



AMA Submission on the Productivity Commission Draft Report: Introducing competition and Informed User Choice into Human Services: Reforms to Human Services

General Comments

The AMA welcomes the opportunity to provide further comments on the Productivity Commission's draft report about introducing concepts of user choice and competition to Australia's human services. Our comments are intended to be read in conjunction with our earlier submission in March 2017. We submit these written comments in place of attending the public hearings currently underway.

The proposed reform directions of interest to the AMA are those that impact on public hospitals and the surgeons who work there. The premise of the Commission's reforms is that the publication of risk adjusted clinical patient outcomes and public hospital performance data will empower patients and their GPs to channel demand for public hospital treatments for elective surgeries to high performing specialists/public hospitals. Further it assumes this will drive increased efficiencies and improved patient outcomes as specialists/hospitals compete for public patient market share and they benchmark themselves against their peers.

The AMA believes this rationale is flawed. Elective surgery public patients have limited opportunity to use outcome data even if it were published. In practice patients that elect *public patient* hospital treatment may be able to choose a specialists prior to their admission but can't specify the same surgeon to treat them in hospital. Choice of doctor is only available to admitted *private* patients – who are outside of the scope of the Commission's recommendations.

The only way a public patient could orchestrate a preferred hospital specialist is to delay admitted treatment and forego surgery booking offers until there is a match with their preferred surgeon. Similarly if a patient sought, and waited for, elective surgery in a different hospital catchment (however unlikely) they would still not be guaranteed a specific surgeon. Exercising choice in this context will only negatively delay patient treatment, blow out public

patient waiting lists and increase the cost of managing public patient elective surgery waiting lists. This is the exact opposite of improving patient outcomes and hospital efficiency.

The Commission has also ignored the significant risks of publishing specialist's public sector performance data before there is any evidence the methodology is able to disaggregate factors that collectively affect public patient outcomes. Public hospitals are large complex organisations managed by State and Territory Governments. The quality of patient care is influenced by the broader team involved in their treatment, not just the specialist. Hospital ICT systems, access to reliable and complete patient records, theatre booking systems, the professionalism and competence of theatre and ward nurses, doctor patient ratios that impact on the frequency of post-operative consults on the ward and budget allocation decisions within the public hospital. Individual surgeons do not make hospital management decisions or have direct influence over them.

If some public hospitals are still struggling to track patients who are transferred between hospitals and unable to guarantee completed discharge summaries are sent to the patient's GP – it is too early to suggest these organisations would have the ICT systems and management systems necessary to reliably separate and accurately report on patient clinical outcomes attributed to the specialist rather other hospital staff involved in the admission, or the impact of the hospital environment.

The model being proposed has the potential to encourage the avoidance of treating high-risk public patients - diabetics, patients who are morbidly obese, patients with complications due to delayed treatment or patients who live geographically distant from the hospital so it is not possible for the surgeon to control post discharge follow up care. Similarly surgeons may be concerned about working in under-funded public hospitals or low socio-economic areas where patient health status is worse than average. This would be counter to the principal of universal access to best available care on basis on clinical need - irrespective of ability to pay. The already long public hospital waiting lists would also likely get worse.

The AMA is similarly opposed to user ratings because they too risk unwarranted damage to a specialist's reputation. The Commission proposes the AIHW would moderate user ratings but it is not clear how AIHW could access the patient's clinical records to ensure specialists are not criticised for aspects of treatment they are not responsible for. It is noteworthy the Supreme Court of NSW awarded a medical practitioner close to half a million dollars after being defamed by a discontented former patient in a targeted social media campaign. There are existing avenues for consumers to lodge complaints about specialist treatment and these should be used –not social media or other user ratings. The AMA is less concerned about patient comments on hospital catering, staff friendliness etc.

Specialists who work in public hospitals should not be forced to publish elective public patient outcomes data as a condition of their employment with State/Territory Governments. Nor is it appropriate that patient eligibility for Medicare rebates for pre-operative private patient consultations are linked to the specialist's participation in publishing public patient outcome data. MBS payments are patient entitlements, not a practitioner payment. They should not be

affected by extraneous factors outside of the patient's control. Since the Commission does not propose the same MBS eligibility restrictions on consultations provided to patients who intend to elect private patient treatment – this idea is wrong headed and should be abandoned. It would add yet another layer of billing complexity and patient uncertainty, increase the cost of private specialists practice and detract from the patient choice the Commission advocates, at the same time as all Governments and providers are working to implement a MyHealth Record.

Furthermore, it is very hard to see how this penalty could be implanted in the MBS payment system. For example, in order to deny an MBS payment to a patient if their preferred specialist does not publish outcomes, Medicare would have to monitor specialists who publish and link the patient's pre-operative consult to the subsequent admitted patient treatment. If instead the specialist doesn't publish admitted treatment outcomes, Medicare would need to claw back the MBS benefit already paid at the time of pre-operative consultation. Or allow the MBS pre-operative consult benefit to stand if the patient ultimately chooses private patient surgery at a private or public hospital.

Overall the extent of user choice for public hospital elective surgeries has been overstated in this draft report and can't be implemented given public patients who choose a specialist prior to admission can't specify the same specialist to treat them in hospital. What is required to lift public patient outcomes and hospital efficiency is adequate and certain funding for public hospitals and a concerted effort from State and Territory public hospital managers.

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