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

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

Date introduced: 24 August 2011
House: House of Representatives
Portfolio: Health and Ageing

Commencement: Sections 1 to 3 on the day of Royal Assent. Schedule 1 to commence on a single day to be fixed by Proclamation but not before the commencement of Schedule 1 to the National Health Reform Amendment (National Health Performance Authority) Act 2011. However, if the provision(s) do not commence within 6 months, beginning on the latter of Royal Assent or the commencement of Schedule 1 to the National Health Reform Amendment (National Health Performance Authority) Act 2011, they commence on the day after the end of that period.

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 amends the National Health Reform Act 2011 to establish the Independent Hospital Pricing Authority (IHPA). The functions, power and responsibilities of the IHPA are detailed in the Bill.

Background

One of the features of the Government’s health reform package first announced in 2010 was the introduction of activity based funding (ABF) and a ‘nationally efficient price’ for the payment of public hospital services. This was to be determined by an independent body, the IHPA.

ABF funds hospitals on the basis of the activity they perform.\(^1\) In Victoria and South Australia it is the dominant funding model for hospitals but there is a considerable amount of activity not funded by

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ABF, for example, teaching, research and public health and health promotion services. Other states and territories have some type of ABF model in place.

ABF relies on a classification system, known as the Australian-Refined Diagnosis Groups, to define and count hospital activity. Each patient classified according to their diagnosis, surgical procedures and other data. There are around 670 patient classes with a different price paid for each one.

### Basis of policy commitment

The more contentious aspects of the Government’s reform package agreed by Council of Australian Governments’ (COAG) in April 2010 have been abandoned but commitment to the introduction of ABF has remained. Under the National Health Reform Agreement (NHRA) signed by COAG in August 2011, a national approach to ABF will commence from 1 July 2012. The nationally efficient price will be used to determine the Commonwealth’s contribution to hospital funding.

The IHPA is one of three national governance authorities established under the National Health Reform Agreement. The Australian Commission on Safety and Quality in Health Care has already been established and the legislation to establish the National Health Performance Authority is before the Senate. This Bill will establish the IHPA.

The purpose of these governance agencies is to monitor the performance of the health care system and improve transparency and accountability. One of ongoing criticisms of these agencies is the lack of detail about how these agencies will work together to deliver improvements to the Australian health system. This Bill does not provide any additional detail.

An Interim IHPA has commenced operation as an executive agency of the Department of Health and Ageing. The Government has appointed the Chair (Mr Shane Solomon), Deputy Chair (Mr Jim Birch) and Interim CEO (Dr Tony Sherbon).

### Operation of the IHPA

The amendments to the National Health Reform Act 2011 set out the IHPA’s functions, powers and responsibility. The main function of the IHPA is to determine the nationally efficient price for public hospital services that are funded by ABF. Other responsibilities include: calculation of block funding

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2. Ibid.
3. Ibid.
4. Ibid.

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amounts\(^7\) for hospitals not funded by ABF, advice on loadings to the efficient price to take into account variations in the cost of delivery (that is, in rural areas), development of the data and reporting standards for state and territory health departments and investigation into cost-shifting disputes. The full list of functions of the IHPA is at **proposed subsection 131** of the Bill.

One of the roles of the IHPA is to provide advice\(^8\) to state and territory governments about the efficient price for a procedure or operation in a public hospital. The Commonwealth will use the nationally efficient price to determine the Commonwealth’s contribution to growth funding for public hospitals. Under the NHRA, the Commonwealth agreed to fund 45 per cent from 1 July 2014 of the efficient growth of hospital services, rising to 50 per cent until 1 July 2017 (clause A3, NHRA). In short, the efficient growth is the increase in price from the base price (as determined by the IHPA in 2012).

**Main issues**

The IHPA does not determine the payments by the states for public hospital services, as highlighted in the submission by Catholic Health Australia (CHA) to the Senate Inquiry into the Bill. The advice provided by the IHPA is not binding on the state and territory governments and the price paid by state and territory governments to hospitals will be at their discretion. CHA has argued that this could lead to uncertainty about the contribution by state and territory governments to the funding of public hospitals.\(^9\) Despite the introduction of a nationally efficient price, it is likely that debates about the adequacy of public hospital funding by each level of government will continue for some time.

**Proposed Part 4.3** empowers the IHPA to investigate cost-shifting and cross-border disputes. The Bill defines cost-shifting (**proposed subsection 138 (1)**) and cross border disputes (**proposed subsection 138 (2)**) and sets out the process jurisdictions must follow to initiate an investigation by the IHPA (**proposed subsection 139**). It is silent, however, on what actions jurisdictions must take if they are found to be complicit in either cost-shifting or in a cross-border dispute. In the event of a cross-border dispute the IHPA may provide advice to the Commonwealth about funding adjustments (**proposed subsection 141** to relevant jurisdictions. The Commonwealth has limited powers with

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7. Block funding refers to hospitals being funded by grants or other means. It is not usually linked to ABF. For example, some rural hospitals are funded by grants which take into account the costs associated with operating hospitals in rural areas and low patient volumes.

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regard to the operation and management of public hospitals and is unable to compel a jurisdiction to make payments to other jurisdictions or alter their policy settings.

There are different approaches to the reporting of the results of investigations into cross-border and cost-shifting disputes by the IHPA. If a jurisdiction is found to be cost-shifting this advice is published on the IHPA’s website (proposed subsection 139(7)). Recommendations about cross-border disputes are given to Health Ministers (proposed subsection 140(6)) and are not publicly available. This would appear to undermine transparency and the extent to which these disputes can be resolved.

Two subcommittees will be established by the IHPA, the Clinical Advisory Committee (proposed Part 4.10) and the Jurisdictional Advisory Committee (proposed Part 4.11). Other committees, where necessary, can also be established under proposed subsection 205. The main function of both these committees is to provide advice to the IHPA on ‘developing and specifying classification systems for health care and other services provided by public hospitals’ (see proposed subsection 177(a) and proposed subsection 196(1) (a) (1) (i)), in addition to other duties prescribed in legislation. The Clinical Advisory Committee must table a report on its operations in Parliament (proposed subsection 193) on an annual basis but the same requirement does not apply to the Jurisdictional Advisory Committee.

The Jurisdictional Advisory Committee provides advice to the IHPA on a range of matters including: adjustments to the nationally efficient price to account for variations in delivering health care, advice on the standards and requirements in relation to provision of data by state and territory governments on public hospital services and the funding models for hospitals (see proposed subsection 196). Advice on these matters has the potential to be a source of great contention among jurisdictions and stakeholders and is likely to influence the calculation of the nationally efficient price. This lack of transparency limits the public scrutiny of the calculation of the nationally efficient price and associated loadings. It is unclear why the reporting standards for both committees are not identical.

Transparency and accountability

The perceived lack of transparency and accountability of the IHPA has been raised by many stakeholders in submissions to the Senate Inquiry and in public hearings. Minister Roxon has likened the IHPA to the ‘Reserve Bank’ of the public hospital system, yet this has been disputed.

10. See for example, submissions from Catholic Health Australia, the Consumers Health Forum and the Australian Healthcare and Hospitals Association, (AHHA) to the Senate Finance and Public Submission, Inquiry into the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011.
12. Australia Private Hospitals Association (APHA), Submission to the Senate Finance and Public Committee, Inquiry into the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011, Canberra, September

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by some stakeholders. It has been suggested that the IHPA’s decisions and advice should be published without delay or comment from Health Ministers. The proposed Bill expressly prohibits the IHPA from reporting publicly without giving Health Ministers 45 days to comment on draft reports (proposed subsection 211).

The IHPA must comply with requests from Health Ministers for reports or the information requests (proposed subsection 208). These reports may be published by the Minister who requested them but not by the IHPA (proposed subsection 208 (4)). A list of the information and advice provided by the IHPA must be included in the annual report of the IHPA which is tabled in Parliament (proposed subsection 210). The Australian Healthcare and Hospitals Association (AHHA) argues that any advice provided by the IHPA should be independent of (all levels of) government and should be publicly available, and, in particular, advice to states and territories about funding models for public hospitals.

CHA also supports full transparency of the IHPA and for the workings of the IHPA be public. To that end, CHA recommends that the proposed clause pertaining to confidential advice to Commonwealth, state and territory governments about future health care costs (proposed subsection 131 (1) (i)) be deleted. They argue that publication of future costs of health services may inform public debate and enhance scrutiny of expenditure on health services.

Representation on the IHPA and IHPA subcommittees

The constitution and membership of the IHPA are detailed in proposed Part 4.4.

The IHPA consists of nine members, including the Chair and Deputy Chair (proposed subsection 143). Each member is appointed by the Minister for Health (proposed subsection 144) with the agreement of the Prime Minister, Premiers and Chief Ministers (proposed subsection 144(3)). The Deputy Chair is to be appointed with the unanimous agreement of all Premiers and Chief Ministers (proposed subsection 144(2)). Each member of the IHPA is appointed for five years (proposed subsection 145). The Bill prescribes that at least one member of the IHPA has substantial experience and standing in either the health care needs or the provision of health care services in rural and regional areas (proposed subsection 144(4)).

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14. Ibid., AHHA
15. Ibid., AHHA
16. Ibid., AHHA
A number of stakeholders argued that their members should have representation on the IHPA and its committees. The Consumers Health Forum (CHF) advocated for consumer representation on the IHPA and each of its subcommittees and for a separate sub-committee for consumers to be established. The Australian Private Hospitals Association (APHA) highlighted the significant expertise of the private sector in the administration of ABF and noted the role that private hospitals play in the delivery of hospital services. This was considered grounds for representation on the IHPA. Similarly, CHA noted the role of non-government public hospitals such as Catholic public hospitals and contended that representation of Catholic public hospitals on the IHPA would be appropriate.

The Women's and Children's Hospital Australasia suggested that expertise in paediatrics would be integral to the IHPA and the Clinical Advisory Committee as current arrangements for ABF do not take into account the additional costs associated with treating children. Dr Kathryn Antioch noted the lack of representation from Aboriginal and Torres Strait Islanders on the IHPA and its subcommittees. She argued that hospital costs for treating Aboriginal and Torres Strait Islanders needed to be weighted accordingly in the calculation of the nationally efficient price.

Governance

Criticisms about the lack of clarity among the various health governance agencies are not new and have been canvassed in three previous Senate inquiries, a House of Representatives Inquiry and Bill Digests. Important questions remain about how the data sharing arrangements among the agencies will work and how conflicts between the efficient price and costs associated with safety and quality standards might be resolved.


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There is provision in the legislation for protected IHPA information (**proposed subsection 220**) to be shared with the Performance Authority, the Australian Safety and Quality Commission and a number of other government agencies. In its **submission** to the Senate inquiry for this Bill, the Department of Health and Ageing outlined the relationship between the various agencies.  

In short, it is limited to information sharing with the Australian Commission on Safety and Quality in Health Care and the National Health Performance Authority (as outlined in **proposed subsection 220**).  

The IHPA must also have regard to the work of the Australian Commission on Safety and Quality in Health Care when calculating the nationally efficient price. Beyond this, there are no formal mechanisms in the proposed legislation facilitate cooperation among the three health governance agencies.

To facilitate integration and cooperation among the various health governance agencies the Australian Institute for Primary Care and Ageing (AIPCA) recommended that a ‘duty of cooperation’ among the governance agencies be enshrined in legislation. This may improve coherence between the agencies and support the overall aim of improving the Australian health care system.  

It was also suggested that the advice of the IHPA should have regard to the Performance and Accountability Framework established by the COAG Reform Council and the Australian Commission for Safety and Quality in Healthcare. This was echoed by the AHHA who argued that safety and quality inputs are important determinants of price.

Both the Australian Medical Association (AMA) and the AIPCA note the lack of mechanisms in the proposed Bill to promote cooperation and information sharing between the various subcommittees and the IHPA. It is unclear what the procedures might be if there is conflicting advice provided to the IHPA by the sub committees. At the **public hearing** held by the Senate Inquiry the AMA argued that collaboration between the two committees was required and that the advice of one committee should not take precedence over the other.

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24. A reciprocal clause is included in the National Health Performance Authority Bill 2011.


26. This is outlined at Schedule C of the *National Health Reform Agreement* (NHRA). It defines the performance indicators for the NHRA and the reporting requirements for jurisdictions.


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Committee consideration

The Bill has been referred to the Senate Finance and Public Administration Committee for inquiry and report by 15 September 2011. Details of the inquiry are at the inquiry homepage. Submissions closed on 2 September 2011 and are publicly available. A public hearing was held on 7 September 2011 and the transcript is available here.

Policy position of non-government parties/independents

At the time of writing, the position of the Opposition, the Greens and the independents on this Bill was not clear. Previously the Opposition has argued that the Bills to establish the three governance agencies should be considered as a single package. The Greens and the independents voted with the Government to establish the Australian Commission on Safety and Quality in Health Care. The legislation to establish the National Health Performance Authority was passed by the House of Representatives with the support of the independents and the Greens and is currently before the Senate.

Financial implications

The 2010-11 Budget allocated funding of $91.8 million for the Pricing Authority and $118.6 million for the Performance Authority over four years.

30. See, for example, the motion moved by the Hon P Dutton on 27 October 2010 at the commencement of the debate about the National Health and Hospitals Network Bill 2010, which established the Australian Commission on Safety and Quality in Health Care. Refer to p. 1757 of House of Representatives Hansard.
31. Mr Katter was not present for the vote. Refer to p. 29 from the House of Representatives Hansard, 17 August 2011.

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