CHERE
CENTRE FOR HEALTH ECONOMICS
RESEARCH AND EVALUATION

Comment on the draft report by the Productivity Commission

Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services
Draft report June 2017

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About CHERE

CHERE is an independent research unit affiliated with the University of Technology, Sydney. It has been established since 1991, and in that time has developed a strong reputation for excellence in research and teaching in health economics and public health and for providing timely and high quality policy advice and support. Its research program is policy-relevant and concerned with issues at the forefront of the sub-discipline.

CHERE has extensive experience in evaluating health services and programs, and in assessing the effectiveness of policy initiatives. The Centre provides policy support to all levels of the health care system, through both formal and informal involvement in working parties, committees, and by undertaking commissioned projects. For further details on our work, see www.chere.uts.edu.au.

Project team

Jane Hall
Mike Woods
Patricia Kenny

Contact details

Centre for Health Economics Research and Evaluation (CHERE)
University of Technology Sydney
Level 2, Building 5D
1-59 Quay Street
Haymarket NSW 2000

p: 02 9514 4720
f: 02 9514 4730

e: mail@chere.uts.edu.au
i: www.chere.uts.edu.au

1 Introduction

The Productivity Commission invited written submissions commenting on the draft report *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*. This is a response to the invitation.

The Centre for Health Economics Research and Evaluation (CHERE) congratulates the Commission for interpreting its Terms of Reference in a manner that best accords with the nature of most Human Services, particularly in the field of health care. The Commission has not applied a narrow market perspective, but has given considered attention to all three ToR issues of competition, contestability and choice. On the issue of end-of-life care, for example, the Commission makes the telling point that consumer choice is of little value if consumers are not able to access an appropriate standard of care in the first place.

Indeed, the issue of access to services is a fundamental concern for consumers, whether limitations to that access are for geographical, financial, cultural or other reasons. Adequate levels of health literacy are required for all consumers to be able to navigate the health system appropriately and to exercise choice. Availability of a health workforce that has the knowledge, skills and attributes to provide team-based, patient-centred care that is safe and of a high quality is an equally important access issue.

2 Chapter 3 End-of-life care in Australia

CHERE agrees with the Commission that many Australians who would prefer to die at home do not have this opportunity (Pages 96-97). It is important, in developing policy and designing programs in this area, to maintain the distinctions between palliative care, end-of-life care, and care at death, and each of those forms of care should be best delivered in the circumstances of the patient, their family, friends and other carers. It is important in developing services for end of life care that family carers are able to maintain their distinct roles and that additional services support rather than replace them [1].

CHERE would like to point out some limitations of the available research on preferred place of death and the need for more appropriate research to identify better estimates of preferences for place of care at the end of life and for place of death. A systematic review [2] found consistent support from the general population for death at home but substantial heterogeneity in preferences among studies of patients and informal carers. An important limitation of the general population research to date is that it has focused on preferred place of death without reference to any specific context or to the place of care over the period of functional decline prior to death. That research has often failed to recognize that these are two separate, though contextually related, decisions and moreover that preferences, as expressed by the patient or differently by the carers, can also change over that period.

More reliable estimates of preferences are required for resource allocation decisions and these could be elicited by asking general population respondents to express preferences in hypothetical choice scenarios which provide specific contextual information.

3 Chapter 4 Reforms to end-of-life care

There is a need for careful consideration of the outcomes used to assess service safety, quality and performance. CHERE agrees that, with additional investment in community-based palliative care services, it will be important to monitor outcomes including the numbers/proportion of patients who die at home with support from these services as well as the number/proportion who receive most of their care at home (Page 127). We consider it important to emphasise the use of the latter rather than the former as a service outcome, despite place of death being easier to measure. We have concerns about death at home being perceived as necessarily the most desirable outcome, embedding incentives in program designs for service providers to encourage informal carers to continue providing care at home when this may not be in the interest of either the carer or the patient. There is some evidence that a preference for death at home is more common among patients than among their informal carers [2]. Thus, the way measures of place of death are used should be carefully considered and should incorporate appropriate safe guards. This is but one example of how incentives which are built into the health care system as part of program design, can generate provider (and consumer) behaviour that may not result in the most desirable outcome for all patients or carers.

CHERE supports the Commission’s identification of limitations in the Aged Care Funding Index for the adequate provision of palliative care, end-of-life care and care at death. The draft report correctly criticizes the unnecessary transfers of patients from residential aged care facilities (RACFs) to a hospital at a very critical time in their lives. There are many failings in this area, with the inadequate training and resourcing of staff in RACFs being but one. We would caution, however, that a simple adjustment of the current ACFI, would be an inadequate solution. ACFI, as with other health care system designs, has many flaws and the Australian Government needs to undertake a wide and deep consultative process to firmly establish the underlying principles of the outcomes wanted from the subsidization of aged care in RACFs, with the adequate delivery of safe, high quality palliative care, end-of-life care and care at death being included.

A separate set of failings, also identified by the Commission, relate to the limited number of people who have the opportunity to prepare, or are supported in preparing, advance care directives. CHERE supports the Commission’s draft recommendations in this area and adds that one of the system failures is the high number of hospital staff who are not aware of, or properly respect, patients’ wishes as expressed in those directives. However, we are also aware from our current research in progress that advanced care directives can be difficult to implement widely.

The draft report discusses the need to improve routine data collections (Page 140-142) and we agree that this is essential. Data is urgently needed, not only to allow for the appropriate measurement of place of care at the end-of-life and place of death, but also to allow for the accurate measurement of health care costs. The diversity of services used to support a person receiving end-of-life care in the community means that it is currently difficult or impossible to measure and cost the non-hospital services used. It is also important that data collection allows for the measurement of both specialist and generalist palliative care services.

4 Chapter 9 Public hospital services

CHERE agrees with the principle of consumer choice of hospital for elective, and where feasible emergency, admissions, and of the particular specialist, as outlined by the Commission, recognizing the requirement to support safety and quality and workforce training and development. The issue of choice in a health setting is often more complex than a single decision. For example, the first choice of specialist may also imply or limit choice of hospital (to where the specialist has admitting rights) or subsequent choice of further specialist treatment where multiple specialties are involved in treatment.

The notion of choice could be extended to the availability of second opinions. Second opinions may improve diagnosis accuracy, or provide alternative treatment options, and therefore increase consumer choice [3]. Second opinions may also provide additional reassurance particularly in the care of complex and life threatening conditions [4]. Currently, a consumer wishing to have a second opinion would need to return to their GP and request a second referral. And such behavior may be taken as a lack of trust in the initial provider [5].

Second opinions have been encouraged by funders, particularly with regard to elective surgery in part as a view to reducing costs. We have not identified a recent review of the literature, but earlier reviews found the evidence inconclusive as the impact on health outcomes and costs. The context for second opinions is changing with the dissemination of clinical practice guidelines [6], and by extension the availability of information on the web, including web based services for the provision of second opinions. There is certainly the opportunity for new business approaches that market second opinions and these may add to overall health care costs without a commensurate increase in health outcomes.

Obtaining a second opinion is a consumer right and quite clearly can provide more consumer choice. However, the role, cost implications and opportunities for exploitation are quite complex.

5 Chapter 10 Information to support consumer choice and provider self improvement

CHERE agrees with the Commission’s recommendations for the increased availability of currently collected data and the extension of data collections to include more information on clinical and patient reported outcomes. There is a substantial body of evidence on how consumers understand and use information on quality, though relatively little of this from Australia [7]. Public reporting of health care performance has taken many different forms; and many evaluations have shown disappointing results with little consumer use of such information [8]. It is likely that more attention should be paid to the design of public reporting to make it comprehensible to consumers [9]. This also underscores the need for more attention to be paid to issues of health literacy, that is improving all Australians’ ability to find, understand and assess relevant information.

New data collections take some time to develop, as new measures have to be designed and tested, and collection systems implemented. Waiting times and out of pocket costs are important items of information for consumers, are easy to measure and generally not known to GP advisers in a systematic way. We recognize that this is not straightforward, given the extent of price discrimination by specialists [3] but are of the opinion these two data items would empower more choice. We are aware that several health insurers are developing such guidance for their subscribers. There is no reason that such information should be not made available to uninsured consumers. Therefore we recommend that eveloping publicly available information should be a priority. .

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