Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services

Productivity Commission Draft Report

July 2017

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1 Overview

The Australian Healthcare and Hospitals Association (AHHA) is pleased to provide this submission to the Productivity Commission on their second stage of the Inquiry on *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services* (hereafter referred to as the Draft Report).

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

While the Productivity Commission's Inquiry examines a diverse array of human services, the AHHA submission to the Inquiry addresses only increased user choice and contestability as they relate to health and health related components of human services.

The healthcare sector is complex in its provision of human services which are delivered by a variety of providers with various funding sources, spread across different levels of government and third party agents. There is also a high degree of information asymmetry between consumers and healthcare providers, placing significant emphasis on the principal-agent relationship between the patient and care provider. The complexity and interwoven nature of the healthcare sector necessitates careful policy design around reforms, to ensure that the broad system impacts and the potential for unintended consequences are considered.

The AHHA supports the concept that well-designed reform, underpinned by strong government stewardship, could improve service quality, accessibility and consumer choice. The more detailed examination of the nature of government stewardship in the Draft Report is welcomed. However, the AHHA remains cautious on the government's capacity to provide effective stewardship of the health system within the private sector where its policy levers, and its capacity to provide stewardship, are limited. Exemplifying this is the limited control it has been able to exert over the private health sector regarding the provision of data for health statistical collections, acknowledged as critical for improving the effectiveness of human services provision[1] and the recent history of implementing national electronic health records (notwithstanding substantial government investment in electronic health record infrastructure).

While many of the issues raised in previous submissions by AHHA to this Inquiry remain pertinent, this submission will focus on relevant recommendations of the Draft Report. However, given the importance of the general principles in assessing any proposed change to market conditions in the delivery of healthcare services previously outlined by AHHA and our overall recommendations, they are reiterated here:

- Increased competition can only be realised with appropriate **transparency**. This includes transparency related to both individual health practitioners/services and provider groups with respect to:
  - Appropriate alternatives for the provision of needed healthcare
  - Pricing practices and costs
  - Health outcomes achieved
  - Quality of healthcare provided across appropriate dimensions
  - Prospective delays in receiving treatment

[1] AIHW. National Health Reform Performance and Accountability Framework. Available at: http://www.aihw.gov.au/health-performance/performance-and-accountability-framework/.

- Increased competition can only be realised with appropriate consumer **health literacy**. This includes:
  - Access to relevant authoritative health information
  - The individual having the capacity to understand and act appropriately with this information, and noting that this will be different for different people and in different circumstances
  - The existence of an appropriate principal-agent relationship between the patient and their healthcare provider with expert guidance to properly enable **informed consumer choice**
- Relevant individual healthcare **data is portable** to enable alternative healthcare practitioners and providers to feasibly provide a competitive alternative. Characteristics of portable data include:
  - Data structures are compatible across vendor applications and use common clinical coding systems
  - Individual health data is maintained in real time
  - Appropriate safeguards are in place to ensure patient confidentiality and health care data security
- The varying **context** in which otherwise similar healthcare is needed means that a change in competition settings will not always work the same way in different settings eg what is feasible in urban settings may not be feasible in non-urban settings implying the need for regionally tailored approaches to competition settings
- There is currently a wide recognition within the health sector of the importance of **integrated healthcare** in achieving better health outcomes, and better use of resources and competition policy should not create perverse or short-term incentives that work against this objective
- Individually short-term rational decisions should not be at the expense of long-term **sustainable health outcomes** or broader **whole-of-system technical efficiency**
- **Funding mechanisms** influence what healthcare services are provided and where they can be provided
- Any increase in competition should not cause an increase in **health inequalities** through perverse incentives or otherwise unintended consequences
- The impact of entrenched professional cultures that prevents clinically safe **expanded scope of practice** consistent with inter-disciplinary competencies must be addressed

AHHA Recommendations

AHHA proposes the following measures should underpin the provision of all health-related services in the public sector, whether delivered by government-owned and controlled agencies or outsourced to the not-for-profit or private sector via competitive and contestable arrangements:

1. To improve **health outcomes** – apply a values based health care model to achieve the best outcomes at the lowest cost
2. To improve **quality** – all services providing publicly funded care must be accredited and report clinical quality indicators
3. To improve **equity** – funding must be based on a universal health care principle
4. To improve **efficiency** – apply a funding model that is measurable by health outcome indicators and that applies risk adjusted funding, determined transparently and independently, that supports service delivery to populations that have access issues
5. To improve **accountability and responsiveness** – ensure timely public reporting of health outcome indicators that are clinically meaningful

2 Proposals Related to Public Hospital Services

AHHA generally supports draft recommendations 9.1, 9.2 and 9.3 relating to public hospital patients being able to choose the public clinic or private specialist where they receive treatment, for patients with a specialist referral to be able to choose which specialist of the appropriate type to consult and for the development of best-practice guidelines supporting patient referral choice.

However, AHHA also note and concur with the caution identified in the Draft Report relating to patient choice not interfering with the quality or efficiency of services that are delivered by public hospitals. AHHA does not agree with the Productivity Commission assessment that, ". . . scale issues are not a sufficient reason to restrict patients' referral choices". While noting the Commission's justification on signalling and resource allocation grounds, a potential loss of scale is an externality of the draft recommendations that has system level implications for accessibility to public hospital services for the entire local population. In smaller markets, there is also the real risk of exacerbating the problem of attracting and retaining an appropriate workforce if public hospital treatments excessively leak outside of natural patient catchment areas. This is likely to be a more prominent issue in communities with smaller public hospitals.

These considerations point to the need for the envisaged reforms to be implemented in close negotiation with state and territory governments, in partnership with local hospital districts and to recognise local population characteristics and public hospital/specialist capacity. General practitioners must also be supported to more proactively inform patients of their right to see a specialist of the appropriate type of their choosing. These proposed reforms also need to be supported by improved performance reporting of consumer relevant and clinically meaningful performance metrics in a timely manner to support informed patient choice.

AHHA supports draft recommendation 9.4 on expanded access to travel assistance but with the cost capped on the basis of the cost of travelling to the nearest clinically appropriate provider. It is noted that this could produce a large increase in the need for government funded travel assistance if draft recommendation 9.1 results in the closure of regional and remote hospitals.

AHHA supports draft recommendation 9.5 to evaluate these referral choice reforms after five years.

AHHA in general supports reform recommendations that improve transparency in the healthcare system to support patient choice and enhance system accountability and efficiency. AHHA supports draft recommendation 10.1 but notes that such reforms would need to be implemented in a more sophisticated manner than proposed in the Draft Report. For example, the demographic profile of the natural catchment area for a public hospital and the varying casemixes will impact on performance metrics in ways unrelated to the quality of services being provided. If performance metrics are not appropriately risk-adjusted then the information could be misleading and counterproductive to the intended aim. It may also not be possible to negotiate workforce reporting metrics acceptable to all parties within the recommended twelve month timeframe.

AHHA supports draft recommendation 10.2 on AIHW transforming the MyHospitals website to better support patient choice. AHHA would further support a proactive agenda that would ensure the necessary data is available in the near future and which would then be reported in a timely and regularly updated manner. AHHA strongly supports the reporting of clinical outcomes data which we note is also consistent with the outcomes based commissioning approach outlined in draft recommendation 7.7.

3 Proposals Related to Public Dental Services

The absence of universal dental healthcare and only a limited safety net for dental services have resulted in significant inequalities in meeting the oral healthcare needs of Australians. While the importance of preventative oral health is well known, under-funding of dental services and lack of access to appropriate providers in many locations has a significant impact on quality of life and future demand for healthcare services, including hospital care.

AHHA supports draft recommendation 11.1 on publicly reporting against nationally consistent benchmarks on clinically acceptable waiting times that are also controlled for triage categories. AHHA also supports a move towards reporting at the provider level.

AHHA supports draft recommendation 11.2 to establish an oral health outcomes framework for public dental services with a focus that includes both clinical and patient reported measures. This is consistent with developments within Dental Health Services Victoria in relation to developing a value-based care framework, including the elimination of low value care. AHHA also notes that this is consistent with draft recommendation 7.7 on outcomes based approaches to commissioning. AHHA agrees that the level of reporting should initially be at the clinical unit level, with a possible move to reporting on individual clinicians at a later stage.

AHHA supports draft recommendation 11.3 to develop comprehensive digital oral health records on public dental services, regardless of the sector providing the service, and for these to be included within My Health Record as a step towards better integration of oral healthcare within the broader healthcare system and noting that portability of individual oral healthcare data is consistent with supporting consumer choice among oral healthcare providers. Furthermore, comprehensive digital oral health records should be required for all private dental services and for these to be uploaded into My Health Record.

In the discussion around these draft recommendations, the Productivity Commission favourably discusses consumer directed care relating to the choice of dental services provider. The Commission also foreshadows a potential blended payment model for public dental services with the provider receiving a risk-adjusted capitation payment, payments for achieving clinical and patient outcomes, and activity based payments for complex and hard to define treatments. AHHA generally supports such an approach but also notes that the fiscal implications would need to be negotiated between the Commonwealth, state and territory governments. However, AHHA also urges caution regarding choice of dental service providers in the private sector, noting the current restrictive practices put in place by private health insurers, whereby preferred providers are identified, with associated lower fees or higher rebates. Additionally, in some cases preferred providers are businesses owned in part or wholly by the insurer.

The Productivity Commission notes the importance of preventative dental healthcare for individuals and the health system more broadly. AHHA supports a shift in the emphasis towards prevention to improve quality of life and to reduce costly potentially preventable hospitalisations.

AHHA acknowledges the recognition in the Draft Report that competition in the market for dental services would not be effective in locations where market conditions do not enable multiple dental service providers to be established. This can also occur where a maldistribution of service providers has resulted in underservicing eg the outer regions of Melbourne compared to inner Melbourne.

The Draft Report also raises the prospect of the Independent Hospital Pricing Authority (IHPA) determining an efficient price for public dental services, similar to the National Efficient Price used for Activity Based Funding of larger public hospitals (draft recommendation 12.2). AHHA considers that there is merit in this suggestion, which has previously been flagged by the current Australian Government.

AHHA supports draft recommendation 12.1 on the introduction of consumer directed care where individuals can choose their own public provider or private provider that elects to be part of the proposed new payment scheme, and the introduction of a blended payment model involving risk-weighted capitation payments, performance based outcome payments and activity based payments for complex and hard to define procedures. Payments under this proposed model should be independently priced.

AHHA supports draft recommendation 12.3 to establish trials to evaluate this proposed new payment model before a staged roll-out. Such trials should be conducted and evaluated independently.

AHHA supports draft recommendation 12.4 to establish a centrally managed system within each state and territory to prioritise access for eligible patients with appropriate funding being provided for the patients to receive clinically and cost effective treatments. Patients should retain the option of receiving treatment beyond the basics where this is privately paid and should have available consumer-orientated information on participating oral health providers.

Government-operated dental clinics should continue to be required to be accredited against the National Safety and Quality Health Service (NSQHS) Standards. Accreditation requirements should also be extended to private dental practices, particularly where these practices are supplying public-funded services.

AHHA supports draft recommendation 12.5 to establish outcomes-based commissioning for public dental services. However, the enabling data infrastructure (including indicator development, data collection, reporting and governance) must first be in place to support this performance framework.

The range of reforms in the provision of public dental services proposed in the Draft Report require care in their implementation to ensure that enabling infrastructure and consumer supports are available, and to avoid unintended consequences. AHHA agrees that a staged implementation would help mitigate these risks and that strong national leadership will be required to successfully implement the proposed recommendations. AHHA recommends that a Commonwealth appointed Australian Chief Dental Officer should oversee this work.

Finally, there is a barrier to more effective workforce reform as a result of dental therapists, dental hygienists and oral health therapists not being able to be issued their own provider number and having to instead rely on dentists' provider numbers for the services they perform. While dentists have opposed provider numbers for these other clinicians, enabling the allocation of provider numbers to these clinicians would contribute to a greater use of the skills of the full dental workforce and enhance overall system capacity and flexibility.

4 Proposals Related to End-of-Life Care

AHHA agrees with the findings of the Productivity Commission that effort and investment are required for improved access and user choice for end-of-life care, in addition to enhanced data development and reporting of end-of-life care data. Primary Health Networks are well positioned to play a key role in the evaluation of community need, improving coordination, commissioning of services, and data collection and monitoring.

Any proposals related to end-of-life care will impact on highly vulnerable patients and their families. Therefore a high degree of caution must be exercised when considering changes to the market settings for end-of-life care. In particular, AHHA urges the Commission to consider:

- The principle of user choice must be balanced with the knowledge that health literacy in Australia is low[2], services are fragmented and not well understood by many health professionals, let alone consumers, and that people who need end-of-life care are most often physically and/or mentally compromised. There is a need for appropriate mechanisms to support consumer choice for end-of-life care, recognising that this may change over time or with disease progression.
- End-of-life care is much less accessible outside of urban settings and there is limited workforce to support the need, regardless of whether the setting is public or private.
- Assurance must be provided that neither secular nor non-secular end-of-life care is discriminated against, explicitly or tacitly.
- The Guidelines for a Palliative Approach in Residential Aged Care and the Guidelines for a Palliative Approach for Aged Care in the Community Setting are currently under review by the Commonwealth Department of Health and any recommendations may be pertinent to the work of the Productivity Commission.
- The strategic framework for provision of end-of-life care varies in each state and territory. Any changes to this already fragmented system need to be carefully considered for second round effects and pass the no-disadvantage test prior to implementation.

AHHA supports in principle draft recommendation 4.1 to ensure that people with a preference to die at home are able to and are supported with appropriate palliative care services. AHHA also notes the observation in the Draft Report (page 131) that, "end-of-life care is core business for the aged care system, and the Australian Government, as steward of the aged care system, is responsible for ensuring that people in the aged care system receive end-of-life care that aligns with the quality of care available to other Australians." While draft recommendation 4.1 is directed at state and territory governments, this should be implemented in partnership with the Commonwealth given the overlapping responsibilities for the care of patients in need of palliative care.

AHHA supports draft recommendation 4.2 that the Australian Government remove restrictions on the duration and availability of palliative care funding in residential aged care and to ensure that residents have sufficient funding to receive end-of-life care that aligns with that available to other Australians. AHHA also recommends that the Australian, state and territory governments jointly investigate how the cost of funding this needed expansion of services could in part be funded by shared savings from reduced hospital presentations and associated patient transport costs.[3]

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[2] 59 per cent of Australians have health literacy skills that are below the minimum level required to allow them to meet the complex demands of everyday life (ABS. 2009. Australian Social Trends. Cat No 4102.0. Canberra).

[3] As the Productivity Commission has been informed through the submissions of other organisations to this Inquiry, the patient transport costs are significant and are largely borne by state and territory governments.

AHHA supports draft recommendation 4.3 that the Medicare Benefits Schedule should be amended to explicitly require general practitioners to discuss advance care planning when providing a health assessment for a person aged 75 years or over and where the patient has the cognitive capacity to meaningfully engage in such a conversation, and for the introduction of a new Medicare item number to enable practice nurses to facilitate advance care planning. Furthermore, AHHA also supports the same explicit requirement for all health assessments performed for anyone in residential aged care where they have the cognitive capacity to meaningfully engage in such a conversation. For the reasons discussed in the Draft Report, advanced care planning needs to be normalised as part of standard healthcare maintenance and planning.

AHHA supports draft recommendation 4.4 that residential aged care facility staff be required to discuss with residents the advantages of developing or updating an advanced care plan within a short period of being admitted to the facility. This support should be read in tandem with the previously indicated support on extending draft recommendation 4.3 to all residential aged care residents that receive a health assessment.

AHHA also supports having advanced care plans developed within a nationally harmonised legislative framework and uploaded onto individual My Health Records.

AHHA supports draft recommendation 4.5 that all governments should ensure that sufficient data is available to monitor how well end-of-life care services are meeting the needs of users across all care settings.

Legislative Framework

Legislation supporting advance care planning varies across jurisdictions, with *statutory directives* that require documentation that meets specific government requirements and, in some jurisdictions, *common law directives* that require a person's wishes, however they are documented, to be legally respected. AHHA recommends national harmonisation of legislation regarding advance care planning documents and substitute decision-makers. This should include agreed and consistent terminology, the use of national guidelines and standardised documentation, and consistent legislation to recognise advance care planning documents and ensure that they are authoritative and enforceable[4].

Supporting Health Professionals

Recognising and diagnosing dying is marred by prognostic uncertainty. This complex clinical decision commonly relies on the skill and experience of the clinician, which can be complemented by clinical tools developed to assist in recognising the dying patient and avoiding potentially harmful and futile treatments.[5,6,7] Raising clinician awareness and access to screening tools may help to minimise prognostic uncertainty and futile care, promoting transparent conversations about treatment choice and care limitations.

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[4] Jones A and Silk K. 2016. Improving End-of-Life Care in Australia. *Deeble Institute for Health Policy Research*, Deeble Issues Brief No. 19.

[5] Cardona-Morrell M and Hillman K. 2015. Development of a tool for defining and identifying the dying patient in hospital: Criteria for Screening and Triaging to Appropriate aLternative care (CriSTAL). *BMJ Supportive & Palliative Care*, 5(1), 78–90.

[6] Kennedy C, Brooks-Young P, Gray CB, Larkin P, Connolly M, Wilde-Larsson B, Larsson M, Smith T and Chater S. 2014. Diagnosing dying: An integrative literature review. *BMJ Supportive and Palliative Care*, 4(3), 236–270.

[7] Richardson P, Greenslade J, Shanmugathasan S, Doucet K, Widdicombe N, Chu K and Brown A. 2014. PREDICT: a diagnostic accuracy study of a tool for predicting mortality within one year: who should have an advance healthcare directive? *Palliative Medicine*, 29(1), 31–37.

For advance care planning to be effective, planning and discussion around people's health care preferences need to become an ongoing part of routine clinical practice. To achieve this, clinician training must include caring for people at end of life and should include medical practitioner responsibility for recognising dying and supporting end of life. Including end-of-life care in continuous professional development, through providing access to peer support mentoring and clinical supervision of all health care providers, will support medical practitioners and clinicians in managing the emotional and ethical challenges of these discussions.

Public and User Awareness

Failure to talk about and plan for death is one of the most significant obstacles to improving the quality of dying. Population health awareness campaigns covering dying, death and end-of-life care will assist in lessening misconceptions and improving understanding of the limitations of healthcare, and the potential adverse consequences of futile health care, especially at the end of life. Such campaigns could also support people in making their choices known and engaging in advance care planning.

5 Proposals Related to Human Services in Remote Indigenous Communities

While some competitive and contestable service arrangements are already in place in remote Indigenous communities, both private and public funded service arrangements are often characterised by less capacity to deliver the full range of health services to meet community needs, and particularly, to provide these services on a regular basis.

The role of Aboriginal Community Controlled Health Organisations (ACCHOs) is vital in providing culturally appropriate care and in circumstances where private service provision will often not be feasible. ACCHOs must continue to be supported to fulfil this role and to develop Indigenous capacity within the healthcare sector.

There is also a role for other health service providers to work in partnership with ACCHOs to complement available services, but these arrangements should be considered as supporting and complementary, not as a substitution for Indigenous-controlled, culturally appropriate services.

AHHA supports draft recommendation 8.1 to increase default contract lengths for human services in remote indigenous communities to ten years unless the service is part of a program trial or it is otherwise justified why the contract length should differ from the default period. This support is fundamentally conditional on the contract having appropriate safeguards to remove contracted providers where serious failure to deliver on the contract requirements is established.

AHHA supports draft recommendation 8.2 relating to the selection processes for services in remote Indigenous communities aimed at improving the efficiency of tendering processes and associated transition arrangements.

AHHA supports draft recommendation 8.3 that commissioning for human services being provided in remote Indigenous communities should have a strong focus on transferring skills and capacity to people and organisations in those communities, as broader community capacity is developed.

AHHA supports draft recommendation 8.4 that would require providers of human services in remote Indigenous communities to have culturally appropriate service provision, respectful of community engagement and governance, collaborate and coordinate with existing providers and community bodies, and employ and train local and Indigenous staff where appropriate to the service delivery requirements. While some of these objectives may result in higher costs, this must be considered in the context of increased likelihood of medium and long term success in sustainably achieving program objectives.

AHHA supports draft recommendation 8.5 that would require governments to develop shared objectives for human services in remote Indigenous communities, assessing the characteristics and needs of Indigenous Australians living in remote communities and sharing information on successful human services delivery programs in these communities.

6 Proposals Related to Family and Community Services

AHHA generally supports the recommendations made in Chapter 7 of the Draft Report as they relate to family and community services. Initiatives to improve system planning, provider selection processes, performance management frameworks and contract management practices will contribute to more effective and efficient delivery of family and community services.

Placing people who use family and community services at the centre of service provision should always be the objective. Similarly, service providers should not be unduly distracted with unnecessary administrative processes to the detriment of their underlying service commitments. As noted in the Draft Report, governments should also draw upon the knowledge and expertise of local providers when determining policies and designing programs.

AHHA supports the broader application of an outcomes focus in the delivery of services. AHHA also support increasing the default contract length to seven years, with this support fundamentally conditional on the contract having appropriate safeguards to remove contracted providers where serious failure to deliver on the contract requirements is established.

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