals](#) website
 - The AIHW collates, analyses and publishes a large amount of data on the health of Australians, health service utilisation, health care costs and expenditure. The AIHW also furnishes the MyHospitals website with data (sourced originally from the states and territories as well as private providers). The website provides data on public and private hospitals but not other health care providers, such as general practitioners, community health services and allied health professionals. The two main performance indicators used on the MyHospitals website are waiting times for elective surgery and emergency department care.
- The Australian Bureau of Statistics (ABS)
 - The ABS collects, collates, analyses and publishes a range of data relating to health and health care. Like the AIHW, much of it focuses on the prevalence of selected diseases and risk factors, health service utilisation and health outcomes. However the AIHW does publish some reports relating to the performance of health care providers. In 2009, for example, for the first time the ABS surveyed Australians and published a report titled [Health Services: Patient Experiences in Australia](#).¹² The report canvasses issues such as the barriers to accessing timely health care, patients' perceptions about their communication with health care professionals and experiences of harmful side-effects after using health care services or products.
- The Australian Commission on Safety and Quality in Health Care (ACSQHC)
 - One role of the ACSQHC is to publicly report on the state of safety and quality in health care, including performance against national standards.¹³ It does this primarily through its report titled [Windows into Safety and Quality in Health Care](#).¹⁴ The report concentrates on providing an overview on clinically relevant topics such as: learning from patient experiences, patient handovers, medication safety, hand hygiene and sentinel events. The ACSQHC does not collect, analyse or report on any performance data relating to individual providers or groups of providers.

The Government's decision to establish the National Health Performance Authority is part of a broader commitment to 'increasing the transparency of government and the services it delivers' and

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12. Australian Bureau of Statistics (ABS), *Health services: patient experiences in Australia, 2009*, cat. no. 4839.0.55.001, Canberra, 2010, viewed 11 March 2011, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0.55.001>
 13. Australian Commission on Safety and Quality in Health Care (ACSQHC), 'Welcome to our website', ACSQHC website, viewed 11 March 2011, <http://www.safetyandquality.gov.au/>
 14. Australian Commission on Safety and Quality in Health Care(ACSQHC), *Windows into the safety and quality of health care 2010*, Sydney, 2010, viewed 11 March 2011, [http://www.health.gov.au/internet/safety/publishing.nsf/Content/windows-into-safety-and-quality-in-health-care-2010/\\$File/Windows%202010%20Web%20version.PDF](http://www.health.gov.au/internet/safety/publishing.nsf/Content/windows-into-safety-and-quality-in-health-care-2010/$File/Windows%202010%20Web%20version.PDF)

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establishing ‘more effective reporting and monitoring of health service providers’.¹⁵ The Minister for Health and Ageing has explained that the Government expected that this would improve the quality of health care services and drive value for money in the health system.¹⁶

Structure, functions and operations of the National Health Performance Authority

The main functions of the Authority will be to monitor and publish reports on the performance of:

- local hospital networks;
- public hospitals;
- private hospitals;
- primary health care organisations; and
- other health care organisations providing health services.¹⁷

The Authority will make Hospital Performance Reports and Healthy Community Reports publicly available through the internet. It will also:

- formulate performance indicators to be used as measures of health service providers’ performance
- collect, analyse and interpret performance data
- promote, support, encourage, conduct and evaluate research relating to the performance of health service providers, and
- advise the Minister of Health and Ageing on the performance of health services providers.

Under the proposed legislation, if the Authority produces a report that shows providers are performing poorly when measured against selected indicators, the Authority must give a copy of the draft report to the manager of the entity or facility, and invite them to provide written comments on the report within 30 days. The legislation does not specify any timeframes within which the Authority must make performance reports publicly available.

The powers of the Authority will be limited to those of the Commonwealth Government in health care.¹⁸ This is important because most health services are provided by the state and territory governments, the private sector and non-government organisations (public hospitals, for example,

15. N Roxon, ‘Second reading speech: National Health Reform Amendment (National Health Performance Authority) Bill 2011’, House of Representatives, *Debates*, 3 March 2011, p. 1, viewed 11 March 2011, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F2011-03-03%2F0012%22>

16. *ibid*

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

18. Refer to **proposed section 67** and **proposed section 64** of the Bill. This is further discussed in the Main Provisions, under the heading ‘Chapter 3 – National Health Performance Authority’.

are owned and operated by the state and territory governments, many primary health care services are delivered by private practitioners, and some community health services are provided by non-government organisations). This means that the Authority, as a Commonwealth agency, will not have access to data on the performance of health care providers, nor will it have any powers to force health care providers to supply relevant data. Instead, the Authority will have to rely on the state and territory governments, private providers and NGOs to supply timely and accurate performance data. These same arrangements underpin the existing arrangements in place for performance monitoring and reporting in health care, including those for the MyHospitals website.

The Authority will be made up of 7 members – a Chair, Deputy Chair and 5 other members – all of them appointed by the Minister for Health and Ageing. In addition, the appointment of the Deputy Chair will require the agreement of state and territory Premiers and Chief Ministers. The appointment of other members will require the agreement of the Prime Minister and state and territory Premiers and Chief Ministers. The Minister for Health and Ageing will be responsible for ensuring that at least one member of the Authority has expertise and significant standing in the field of regional and remote health care. Members will be appointed for a period of no longer than 5 years.

The Authority will have a full-time CEO responsible for the day-to-day administration. The CEO will be appointed by the Minister for Health and Ageing for a period of no more than 5 years. The CEO will not be a member of the Authority. Staff of the Authority will be engaged under the *Public Service Act 1999*, and the Authority will be able to engage consultants and establish advisory committees to assist it carry out its functions.

Committee consideration

The Bill has been referred to the House of Representatives Standing Committee on Health and Ageing for inquiry. Details of the inquiry are at the [inquiry webpage](#).¹⁹ The Committee convened a sub Committee which held one public hearing. Officials from the Department of Health and Ageing appeared as the only witnesses (the transcript of the hearing is available [here](#)). Eight submissions were made to the Inquiry and these are [publicly available](#).

Policy position of non-government parties/independents

At the time of writing, the position of the Opposition was not clear. When the legislation was introduced into the House of Representatives, the Opposition stated that it would consider the

19. Parliament of Australia, House of Representatives Standing Committee on Health and Ageing, *Inquiry into National Health Reform Amendment (National Health Performance Authority) Bill 2011*, House of Representatives Standing Committee on Health and Ageing website, viewed 11 March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/index.htm>

legislation in 'due course' and that it was 'interested' in the findings of the (House of Representatives) Inquiry.²⁰

During the Senate debate about the establishment of the ACSQHC, the Greens expressed their interest in obtaining further details about the relationship between the National Health Performance Authority and the ACSQHC.²¹ This was to ensure that the work of the agencies was complementary. The Greens also expressed an interest in whether the accountability framework for the National Health Performance Authority would be legislated and noted the challenges associated with establishing a nationally consistent approach.

The Independents (Messrs Crook, Katter, Oakeshott, Wilkie, Windsor) and the Greens (Mr Bandt) have previously voted with the Government on matters relating to health reform, such as the establishment of the ACSQHC but it is not clear if this tradition will continue. No public statements have been released by the Independents in relation to this Bill. The position of the Greens on this Bill is also not yet known.

Summary of submissions made to the House of Representatives Inquiry

The submissions made to the House of Representatives Inquiry into the Bill were broadly supportive of the establishment of the National Health Performance Authority. However, the submissions raised a number of concerns:

- Composition of the Authority

The majority of submissions were concerned that specific groups or organisations were not specified in the composition of the Authority. For example, the Consumers Health Forum (CHF) advocated for consumer representation on the Authority²² and the Australian Medical Association – Federal (AMA) suggested that at least one member of the Authority should be nominated by the AMA and the legislation amended accordingly.²³ The views of the submitters are perhaps best represented by Catholic Health Australia (CHA) who argued that the composition of the Authority should include: persons with substantial knowledge and experience in the operation of public hospitals, private hospitals, primary health care and provision of private

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20. P Dutton, *What health reform?*, media release, 3 March 2011, viewed 11 March 2011, <http://www.peterdutton.com.au/MediaHub/MediaReleases/tabid/75/articleType/ArticleView/articleId/193/What-health-reform.aspx>
 21. R Siewert, 'Second reading speech: National Health and Hospitals Network Bill 2010', Senate, *Debates*, 2 March 2011, p. 84, <http://www.aph.gov.au/hansard/senate/dailys/ds020311.pdf>
 22. Consumers Health Forum of Australia (CHF), Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub02.pdf>
 23. Australian Medical Association (AMA), Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub05.pdf>

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or non-government health care services.²⁴ CHA also suggested that this should be prescribed by legislative instrument.

- Powers of the Authority

The AMA argued for the Authority to have sufficient powers to improve data integrity and reduce data manipulation, including the naming of states that did not provide data in a nationally consistent format.²⁵ They also argued for the Authority to be given powers to audit data provided by State governments and prosecute officials for the provision of incorrect or inaccurate data.²⁶ To improve overall health system performance, the AMA suggested that the Authority provide feedback to health care providers on a regular basis. This was supported by the Business Council of Australia (BCA) who suggested that the Authority should have the capacity to recommend changes to improve the functioning of the sector.²⁷

- Clarification of the relationship among the various health governance authorities and other Government agencies

A reoccurring theme of the submissions was the lack of clarity among the various health governance authorities to be established by the Government. As a corollary to this, the BCA argued that there was a lack of clarity about the focus and objectives of the Authority.²⁸

Stakeholders raised concerns that the relationship between various organisations such as the Australian Commission on Safety and Quality in Health Care, the Australian Council on Healthcare Standards, the Australian Institute of Health and Welfare and the Australian Bureau of Statistics were not articulated or clarified in the proposed Bill.²⁹ Many stakeholders advocated strongly for

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24. Catholic Health Australia, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub08.pdf>
 25. Australian Medical Association (AMA), Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub05.pdf>
 26. Australian Medical Association (AMA), Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub05.pdf>
 27. Business Council of Australia (BCA), Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub04.pdf>
 28. BCA, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub04.pdf>
 29. See, for example, Catholic Health Australia, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub08.pdf>

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a nationally consistent set of performance indicators with the collection of information by a single, national body.³⁰

- Engagement with relevant stakeholders on the development of rules and performance indicators

Reflecting concerns about adequate representation on the Authority, stakeholders sought to ensure adequate consultation in the development of any rules, performance indicators and standards to be developed by the Authority. It was considered appropriate that consultation with relevant stakeholders should be prescribed in legislation.³¹

- Performance management

Concern was raised that the Bill does not seek to define poor performance³² or how performance might be measured.³³ The AMA argued that the performance indicators developed by the Authority should be subject to parliamentary scrutiny.³⁴ The BCA noted that the remit of the Authority did not extend to the entire health care sector and this was considered a limitation to improving overall performance of the health care system.³⁵ The Australian General Practice Network and CHA both noted that 'poor performance' can be the result of extrinsic factors over which a health care provider has little or no control.³⁶ It was suggested that these factors needed to be taken into account when considering underperformance. The Australian Council on Healthcare Standards advocated for consistent, complete and accurate reporting of

30. See, for example, Australian Private Hospital Association, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011,

<http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub01.pdf>

31. See, for example, submissions from the AMA and CHF

32. National Primary Health Care Partnership, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011,

<http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub06.pdf>

33. CHF, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub02.pdf>

34. AMA, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub05.pdf>

35. BCA, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub04.pdf>

36. Australian General Practice Network, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub07.pdf> and CHA, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub08.pdf>

underperformance in a timely manner.³⁷ It was argued that the timing of reporting about underperformance was important to improving performance.³⁸

Stakeholder commentary about health system governance

The proposed arrangements for health reform have been subject to three Senate Inquiries and generated significant stakeholder interest.³⁹ One of the criticisms of the proposed package made in submissions and during public hearings was the lack of detail about how the various governance agencies will interact and the lack of integration between the various governance authorities.⁴⁰ The governance arrangements are unchanged from the previous health reform package and no additional detail has been provided in the proposed Bill.

Many of the concerns raised previously by stakeholders remain pertinent. The submission by Catholic Health Australia (CHA) to the Senate Community Affairs Committee inquiry raised a number of issues which have not been addressed by the Bill. CHA highlighted that there were no policy mechanisms to compel the not for profit private sector to comply with the performance framework.⁴¹

CHA also advocated for 'clearly articulated goals and objectives' for the development of performance standards and monitoring frameworks as well as strong clinician and expert input into their design, implementation and ongoing evaluation.⁴² This concern was echoed by Professor David Pennington who noted that medical practitioners, university medical school and health science faculties were not mandated in the clinical governance aspects of the National Health Performance Authority.⁴³ Involvement of medical practitioners in hospital clinical governance was considered a

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37. Australian Council on Healthcare Standards, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub03.pdf>
38. Australian Council on Healthcare Standards, Submission to the *Inquiry into the National Health Reform Amendment (National Health Performance Authority) Bill 2011*, March 2011, <http://www.aph.gov.au/house/committee/haa/billhealthreform/subs/sub03.pdf>
39. The following Senate Committees have conducted inquiries into the proposed arrangements for health reform: [Senate Community Affairs Committee](#), [Senate Finance and Public Administration Reference Committee](#), [Senate Economics Legislation Committee](#) (this Inquiry focussed on the financial aspects of the NHHN package, namely the proposed arrangements for GST). Each of these Inquiries received submissions and conducted public hearings.
40. Senate Community Affairs Committee, *Inquiry into the National Health and Hospitals Network Bill 2010 – Final Report*, November 2010, http://www.aph.gov.au/Senate/committee/clac_ctte/Nat_hlth_hospital_network_43/report/c01.htm#anc8, paragraphs 1.45-1.50. In addition, there was widespread consensus among stakeholders that the legislative arrangements for each governance authority should be considered as a single package.
41. Catholic Health Australia (CHA), Submission to Senate Community Affairs Legislation Committee, *Inquiry into the National Health and Hospitals Network Bill 2010*, November 2010, viewed 11 March 2011, <https://senate.aph.gov.au/submissions/committees/viewdocument.aspx?id=04af6b11-f211-4e2b-bee2-0b7fa3d3ccba>
42. Ibid
43. D Pennington (Prof), Submission to the Senate Finance and Public Administration Committee, *Inquiry into COAG reforms relating to health and hospitals*, June 2010, viewed 11 February 2011,

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necessary prerequisite for improving the quality of health care and clinical governance in Australian hospitals. He also argued that centralised reporting would be ‘expensive and largely ineffective’ and raised concerns about how reporting would translate into changes at the local hospital level.⁴⁴

In broader discussions about improved transparency and accountability, such as the MyHospitals website, commentators have argued that ‘meaningful’ data is required.⁴⁵ Measures such as waiting lists and emergency waiting times are not considered appropriate measures of quality by some commentators.⁴⁶ Although greater transparency and accountability in the Australian health care system is broadly endorsed by stakeholders, careful design so that improvements in system performance can be achieved is considered a pre-requisite.⁴⁷

The AMA is supportive of a stronger framework for transparent reporting. In addition to the comments made in the submission made to the House of Representatives Inquiry, previous submissions to Government have indicated the AMA’s support for national monitoring of public hospital performance and the development of national targets and performance indicators.⁴⁸ It was envisaged by the AMA that the development of targets and performance indicators would be a joint effort between Commonwealth, State and Territory governments. More recently, the AMA has argued that performance monitoring of public hospitals should not come at the expense of patient care and that sufficient resourcing will be required to achieve performance targets.⁴⁹

Financial implications

The 2010-11 Budget allocated \$118.6 million over four years for the establishment of the National Health Performance Authority.⁵⁰ The costs associated with the establishment of the National Health Performance Authority have been partially offset by the Government’s decision to cease the

<https://senate.aph.gov.au/submissions/committees/viewdocument.aspx?id=9300bcae-ced0-44d0-96a3-e6d184019548>

44. Ibid
45. See, for example, comments by Philip Davies and Tim Woodruff as part of a ‘Croaky’ blog post on [MyHospitals](#), 16 December 2010, viewed 11 March 2011.
46. See, for example, comments by Professor David Pennington as part of a ‘Croaky’ blog post on [MyHospitals](#), 16 December 2010, viewed 11 March 2011.
47. See, for example, CHA, Submission to Senate Finance and Public Administration Committee, *Inquiry into COAG reforms relating to health and hospitals*, May 2010, viewed 11 March 2011, <http://www.cha.org.au/site.php?id=915>, p. 8.
48. Australian Medical Association (AMA), *AMA Federal Budget Submission 2010-11*, January 2010, viewed 11 March 2011, <http://ama.com.au/system/files/node/5284/AMA+Federal+Budget+Submission+2010-11-2.pdf>
49. AMA, *AMA Federal Budget Submission 2011-12*, February 2011, viewed 11 March 2011, http://ama.com.au/system/files/node/6394/AMA+Budget+Submission+2011-12_FINAL-3.pdf
50. Explanatory Memorandum, op. cit., p. 2

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Hospital Accountability Performance Program, a saving of \$9.1 million.⁵¹ The estimated net cost for the Authority is \$109.5 million over four years.⁵²

Main issues

Effective health system governance

According to the Minister for Health and Ageing, the National Health Performance Authority will exist to 'improve quality, increase transparency and drive value for money in the health system'.⁵³ It is unlikely that the Authority, as a single entity, will be able to achieve these objectives; its main role is to make performance standards in the health system more transparent by publishing reports and nationally consistent data. To achieve the other stated objectives – improved quality and better value for money – the National Health Performance Authority will have to work closely with other national governance agencies, particularly the Australian Commission on Safety and Quality in Health Care and the proposed Independent Hospital Pricing Authority.

This Bill does not provide any details on how the three national governance agencies will work together to deliver improvements in the Australian health system. Nor does it explain how the new public reporting mechanisms will affect existing ones such as those listed in the section above. Some outstanding questions about national governance of the health system that have yet to be answered include:

- How will data sharing arrangements between the three national governance agencies work?
- Will one of the three national governance agencies be responsible for pooling and assessing data from all agencies? If so, how will data on costs, quality and safety, and compliance with clinical standards be combined and evaluated?
- What mechanisms will be put into place to resolve conflicts that might emerge over the 'efficient' price of hospital services and the need to ensure health services meet safety and quality standards?

The Government's approach to improving performance in the health system relies heavily on public reporting. In her second reading speech, the Minister for Health and Ageing explains some of the ways public reporting can stimulate providers to improve standards. They include:

- identifying high performers and transferring their successes to other areas;

51. Explanatory Memorandum, op. cit., p. 2

52. Explanatory Memorandum, op. cit., p. 2

53. N Roxon, 'Second reading speech: National Health Reform Amendment (National Health Performance Authority) Bill 2011', House of Representatives, *Debates*, 3 March 2011, p. 2, viewed 11 March 2011, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F2011-03-03%2F0012%22>

- identifying areas of poor performance so that action can be taken; and
- providing information so that people can make more informed choices.⁵⁴

Internationally, one of the most common forms of public reporting in health care is publishing scorecards or league tables. This Bill does not make any suggestion that the National Health Performance Authority would publish data in this form, and the existing MyHospitals website does not publish scorecards or league tables. However evidence on the impact of scorecards and league tables is relevant to discussions about public performance reporting in health care.

There is some evidence that public performance reporting can stimulate providers to improve the quality of care. In the United States, for example, some researchers have found that when information on mortality rates after cardiac surgery was publicly released, hospitals with poor results made changes and improved the quality of care.⁵⁵ In contrast however, other researchers have found that publishing performance report cards did not lead to improved performance.⁵⁶ Researchers conclude that one of the keys to success with public reporting is to think carefully about the connections between ‘upstream’ factors, such as the design and implementation of performance monitoring systems, and ‘downstream’ factors, such as ways of achieving quality improvements in health care services.⁵⁷

It is not yet clear how the ‘upstream’ National Health Performance Authority proposed in this Bill will connect with ‘downstream’ factors, namely health care providers. In the most extensive discussion to date on the role of the Performance Authority, the Government stated that:

Hospital Performance Reports and Healthy Community Reports will help Australians make more informed choices about their health services. They will clearly and quickly identify areas of high performance, and support the spread of effective and innovative practices across the country. They will help ensure that the standard of care patients receive continues to improve. Transparent reporting will also allow poor performance to be quickly and easily identified, so that interventions can be made before problems become entrenched’.⁵⁸

This Bill, however, does not give the Authority any enforcement powers; it cannot compel state and territory governments, private and non-government organisations to provide performance data, and it cannot compel individual providers to make changes that will lead to better performance. Whilst it

54. *ibid*

55. See for example: CH Fung, Y-W Lin, S Mattke, C Damberg, PG Shekelle, ‘Systematic review: The evidence that publishing patient care performance data improves quality of care’, *Annals of Internal Medicine*, vol. 148, 2008, p. 111-123.

56. See for example: WA Ghali, AS Ash, RE Hall, MA Moskowitz, ‘Statewide quality improvement initiatives and mortality after cardiac surgery’, *Journal of the American Medical Association*, vol. 277, 1997, pp. 379-382; M Moscucci, KA Eagle, D Share, D Smith, AC De Franco, M O’Donnell et al, ‘Public reporting and case selection for percutaneous coronary interventions: an analysis from two large multicentre percutaneous coronary intervention databases’, *Journal of the American College of Cardiologists*, vol. 45, 2005, pp. 1759-1765.

57. Fung, Lin, Mattke, et al, *Annals of Internal Medicine*, 2008.

58. Australian Government, ‘A National Health and Hospitals Network for Australia’s future: delivering better health and better hospitals’, Canberra, 2010, p. 47.

is unreasonable to expect that a national governance agency or national performance and accountability framework will be able to directly change practice on the ground level, it is important to understand what mechanisms will be established to help diffuse innovations in health care. The Government has not yet explained what types of interventions will be made to resolve performance problems, how these interventions will be implemented and who will be responsible for evaluating their effect. The issue of connecting performance standards and practice is particularly pertinent to the private and non-government sectors (both of which play a significant role in health care service delivery) where governments have less direct control and influence over providers' day-to-day practice.

Data collection and reporting

The National Health and Hospitals Network (NHHN) Agreement sets out the Performance and Accountability Framework (Schedule D) and National Governance (Schedule E) for the new arrangements.⁵⁹ Under clause 64 of the Heads of Agreement – National Health Reform, these are still in effect. Schedule D notes that the Commonwealth will provide data to the National Performance Authority regarding primary care organisations and the states will provide data about local hospital networks. The data to be provided includes patient level and hospital level service data and financial payment and other financial information relating to the provision of services by public hospitals and primary care organisations.⁶⁰ The National Performance Authority will then publish reports based on this information (**proposed subsection 60 (1) (b)**). Information provided to the National Performance Authority may also be provided to the COAG Reform Council. This raises questions about the role of the Commonwealth in relation to the provision of data to the Authority and what structures (or agencies) will be established to enable the Commonwealth to collect this information.

It is unclear how many primary health care providers will be monitored directly by the National Health Performance Authority. Medicare Locals have a coordination role but are not responsible for delivery of primary health care. Currently, the reporting responsibilities for Medicare Locals are in relation to the development of 'Healthy Communities Reports'. Although the reporting framework is not yet agreed by COAG, it is envisaged that the reporting framework will reflect service and financial standards and Medicare Locals, over time, will be subject to performance management arrangements.⁶¹ Despite this, Medicare Locals have no real performance monitoring powers over state, private and non-government providers in their local area, irrespective of whether they are part of a Medicare Local.

59. Council of Australian Governments, *National Health and Hospitals Network Agreement*, April 2010, viewed 11 March 2011, http://www.federalfinancialrelations.gov.au/content/related_agreements/NHHN_Agreement.pdf

60. *Ibid.*, D6, p. 35.

61. Department of Health and Ageing, *Guidelines for the operation and establishment of Medicare Locals*, 2011 Medicare Locals, Invitation to Apply #248/1011, pp 11.12. [http://www.health.gov.au/internet/main/publishing.nsf/Content/grantITA2491011/\\$FILE/Medicare%20Locals%20Guidelines%20and%20Information%20for%20applicants.doc](http://www.health.gov.au/internet/main/publishing.nsf/Content/grantITA2491011/$FILE/Medicare%20Locals%20Guidelines%20and%20Information%20for%20applicants.doc),

The NHHN also notes that the National Performance Authority will provide quarterly public reports (clause E24, Schedule E) on every local hospital network and every hospital in the network, every private hospital and every primary health care organisation. This represents a significant reporting burden for these organisations which may be in addition to what is already required from State health departments. The frequency of reporting by the National Performance Authority is not specified in the legislation and this has not yet been determined. As has been previously noted, the National Health Performance Authority is reliant on the goodwill of these organisations to provide information in a timely manner.

Private hospitals

Clause D8 of Schedule D (NHHN) notes that the arrangements governing private hospitals under the National Performance Authority and the Independent Hospital Pricing Authority will be set out in the legislation establishing these bodies. Currently, the proposed legislation is silent on the arrangements for private hospitals. It may be that the Commonwealth is relying on the states to ensure the provision of information from private hospitals as they have overarching responsibility for local hospital networks. However, arrangements for private hospitals in local hospital networks vary from state to state. Most states have developed safety and quality reporting frameworks with which private hospitals must comply, yet the extent to which this information will be shared, if at all, with the National Health Performance Authority is not known.

Many private hospitals in Australia are accredited by the Australian Council on Healthcare Standards (ACHS) and provide regular reports against quality standards. Participation in accreditation processes is voluntary. Summaries of these reports are made publicly available but information is de-identified. Although ACHS is an independent organisation, it is not clear whether information will be shared between these two agencies or what arrangements might be established to streamline some of the reporting requirements for private hospitals. It is intended that the National Health Performance Authority will monitor and prepare reports on private hospitals, yet the lack of any specific provision regarding private hospitals in the proposed Bill perhaps highlights the jurisdictional limits of the Commonwealth. It should be noted, however, that some private hospitals in Australia voluntarily report data to the MyHospitals website and participate in accreditation processes. Much of this information is publicly available.

Key provisions

Schedule 1 – Amendments

National Hospitals Health and Network Act 2011

Chapter 1 - Preliminary

Items 6 to 35 of the Bill insert (or repeal and substitute) definitions for various terms used in the Act, including:

- local hospital network: the proposed definition makes provision for the Minister to declare a body a LHN despite their not being a body corporate established by a law of a State or Territory and known as a LHN. Such a body is to be specified in a legislative instrument, which is disallowable. This is designed to allow for states which use different terminology and, or seek to establish a network of hospitals on a non-statutory basis, to be treated as a LHN under the Act
- personal information: this has the same meaning as it does in the Privacy Act 1988
- primary health care organisation: means a body or organisation of a kind specified in a legislative instrument made by the Minister
- the terms private hospital and public hospital refer to a facility specified in a legislative instrument made by the Minister
- protected Commission information refers to information that was obtained by a person in their capacity as an official of the Commission and relates to the affairs of a person, other than an official of the Commission. There is also a parallel definition for protected Performance Authority information.

Chapter 2—Australian Commission on Safety and Quality in Health Care

Part 2.7—Secrecy

Item 127 proposes the insertion of a **Part 2.7** dealing with issues of secrecy and disclosure of information.

Basically, it is an offence for a person who is or has been an official of the Commission and has obtained protected Commission information in that capacity, to disclose that information to another person, or to use that information. The penalty is two years imprisonment or 120 penalty units⁶² or

62. Breaches of statute law in Australia are usually prescribed in terms of **penalty units**. The unit value is reviewed every year to allow fines to keep pace with inflation.

both (**proposed subsection 54A(1)**). However, it is not an offence for an official of the Commission to use or disclose information if it is authorised by Part 2.7 of the Act, or if it is done in compliance with a requirement under a law of the Commonwealth, or a prescribed law of a State or Territory (**proposed subsection 54A(2)**).

Parallel provisions to those above, circumscribing the use and disclosure of protected Commission information by a person who is a member of a committee established under section 50, are created by **proposed subsection 54C**. As above, the penalty is two years imprisonment or 120 penalty units or both (**proposed subparagraph 54C(2)(c)**). However, it is not an offence to use and disclose protected Commission information for the purposes of the Act, or in the performance of functions of the committee under the Act, or in the course of a person's service as a member of the committee **proposed subsection 54C(3)**.

Exceptions from the offence Part relating to disclosure of protected Commission information include:

- disclosure or use for the purposes of the Act, for the performance of the Commission's functions, or in the course of the official's employment or service with the Commission (**proposed subsection 54B**)
- disclosure to a Commission committee (**proposed subsection 54C**)
- disclosure to the Minister (**proposed subsection 54D**)
- disclosure to the Treasurer (**proposed subsection 54E**)
- disclosure to the Secretary or an APS employee of the Department authorised to receive it (**proposed subsection 54F**)
- disclosure to a Royal Commission (in which case the Chair of the Performance Authority can impose conditions on the use of the information) (**proposed subsection 54G**)⁶³
- disclosure of information about the affairs of a person if the person has consented (**proposed subsection 54K**)
- disclosure of information that is already lawfully publicly available (**proposed section 54L**).

The list above is supplemented and the scope of exceptions, sufficiently widened with regard to disclosure by another two circumstances. Firstly, where the Chair of the Commission is satisfied⁶⁴ that particular protected information will assist one of a number of specified agencies, bodies or individuals to perform or exercise their powers or functions (**proposed section 54H**). Secondly, where the Chair of the Commission is satisfied that particular protected information will assist one of a number of specified agencies, bodies or individuals to research, that information may be disclosed, so long as it does not make it possible to identify a particular patient (**proposed section 54J**).

63. Because such conditions would be limited to a particular case and do not represent a general statement of the law, they are not a legislative instrument.

64. However, the Bill is silent as to examples of the considerations that might satisfy the Chair of the Commission that particular protected information should be disclosed.

Chapter 3—National Health Performance Authority

This newly inserted chapter establishes the National Health Performance Authority ('the Authority') and provides for its functions, powers and liabilities.

Proposed section 60 provides that the Authority has functions which include and entail

- monitoring, preparation and publication of reports on matters relating to the performance of
 - Local hospital networks
 - Public hospitals
 - Private hospitals
 - Primary health care organisations
 - Other bodies or organisations that provide health care services
- formulation of indicators, and also the collection, analysis and interpretation of information to be used in the Authority's monitoring and reporting functions. Such indicators are not legislative instruments
- promoting, supporting, encouraging, conducting and evaluating research for purposes in connection with the performance of the Authority
- such functions (if any) as are specified in a written instrument given by the Minister, though such an instrument is not a legislative instrument
- providing advice at the Minister's request, about matters relating to any of the functions of the Performance Authority
- anything incidental or conducive to the performance of the abovementioned functions.

Proposed section 65 provides that the Minister may, by legislative instrument, make rules to be complied with by the Authority in performing its monitoring and reporting functions.

Proposed section 66 provides that the Minister may, by legislative instrument, direct the Authority to formulate performance indicators.

Proposed section 67 states that the Authority has the power to do all things necessary or convenient to be done for, or in connection with, the performance of its functions. This should be read in the context of the constitutional limits listed in **proposed section 64**. Section 64 circumscribes the performance of Commission's functions to the constitutional grounds stipulated. It seems therefore, that the practical effect will be that, the power of the Authority will be limited to those of the Commonwealth Government in health care.

Part 3.3—Constitution and membership of the Performance Authority

In light of the concerns raised about the Commission having the appropriate expertise to fulfil its objectives⁶⁵ it is unclear as to why **proposed subsection 72(4)** makes a requirement that the Minister must ensure that

- at least one member of the Performance Authority has substantial experience or knowledge and significant standing in the following fields
- health care needs of people living in regional or rural areas,
- the provision of health care services in regional or rural areas.

It could be argued that at least two (or more) members of the Authority should possess such experience or knowledge and significant standing in those fields. Furthermore, the drafting of the Bill is such that it is unclear as to whether that minimum one person must possess that knowledge and standing in both of those fields or only one of them. If it is necessary to only possess knowledge or experience and standing in one of those fields, then in light of the requirement that there only be at least one such member, this may very well affect the outcomes of the Authority's work and the extent to which it can achieve its objectives. The Bill is otherwise silent on the qualifications and experience expected of other members of the Authority.

Part 3.4—Terms and conditions for members of the Performance Authority

This Part contains provisions relating to conditions of employment including: remuneration, leave of absence and resignation. The requirements for timely disclosure of interests to the Minister and the Performance Authority, by a member of the Authority are spelt out (**proposed section 77**). There are also provisions relating to approval by the Minister being required for outside employment by a full-time member of the Authority. Where part-time members of the Authority are engaging in other paid employment, they are under a duty to avoid a conflict of interest.

Proposed section 81 states that a Minister may at any time terminate the appointment of a member of the Authority. However, examples of the kinds of considerations that would invite such a decision are not spelt out. This contrasts with **clause 26** of the NHHN Bill which explicitly lists the circumstances under which a Minister *must* terminate the appointment of a Board member, in addition to providing the Minister with a Minister *discretionary* power to terminate for misbehaviour, or physical or mental incapacity.

Part 3.7 deals with the role, appointment, outside employment, disclosure of interests, and termination of appointment of the Chief Executive Officer.

65. Senate Community Affairs Committee, *Inquiry into the National Health and Hospitals Network Bill 2010 – Final Report*, November 2010, http://www.aph.gov.au/Senate/committee/clac_ctte/Nat_hlth_hospital_network_43/report/c01.htm#anc8

Part 3.10—Reporting obligations of the Performance Authority

Part 3.11—Planning obligations of the Performance Authority

These Parts contain provisions requiring among other things, that the Minister to be kept informed of the operations of the Authority (**proposed section 109**). The Authority must produce an annual report and a strategic plan (**proposed sections 111 and 112**). Where the Authority provides advice to the Minister about a particular matter under subparagraph 60(1)(g),⁶⁶ within 12 months after that time, the Authority must prepare a statement to the effect that the Performance Authority gave advice about that matter to the Minister and publish the statement on its website (**proposed section 110**). To be sure, this is a statement that advice was given to the Minister on a particular matter, it is not the content of the advice which must be published. From the perspective of transparency and accountability, it is unclear as to why such a length of time must pass before such a statement is published, and why it is that the timeframe cannot be six months (or less), for example.

Part 3.12—Secrecy

This part contains secrecy and disclosure provisions relating to protected Performance Authority information that basically mirror those in Part 2.7 of Chapter 2.

Chapter 4—Miscellaneous

This chapter contains provisions designed to protect patient confidentiality.

Concluding comments

The purpose of the National Performance Authority was originally envisaged to undertake ‘comparative analysis across jurisdictions, identify best practice and focus on the achievement of results.’⁶⁷ Section 42 of the Heads of Agreement – National Health Reform, notes that the National Performance Authority will ‘develop and produce reports on the performance of hospitals and health care services, including primary care services.’⁶⁸ Apart from the reporting function of the Authority prescribed at **proposed section 60 (1) (a)**, the legislation does not appear to reflect the initial remit of the Authority, except in very broad terms (see **proposed section 60 (1) (d) and (e)**). It appears that there is a lack of clarity about the role and function of the Authority as the Minister’s Second Reading speech noted that the National Health Performance Authority will exist to ‘improve

66. This subparagraph requires the Authority, at the request of the Minister, to advise the Minister about matters relating to any of the functions of the Performance Authority.

67. Council of Australian Governments, *National Health and Hospitals Network Agreement*, April 2010, viewed 11 March 2011, http://www.federalfinancialrelations.gov.au/content/related_agreements/NHHN_Agreement.pdf, E25, p. 41.

68. Council of Australian Governments, *Heads of Agreement – National Health Reform*, February 2011, p. 7, viewed 11 March 2011, http://www.coag.gov.au/coag_meeting_outcomes/2011-02-13/docs/communique_attachment_20110213.pdf

quality, increase transparency and drive value for money in the health system.’⁶⁹ This differs to what has been previously outlined by Government.

The operation of the National Health Performance Authority is limited to the powers of the Commonwealth Government in health care. Simply put, the National Health Performance Authority will be reliant on the state and territory governments, private providers and NGOs to supply timely and accurate performance data. Although such arrangements exist for the MyHospitals website, it remains to be seen whether they can be sustained in the long term and successfully extended to private providers and NGOs.

The Bill does not provide any guidance about how the proposed governance agencies will work together to deliver improvements in the Australian health system. This lack of detail combined with the lack of power attributed to the Authority raises questions about the extent to which the Authority can achieve its objectives as set out in the Bill (see **proposed section 60**) or as articulated by Government.

69. N. Roxon, op cit

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