

## **How greater competition, contestability and informed user choice could place users at the heart of service delivery in public hospital services.**

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This submission contends that greater competition and contestability in public hospital services will not increase their efficiency nor will it enhance informed user choice. Salient points made are: 1. analysis of inpatient data, has shown that the efficiency of services differs in, and across, metropolitan and rural hospitals in NSW. 2. achieving greater efficiency of hospital services, by reducing the variation in service delivery among and between public hospital services, is unlikely to be achieved without the engagement of health professionals and managers who work in public hospitals. 3. patient centered 'managed competition' should be considered as a payment model for health services. 4. data published to facilitate improvements in public hospital services, over and above those available, are data showing the clinical outcome of treatment by speciality by hospital. 5. all types of public hospital services and patient populations are suited to greater user choice over clinician or hospital. However, for greater user choice to be realized, many consumers will require the support of an independent advocate/agency to represent their interests.

### **Introduction**

The Productivity Commission's Issues Paper: Reforms to Human Services, released December 2016, asks for public submissions about how greater competition, contestability and informed user choice could place users at the heart of service delivery in public hospital services. This submission is provided in response to that request.

The submission begins by providing a context in which public hospital/health services are delivered under each of the core themes: competition, contestability and informed user choice. Following, under each of the relevant headings provided in the Issues Paper are comments and/or suggestions about: the efficiency of public hospital services and how this differs across regions in NSW; how greater competition, contestability and informed user choice in public hospital services could be complemented; what further data should be published to facilitate improvements in public hospital services through benchmarking, and inform greater user choice about clinician and/or hospital services; and which types of public hospital services and patient populations are suited to greater user choice.

### **How greater competition could place users at the heart of service delivery**

Before commenting about possible ways to achieve greater competition in the provision of public hospital services, the nature of the health market requires clarification. Neoliberal ideology contends that markets, in which is competition are efficient and self-regulating, and that government involvement is useful, but is only required to provide those public goods and services that private enterprise has no interest in providing because they do not generate a direct economic return on investment<sup>1</sup>. The best use of public spending is seen to be when it creates employment in the private sector, thus supporting a market approach to the delivery of services, where individual responsibility and freedom of choice rule<sup>2</sup>. In addition, opening state borders to free trade is viewed as positive, because it will 'ultimately' benefit all<sup>3</sup>.

However, in the terminology of economics, the health market is a failed market, because it does not satisfy the attributes of a free competitive market<sup>4</sup>. In a free market, consumer demand for a commodity (product or service) will drive the supply of that commodity to the point where an equilibrium is reached. At this point the price of the commodity should stabilize; if the demand is greater than the supply the price will rise and if the supply is greater than the demand the price will fall. These conditions do not apply in health. For example: under the policy of Activity Based Funding, the price for each episode of care in major hospitals is set by the Independent Hospital Pricing Authority (an independent Government agency), clearly demonstrating that the health market is not self-regulating<sup>5</sup>. This failed market can only operate successfully with the involvement of government, through its legislation and associated regulations and policies<sup>2</sup>.

Previous attempts by government to increase competition in the health market and/or in the delivery of publicly-funded health services, using legislation and regulations, have not been successful. These policies have not resulted in significant improvements in the health of the population, but have increased the financial burden carried by taxpayers and/or consumers. For example, over time there have been increasing government subsidies to the private health insurance industry, with the aim of increasing competition. At the same time, recently, private health insurance premiums have increased by about 5.6 per cent, which is well above the 3.5 per cent CPI increase for Health (September 2015 to 2016)<sup>6</sup>. If people are hospitalised and use their private health insurance, there is a financial gap between the amount paid by the private health insurer and the hospital costs, which again the consumer is expect to meet. It is estimated that 10 per cent of people who have private health insurance do not use it when hospitalised, because they cannot afford to pay any gap in fees<sup>7</sup>. Thus, a financial benefit flows to the insurer, while the financial burden of the cost of care flows back to the taxpayer. Consumers are now paying threefold for their health care, firstly through their taxes, which are re-distributed by government, secondly for their private health insurance premiums, and thirdly at the point-of-care. The benefit of this industry to the health of the population has never been evaluated.

Given the above comments, it is hard to see how free market principles can be successfully applied to a system which purpose is to enable government to meet its public good responsibilities, rather than a profit motive.

### **How greater contestability could place users at the heart of service delivery**

Contestability requires that all consumers have access to the same set of services and can choose the service that best meets their clinical needs – there are no impediments. This is not the case in public hospitals, in which the availability of health services is often constrained by the non-availability of specialist clinicians, inpatient beds, specialist technology and other equipment. This is particularly the case in regional, rural and remote locations. As well, the level of health services that are available in public hospitals are determined by State health policy, through which the Role Delineation level of hospital services is used to restrict the level of services that are provided in individual hospitals. The rationale for this approach is based on sound principles of ensuring quality and safety for patients, and is viewed as an economically responsible use of taxpayers' dollars overall.

Many consumers who access public hospital services do not have private health insurance and/or the money to pay an up-front fee for their health care. Therefore, these people are not able to access private health services in a timely way. The diagnostic service industry is a prime example of a failure of health policy in providing greater contestability in the health market. The private diagnostic service industry has grown over time to dominate the provision of diagnostic testing, supported by the medical community. When a general practitioner orders a diagnostic test for a patient, often brand forms are used whereby the patient no longer is given a choice between whether they attend a public hospital for their test, where there is no charge, or a private service located in the community. These private services now charge a fee of \$66 over and above the Medicare payment<sup>8</sup>. Currently there are minimal constraints on these private service providers, and there are no publicly displayed indicators to show the quality of the service, or the outcome, in terms of improving individual health or well-being, once a service has been provided.

This change in service delivery raises several problems for some consumers, who often respond by not having the diagnostic test when it is ordered. The monopoly of the private diagnostic service industry raises questions, such as: Where do people now go, who cannot afford the gap in fees charged by these private service providers? Where is the competition, when all the service providers charge the same fee over and above the Medicare rebate? How is contestability to be achieved?

### **How greater informed user choice could place users at the heart of service delivery**

Although health services would not exist without consumers, they have limited power compared with that exercised by health professionals and the other interest groups. When consumers are ill, their interest is to have access to high-quality health services, preferably close to where they live, and at least cost to them. Most consumers do not have expert knowledge about their condition, or how to navigate the health system, and therefore, when they are ill, they are not able to make rational choices about which doctor they should see, or which hospital has the best outcome for certain procedures, or the best record in minimising negative outcomes, for example hospital-acquired infections<sup>9,10,3</sup>.

Consumers currently rely on their general practitioner for appropriate care and/or for referral to a specialist, or to the Emergency Department of a local hospital, which is usually of the general practitioner's choice<sup>11,9,12</sup>. Further, many people who are on low incomes do not access health care in a

timely way, because queues in the public system are long, and they cannot afford the private care which may be more immediate<sup>13</sup>.

Consumers are not able to know the type or amount of services required to cure illness or to maintain good health, and therefore they do not drive demand for health services directly. The neoclassical mechanism, of the market forces of consumer demand driving the supply of goods and services, does not apply in the health market. In fact, the health market in most Organisation for Economic Cooperation and Development countries is supply-driven, where the supply of goods and services drives the demand for them<sup>14</sup>. This explains governments' continuing focus on the formulation of health policies that curtail expenditure – one of their interests is to cap the supply of health-related goods and services in this quasi-market.

### ***The efficiency of public hospital services and how this differs across regions in NSW***

Improving the efficiency of public hospital services was one of the goals of the recent National Health Reform, which contains strategies designed to achieve the engagement of public hospitals and general practice groups, by providing financial incentives through the policy of Activity Based Funding to States and Territories and their Local Hospital Networks, and by creating Medicare Locals using public-private partnerships<sup>15</sup>. However, these strategies provide no incentives for greater technical efficiency at the public hospital or general practice level. Nor do these strategies address the impediments that Hancock (1999) identified as hindering the coordination of patient care among these services<sup>16</sup>.

A case study of the impact of the policy of Activity Based Funding in public hospitals in one Metropolitan and one Rural Local Health District in NSW showed that patients admitted with a chronic condition, that was identified by the Australian Institute Health and Welfare as possibly suitable for treatment outside an acute hospital setting, were still being admitted to hospital<sup>17</sup>. Thus, at least for the three-specific clinical conditions included in this study, sustainable change in patient throughput (efficiency) was not observed. Such change would require the deployment of other incentives (not just funding), which influence the clinical practices and behaviours of professional, clinical and corporate employees who work within public hospitals.

In some hospitals in both the Local Health Districts studied, it is estimated that care was being provided to these patients at less than the price paid (based on the National Weighted Activity Unit inlier price weight), while in other hospitals the cost of the care provided exceeded the price paid for it. Hospitals could provide care within or below the price paid by the Independent Pricing Authority simply by reducing the length of stay of patients in the hospital. It must be remembered that discharging patients from hospitals within a benchmark length-of-stay does not necessarily indicate better clinical outcomes for patients. In fact, patients, may be clinically worse-off, and recover more slowly than would otherwise be the case.

In summary, there is variation in service delivery between public hospital services, in metropolitan and in rural Local Health Districts. The most recent health policy to attempt to improve the efficiency of public hospital services (Activity Based Funding), appears to have inbuilt incentives for hospitals to continue to admit patients who could safely receive their care in a non-acute setting, to discharge them within a shorter time-period than that expected by the Independent Pricing Authority, and, in

so doing, to give the impression of hospital efficiency (greater throughput of patients). The outcome of health policies described thus far, show that government should be cautious in its belief that it has real influence in predicting the outcomes, or controlling for the unintended consequences, of its health policies.

To address the problems identified in the Issues Paper, hospitals (public and private) should monitor their resource use compared with the National Efficient Price paid for certain clinical conditions (Diagnosis Related Groups), with the view of reducing variability between and among hospital services. Future Commonwealth incentives designed to improve efficiency in public hospital services should flow direct to those hospitals or health services which have achieved efficiency.

Relevant State and Territory health agencies (e.g. NSW Bureau of Health Information and NSW Clinical Excellence Commission), should return data collected from individual hospitals in useable formats, with the aim that those data are used by individual hospitals to enhance clinical outcomes for patients, and the efficient delivery of hospital services. These agencies should be linked directly with their Commonwealth counterpart.

In responding to the question about, whether there should be policy trials to test alternative approaches to introducing greater user choice, and a phased implementation of reforms, the following point is made and an alternative approach is offered. Incremental reform does not change the core values or structure of existing health services; it plays at the margins, and therefore is only useful if the main objective is to maintain the *status quo*. Therefore, when a reform is introduced, the structure(s) and/or mechanism(s) which the reform is replacing, should be dismantled. The reform might need to be refined to smooth out any unintended consequences once implemented, but each refinement should be designed to continue to improve the system and/or processes.

***How greater competition, contestability and user choice in public hospital services could be complemented.***

Funding models mentioned in the Issues Paper (such as those that incorporate quality indicators, bundle payments across services, or make capitation payments to providers) have been used in the past (here or overseas), and each has been shown to have limitations for the allocation and distribution of public monies. Patient centred 'managed competition' should be considered as a payment model for health services. A patient centred model of managed competition would consist of vouchers being provided to everyone who has a Medicare number, based on their health profile. Consumers would use these vouchers to purchase health care/services when required. The health service provider would exchange the vouchers for dollars, once the service had been provided. This payment model is a variation on the models of 'managed competition' described by Scotton in 1995, and by Richardson in 2005<sup>18,19</sup>. Funding models that incorporate quality indicators, such as clinical outcomes, rather than the system outputs, such as patient throughput, would also facilitate a patient centred approach to the funding of hospital services. To be successful, this payment model would require a different accounting system to that which exists currently, and a commitment to building the public infrastructure to give patients options/choices about where, and from whom, to purchase services that best meet their clinical needs, at an affordable cost.

In relation to making comments about possible changes in demand management by state and territory governments, as mentioned previously, the health system is supply-driven. State and Territory governments already have several mechanisms that are designed to cap the supply of health service infrastructure, and, in so doing, to manage the demand for health services. These include, caps on the number of medical trainee positions, the number of public hospital beds and infrastructure funding. Changes in demand management at the point of care, would require support from government, and changes in the professional culture of clinicians and in the organisational culture of public hospitals, which to date have not been achieved through the implementation of health policies.

The different professional and organisational cultures are known impediments to better coordination between primary and tertiary healthcare services providers, as mentioned previously. Co-ordination between these services might be improved, if mutual respect between health professionals was fostered early during their professional training. This could be achieved by, rotating students between public and private hospital and community-based healthcare services during their clinical training, and by health professionals working in clinical teams. To be successful this would require a team approach to education and training, and the centralised co-ordination of clinical education and training among: universities and other training institutions, private hospitals, public hospitals, community health services, general practice clinics, and specialist clinics.

Strategies mentioned in the Issues Paper to improve access to services in regional and remote areas through reforms, such as greater use of telehealth, expanding the scope of practice of nurses, and more fly-in-fly-out arrangements are currently available, (and operate in some areas) thus none of these can be considered a reform. On the surface, each of the suggestions in the Issues Paper do provide a solution, but none of them solve the problem, which is: how to attract and retain qualified health professionals in regional and remote areas. One way to attract health professionals to regional and remote areas is to employ, at the same point in time, a critical mass of health professionals (i.e., three or more). This number of staff is the minimum required to constitute a team, which would benefit patient care by providing service continuity. A team approach would also benefit staff by providing professional support for case-conferencing, cover for staff to attend on-going education and training, and for holiday relief.

***What further data should be published to facilitate improvements in public hospital services through benchmarking, and inform greater user choice about clinician and/or hospital services?***

Many of the indicators of performance mentioned in the Issues Paper are currently available, but could be made more accessible to consumers. These performance indicators include: quality and safety, waiting times for surgery, response rates to emergency care, patients' satisfaction with the care provided while in hospital, and satisfaction with the quality of hotel type services (food etc). To make informed choices about clinician and/or hospitals services, consumers need access to all levels of information i.e., individual clinician performance, clinician led-team outcomes, and hospital outputs compared with peers.

Analysis and publication of further data, to facilitate improvement in hospital services through benchmarking are those data showing the clinical outcomes for patients, such as: outcome of

treatment, comparison of treatment options, and consumer ratings on their level of functionality following treatment in hospital. Examples are: the degree of improvement in functionality following surgical intervention such as a hip replacement (baseline and at 3 months), and the improvement in patients' biochemical markers (baseline and at 6 months) following medical intervention etc. These data should be standardized and made available in real-time.

The mechanisms for assembling and communicating data and information to patients mentioned in the Issues Paper, (e.g. MyGov website and mobile phone apps) are potentially available, but these are not accessible to all. Making each existing mechanism easily available by refining its user-friendliness, increasing awareness of its availability and usefulness, and including a greater range of performance indicators should be given priority over introducing new mechanisms.

### ***Types of public hospital services and patient populations suited to greater user choice***

All health services and clinical decisions are potentially susceptible to greater user choice and competition between clinician and/or hospital. Patients should be given choice over all decisions related to their health and well-being on their first contact with the health system, and at each point when a decision is being made about changing their treatment regime.

Both clinical diagnosis and the possible treatment options, require expertise over and above that which most consumers have. Thus, a continuing dialogue between the treating clinician and the patient is required. In cases where a patient is unable to independently make decisions, an independent advocate, of the patient's choice, should be involved to support patients in their making difficult choices about their health needs. There are situations where patients who because of their condition (e.g. unconsciousness) are unable to be consulted directly and in such cases, the next-of-kin (or carer) should be consulted. In situations where neither of the above options are practicable, enabling informed user choice requires an alternate mechanism to be developed, such as the establishment of an independent agency (i.e., not-for-profit/government funded), which is empowered to represent the interests of consumers.

Such an agency could also enhance consumer protection by brokering the best treatment options, or timely access to services for patients who are unable to do so on their own behalf. Existing consumer protections also would be enhanced through increasing consumer awareness about where to access information about the clinical performance of individual clinicians and hospitals, and by operating as a one-stop-shop for other health service information. For example, how people who are not English-speaking can access an interpreter service (i.e., access to someone who speaks English and who also speaks their native language, and who is independent from the immediate family). Hospitals, for their part should include in open disclosure reports data about the health professional(s) clinical practice performance, over 3-years prior to the event. Trends in hospital performance should be displayed publicly, for example every 3-5 years.

The assumption underpinning the question 'who should bear the cost of greater user choice' is that it will cost more. User choice (i.e., being able to choose between which product or service to purchase) is a component of the making of any decision about purchasing a service or product. Introducing greater user choice should not increase costs to the consumer or to the taxpayer. If there are costs associated with introducing greater user choice (e.g. establishing an independent

agency), those costs should be met by re-distribution of funding from the existing health budget. For example, withdraw or reduce Commonwealth funding currently provided as subsidies to the Private Health Insurance industry and re-invest those funds in creating health service infrastructure.

In responding to the question about how to deliver choice to patients in regional or remote areas, it is acknowledged that patients have a variety of requirements, based on their clinical condition and socio-economic circumstances. The provision of funding for travel for people who live in regional area to access health services for planned treatment/intervention is available, but for many people who have family and work commitments travelling to access health services is not realistic. Further, patients who require unplanned, or semi-urgent treatment in a better serviced area, find that it is often quicker to use informal transport than the Ambulance service. Using informal transport, which is usually provided by a relative or friend, results in the cost of travel being met by that individual, rather than the taxpayer (the funder of public hospitals). The frequency and impact of this practice should be investigated.

Ideally, rather than patients travelling to better-services areas, employing a greater number of general physicians, practice nurses and allied health staff to work in rural areas where there are few, would help. The economic benefits of this strategy, such as reducing the amount of public expenditure on health care in the short-term are unlikely to be realised, but the long-term benefits could be substantial, particularly for people living with chronic disease. For example, this patient cohort might not seek acute health services as frequently out of their local area thus reducing travel costs. Local access to monitoring and management would delay the sequelae of their disease, which in turn may result in improved quality of life and fewer admissions to hospital over the long-term.

## Bibliography

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<sup>1</sup> Stilwell, F 2012, *Political Economy: the contest of economic ideas*, 3rd Edn, Oxford University Press

<sup>2</sup> Stilwell, F 2011, 'The State: Competing Perspectives', *Readings in Political Economy, economics as a social science*, 3rd Edn, pp. 274-277, Tilde University Press Ltd, Australia

<sup>3</sup> George, S 2013, 'The rise of illegitimate authority and the threat to democracy', *Journal of Australian Political Economy*, vol. 72, pp. 5-22.

<sup>4</sup> Spies-Butcher, B 2014, 'Markets, Universalism and Equity? Medicare's Dual Role in the Australian Welfare State', Special Issue, ISSN 0156-2826, Addressing the Real Disease? The Political Economy of Health, *Journal of Australian Political Economy*, vol. 73, pp.18-40.

<sup>5</sup> Independent Hospital Pricing Authority 2011, *Literature Review: Efficiency, international best practice in ABF and future payment reform*, IHPA, viewed 18 September 2013, <http://www.IHPA.gov.au>

<sup>6</sup> Australian Bureau of Statistics, 6401.0 - Consumer Price Index, Australia 2016, viewed 6 January 2017, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/6401.0>

<sup>7</sup> Seah, S, Cheong, T, & Anstey, M 2013, 'The Hidden cost of private health insurance in Australia', *Australian Health Review*, vol. 37, pp. 1-3.

<sup>8</sup> Baker, D 2014, 'Cutting Health Costs: Lowering Out of Pocket Expenses by Changing Processes', Special Issue, ISSN 0156-2826, Addressing the Real Disease? The Political Economy of Health, *Journal of Australian Political Economy*, vol. 73, pp. 40-57.



<sup>9</sup> Hollingsworth, B & Peacock, S 2008, *Efficiency Measurement in Health and Health Care*, Routledge, London and New York

<sup>10</sup> Davidson, B 2011, 'Contestability in Human Services Markets', *Journal of Australian Political Economy*, vol. 68, pp. 215-239

<sup>11</sup> Johnston, J & Duffield, C 2002, 'Strategic Public Governance in Australia Health: The "Unsmart" Incapacitated State', *Administrative Theory and Praxis*, vol. 24, no 1, pp. 125-144

<sup>12</sup> Britt, H, Miller, G, Henderson, J, Charles, J, Valenti, L, Harrison, C, Bayram, C, Chambers, T, Zhang, C, Pam, Y, O'Halloran, J, Pollack, A 2013, *A decade of Australia general practice activity 2003-04 to 2012-13*, general practice series no. 30, ISBN 978-1-74332-379-3, Sydney University Press

<sup>13</sup> Baker, D 2014, 'Cutting Health Costs: Lowering Out of Pocket Expenses by Changing Processes', Special Issue, ISSN 0156-2826, Addressing the Real Disease? The Political Economy of Health, *Journal of Australian Political Economy*, vol. 73, pp. 40-57

<sup>14</sup> Loepky 2014, 'Canada, Health and Historical Political Economy', Special Issue, ISSN 0156-2826, Addressing the Real Disease? The Political Economy of Health, *Journal of Australian Political Economy*, vol. 73, pp.172-184.

<sup>15</sup> Council of Australian Governments 2011, *National Health Reform Agreement 2011*, COAG, viewed 10 October 2012, [http://www.federalfinancialrelations.gov.au/content/npa/health\\_reform/national-agreement.pdf](http://www.federalfinancialrelations.gov.au/content/npa/health_reform/national-agreement.pdf)

<sup>16</sup> Hancock, L 1999, *Health Policy in the Market State*, ISBN 1 86448 724 0, Allen Unwin.

<sup>17</sup> Sheridan, J 2016, Activity Based Funding: The implications for Australian health policy, viewed 4 January 2017, <https://ses.library.usyd.edu.au/handle/2123/15763>

<sup>18</sup> Scotton, RB 1995, Managed competition: Issues for Australia, *Australian Health Review*, vol. 18, pp. 82-104.

<sup>19</sup> Richardson, J 2005, 'Priorities of health policy: cost shifting or population health' *Journal of Australian and New Zealand Health Policy*, vol. 2, no. 1, doi: 10.1186/1745-6482-2-1.