SUBMISSION

Introducing Competition and Informed User Choice into Human Services: Reforms to Human services – Draft Report

14 July 2017

Introduction

The Victorian Healthcare Association (VHA) welcomes the opportunity to respond to the Productivity Commission's Draft Report - Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services.

The VHA is pleased that the Productivity Commission (the Commission) has taken account of a number of concerns expressed in the last stage of the inquiry but there is still inherent weaknesses in some recommendations outlined in the Draft Report, particularly regarding equity and access to services.

The Commission makes it clear that "the benefits of its draft recommendations, including improved service outcomes for users, would outweigh the fiscal (and other) costs" (Draft Report, Page 9) and that "On the basis of the available information, the Commission considers that governments should not allow the unequal distribution of these fiscal effects to become a barrier to reform." (Draft Report, Page 9).

The VHA does not agree with the Commission's view that equitable distribution of services should be to some extent sacrificed to implement these reforms.

We urge the Commission to fully consider how services and clinicians will effectively function in a marketised environment, factoring in the higher ethical responsibility clinicians have in managing clients' health conditions, over and above just simply meeting expectations of care[1] [2] and how service provision can be secured for people who may have difficulty accessing care in a competitive market.

We believe that the Commission needs to bear in mind that many of the normal rules that apply to competitive markets do not apply in health care. These include significant information asymmetry between providers and consumers which often confounds the

[1] The Science PT. The Ethics of healthcare Advertising. http://thesciencept.com/ethics-of-healthcare-advertising/ 2-17. Accessed 30 June 2017
[2] Adam Meakins. The Sports Physio. Great Expectations… https://thesports.physio/2017/06/04/great-expectations/ 2017. Accessed 1 July 2017

ability of patients to adequately determine the quality of health services[3] and limitations in the supply of providers[4] [5] due to the stringent entry requirements of clinician training and accreditation.

We believe that some of the recommendations in the draft report, including provision of customer ratings of services, centralised access points and in some cases competitive tendering to bring in new providers rather than providing more resources to strengthen existing providers (at least initially) will not result in improvements to service provision and access to care, and need to be considered prudently.

The VHA is pleased that the Commission has recommended seven year default terms and longer periods for tender application for providers of family and community services. We believe that the length of this term will allow services to concentrate on developing high quality services and give staff working in these services greater certainty of tenure, facilitating recruitment and retention.

1. End of life care

Response to recommendation 4.1

The Commission has recognised the high quality of existing palliative care services and the need for more community based palliative care places to be made available, so that more people will be able to die in their home if that is their preference.

The introduction of market based or competitive processes to palliative care service provision as is specified in recommendation 4.1 needs to take into account the highly integrated and collaborative nature of these services. There is a significant risk that in a competitive environment this collaboration will be lost as providers compete to offer the same products.

In many instances, patients in need of palliation and their carers require guidance and support, rather than provision of a wide range of service providers to choose from. Our members are concerned that palliative care patients and their families have many complex issues to deal with that, many of which would be needlessly complicated by the addition of selecting an appropriate service provider.

The VHA supports the part of recommendation 4.1 that suggests a needs analysis be

[3] Goddard, M. (2015). Competition in Healthcare: Good, Bad or Ugly? International Journal of health policy and Management. Sep 4 (9): 567-569. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4556571/ accessed 30 June 2017

[4] EconPort. Common Market Model Assumptions http://www.econport.org/content/handbook/industrialorg/Competitive/Assumptions.html accessed 29 June 2017

[5] http://www.economicsdiscussion.net/market/features-of-a-perfectly-competitive-market/7108 Features of a Perfectly Competitive Market. Accessed 29 June 2017

conducted to identify areas where there may be a need for more palliative care services. Funding may need to be concentrated into rural and remote areas, where market failure exists. In such cases, competitive processes could be used to identify providers where there is no existing palliative care service provision.

However, in areas where providers already exist, we believe that state and federal governments should look to strengthen existing providers by affording them with extra resources to improve client care and service integration. There are few areas of health care where the development and maintenance of collaborative relationships between services is more important than in palliative care.

We believe this step should be taken before the introduction of competitive processes to find new providers is considered.

The VHA supports recommendations for 24 hours per day, 7 days per week care to be provided to palliative clients, but we believe that the Commission should consult widely with the sector to assess exactly what this care would entail. Depending on the level of coverage required, this may be hard to achieve in some areas due to recruitment challenges and services may need an injection of funding to provide these services.

Palliative care patients often do not need such intensive support for the whole duration of their care – indeed they may only need it at the very end of their life and needs may change throughout an episode.

We are supportive of the development of a dataset for government to monitor the provision of palliative care services, although it is likely that investment will be required to determine what these measures are and how they can fairly reflect the quality of a palliative care service.

However, we do not believe that this should include the collection of outcome measures based on subjective client or carer perceptions of care (e.g. star ratings of services) due to the vulnerable circumstances of clients in these services.

Response to recommendation 4.2

The VHA supports recommendation 4.2 outlining the case for additional funding for residential aged care facilities (RACFs) to improve their capacity to provide of end of life care. The best approaches to this are likely to be investing in training for existing RACF staff to develop general skills, and development of pathways and triggers for referral to specialist services when a patients' needs increase. Similarly, RACFS could be provided with funding to contract specialist palliative care services when required.

Response to recommendation 4.5

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With regards to publishing data for the purposes of informed user choice, the VHA supports the development of datasets to allow government to monitor the quality of services and to provide clients with information about providers, but we are concerned to ensure that the data is objective and fairly represents the quality of services provided.

Furthermore, our members believe that there needs to be a greater emphasis on education of the general public and health workforce in issues regarding death and dying before sophisticated strategies are implemented to facilitate informed user choice. Education about the circumstances a dying person will face and services that they are likely to require may improve clients' experience more than the provision of information about a range of services.

2. Public Hospitals

Response to Recommendations 9.1 and 9.3

The VHA shares the Commission's aspiration of improving patient choice in public hospitals and we are committed to the development of practical solutions to improve client care.

The most significant recommendation made by the Commission centers on the right for patients with a specialist referral to choose the public outpatient clinic or private specialist that they wish to attend.

The VHA is supportive of reforms to improve patient choice but cannot fully support the Commission's recommendations as they currently stand. We support the right of a client to choose their own private specialist or conversely attend the nearest public outpatient clinic, as long as existing funding mechanisms for public and private services remain in place. The VHA supports reforms that facilitate GPs to provide greater choice to patients.

At this stage, we are unable to endorse recommendation 9.3, which, if implemented, would allow patients to be able to seek treatment at high performing public hospitals, even if they are not located near their home. The Victorian Department of Health and Human Services, with the participation of public hospitals, is currently undertaking a significant body of work to introduce statewide referral pathways, clinical capability frameworks and geographic service plans. The VHA supports this and is concerned that the reforms recommended by the Commission would undermine much of this work, as it is predicated on understanding current, and projecting future, patient flow and demand.

At present, most work done by public hospitals is for people in their geographical area, with some exceptions including when a patient cannot access care near their home or some specialties that may only be located in higher acuity hospitals.

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Many hospitals develop strong local connections and direct most of their resources into providing high quality healthcare for their local communities. Therefore, hospitals have a strong understanding of services that are offered in their local area but less so in other regions. If more people from outside a hospital's geographical area seek out-patient and in-patient care, they will require extra resources to keep updated databases of services that are not in their catchment, and in situations where this information is not available, clinicians will need to devote significant time and resources to discharge planning (already a complex process), increasing the cost of service provision and further adding to a significant administrative burden.

The Commission's recommendations appear to focus on a single separation – for example, an elective surgery procedure – as the critical element of choice for patients. It is important to note that much of the clinical success of surgery is based on post-operative care and rehabilitation, often delivered in community settings close to a patient's residence. The potential decoupling of surgical care from local post-operative and rehabilitation services may present increased risks for patients, and in cases where avoidable complications occur as a result of patients seeking care outside of their catchment, the costs to the health system will far outweigh any hypothetical efficiencies gained by the recommended policy change.

Furthermore, it is unlikely that many clients will be able to exercise informed choice to arrange the array of services that may be needed post operatively or post discharge (especially from a hospital bed).

The implementation of recommendation 9.3 will almost certainly change the demand profile for out-patient services such that some hospitals and specialists will attract more clients and have longer waiting times, potentially becoming victims of their own success.

Less attractive services will suffer falling demand and have more difficulty in maintaining services. This is particularly of concern in rural and remote areas and could lead to loss of local services. Surgeons and other specialists may leave a town if they are unable to attract the volume of clients needed to develop their skills and maintain competence, as well as manage a viable practice.

The loss of medical and hospital services can also have profound effects on local communities including residents leaving town or difficulty attracting new residents. Therefore it is critically important that distribution of these services is not left solely to market forces.

The VHA recommends that if reforms to access to outpatient clinics are implemented they should be coupled with increased support for public hospitals that suffer from a loss of demand for services. The Commission correctly asserts that increased user choice has potential to drive improvements for hospitals but some services, especially those that are already disadvantaged in terms of lack of facilities, difficulty to attract staff (e.g. in rural

areas) or due to geographical isolation will struggle to compete in a marketised environment.

Patients often need extra support to make informed decisions about services or specialists that they choose to provide treatment. For example, patients will need to be quickly informed if an out-patient service or specialist that they have identified as their preferred provider can provide the care they need. There will be many situations where even the best information provided to a client on a website or similar platform will not be able to assist a consumer to make this choice.

Response to Recommendation 9.4

The VHA supports recommendations that provide improved travel assistance to consumers, but caution that this will not fully compensate for increased costs of providing care significant distances from a person's home. We believe that the level of assistance should be based on the cost of getting to the nearest provider that can provide an appropriate service and include assistance for carers to visit and support the patient.

Response to Recommendations 10.1 and 10.2

Publishing performance data could help to assure patients that clinicians are competent and the system is working effectively.[6] Reporting has commenced in other jurisdictions[7] and the VHA supports the provision of carefully chosen performance measures for hospitals and clinicians that inform patient choice.

We agree that the publishing data about service providers should be progressively phased in and could start with information about registration details, location, levels of activity and out-of-pocket charges.

However, publishing of other data must be informative and assist patients to make decisions about their health care, and not mislead them.[8] The VHA believes that there are significant risks in publishing subjective data such as user ratings as there may be a tendency for such data to be biased, either for or against a service.

In the United States, the use of patient satisfaction ratings contributed to loss of job satisfaction among physicians when they perceive that these ratings could result in

[6] Hamblin, R; Shuker, C; Stolarek, I; Wilson, J; Merry, A.F. (2016). Public reporting of healthcare performance data: what we know and what we should do. The New Zealand Medical Journal. (2016). 11th march 2016. Vol 129 No; 1431 https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2016/vol-129-no-1431-11-march-2016/6842 accessed 5/7/17

[7] The Conversation. Bachus marsh baby Deaths: Australia should learn from the UK and publish clinician performance data. October 18 2016. https://theconversation.com/bacchus-marsh-baby-deaths-australia-should-learn-from-the-uk-and-publish-clinician-performance-data-67134 Accessed 5/7/17

[8] Hamblin, R et al. op.cit.

adverse professional consequences.[9] Satisfaction may also be more reliant on perceptions that their expectations have been met rather than the healthcare outcomes achieved and may even be harmful if used as a quality of care measure.[10] There are also concerns that performance measurement criteria for clinicians that incentivise high patient satisfaction scores may lead to provision of healthcare driven by patient satisfaction rather than evidence based practice, although there is little demonstrable evidence for this at present.[11]

Similarly, reporting of clinical outcome data, including patient-reported outcome measures, needs to be weighted accurately to account for acuity and complexity of a hospital's caseload and be reported in such a way as to convey an authentic picture of how a clinician or hospital has performed against other providers with similar patient profiles, and in a way that can be readily understood by the general public. The VHA believes that the reporting of this type of data should only be implemented when measures are sufficiently sophisticated to fairly reflect the performance of a service or clinician.

The presentation of data about services or clinicians needs to take into account that many potential consumers lack sufficient understanding of statistics to fully understand the data, and it may need to be accompanied by detailed explanations.[12] Patients with poor health literacy may also have difficulty understanding health performance data.[13] Similarly, for many clinicians, caseloads for particular conditions may be too low to generate sufficient statistical power to reliably provide a clinician rating.[14]

3. Public Dental Services

Response to Recommendations 12.1

The VHA generally supports the vision articulated for public dental services in the Draft Report but we are concerned that the Commission's recommendations will have limited impact on accessibility for public dental services.

The Commission correctly pointed out that public dental services largely provide emergency and urgent treatments for clients and do not focus enough on early

[9] Zgierska, A; Rabago, D; Miller, M.M. (2014). Impact of patient satisfaction ratings on physicians and clinical care. Patient Prefer Adherance 8: 437-446 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3979780/ accessed 7/7/17
[10] Ibid
[11] Ibid
[12] Hamblin, R et al. op.cit.
[13] Hamblin, R et al. op.cit.
[14] Walker K, Neuburger J, Groene O, et al. 2013. Public reporting of surgeon outcomes: low numbers of procedures lead to false complacency. The Lancet 382(9905): 1674–7. Cited in Hamblin, R; Shuker, C; Stolarek, I; Wilson, J; Merry, A.F. (2016). Public reporting of healthcare performance data: what we know and what we should do. The New Zealand Medical Journal. (2016). 11th march 2016. Vol 129 No; 1431 https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2016/vol-129-no-1431-11-march-2016/6842 accessed 5/7/17

intervention and prevention. However, this is chiefly necessitated by long public dental waiting lists and high demand for urgent care treatments. Public dental practices do not have the funding or resources to provide more preventative care and as a result many patients remain on waiting lists for extended periods.

Our members have indicated that the payment system in Victoria has some similarities to that being proposed by the Commission. Public dental services are currently paid in dental weighted activity units and the price they are paid to provide a course of care is not directly determined by the amount of care that a client requires.

The introduction of performance based and activity payments for complex and hard-to-define procedures could better reflect the true cost of providing care and therefore represent an improvement on the current funding model, but the whole payment model is unlikely to result in a great deal of change in demand of public dental services in Victoria, unless the payments made to practices are sufficient to encourage public providers to expand their service or attract private providers to participate in the scheme.

Indeed, our members have informed us that many private providers do not take on clients with vouchers from the public system for this reason. Clients with vouchers sometimes cannot find a provider who would treat them and have no choice but to return to a public dental waiting list.

When public dental services have been provided with short term funding boosts, they have been able to reduce waiting lists as was indicated by the Commission. The VHA believes that there is a strong case for increasing funding to public dental providers, as this will result in more people receiving treatment.

Unfortunately, funding arrangements such as the National Partnership Agreement on Adult Public Dental Services have usually been short term in nature. Public providers and their clients would benefit from longer term and more consistent funding arrangements.

Response to Recommendations 12.3

We agree that the transition to a consumer directed care approach should involve trialing the system in a small number of test sites as suggested in recommendation 12.3. The trial should be of sufficient length to determine if there is any impact on access to services and quality of care and the trial should only be broadened if demonstrable improvements are seen in these three areas

Response to Recommendations 11.1 and 11.2

The VHA supports the measures outlined in recommendation 11.1 if they are applied to all providers of public dental services so that consumers can have more information to advise their choice of providers.

The VHA supports the principle of the development of an outcomes payment schedule, but we withhold support for performance based outcome payments until the schedule has been developed and its content reviewed. We caution against the use of subjective measures by clients for the same reasons outlined earlier in this submission.

In Victoria public dental services already report against a range of outcome measures and we look forward to the development of a new framework being completed by Dental Health Services Victoria.

Response to Recommendation 12.4

The VHA does not support this recommendation and believes that services are best placed to manage their own waiting lists and triaging of clients, while accepting that some improvements in intake processes may be required.

Centralising of triaging and access to services has been trialed in both the NDIS and MyAgedCare reforms in recent times, with mixed results. These systems divorce the allocation of services from the provision of services, such that an agent (in this case the centralised triaging point) assesses the needs of a client and then provides them with information about a range of possible providers.

However, in both the NDIS and MyAgedCare, our members have reported significant problems with similar centralised access points. Problems include

- clients getting lost in the system
- clients falling through gaps and not getting services that they require
- poor communication between service centres and clients
- service centres staffed by workers that lack qualifications and are unable to adequately conduct holistic assessments
- lack of timeliness of assessments for clients
- inadequate follow up for clients who are difficult to contact
- health care services needing to spend time advocating for clients and supporting them in their interactions with MyAgedCare and NDIS (when in the past the services would have simply triaged the client themselves and arranged treatment at far less cost and a more timely manner)

It is important to recognise that health care markets are generally characterised by frequent market failure and trust between clients and providers (who are ethically bound to act in their patient's best interest). We believe that it would be more pragmatic and practical to support or educate providers and services to better facilitate client choice rather than create an inefficient centralised access system, in addition to existing service providers.

If the Commission was to persist with recommending this concept, the centralised access point would need to be well staffed with people who have a strong knowledge of dental conditions and excellent interpersonal skills, and can rapidly respond to client needs and arrange care quickly.

At this stage, our members feel that NDIS and MyAgedCare access points are providing a lower standard of support than individual intake services that are a feature of many health services.

4. Further information

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