



HEALTH CONSUMERS'
COUNCIL
YOUR VOICE ON HEALTH

Reforms to Human Services

Productivity Commission Issues Paper

Response to Issue 5: Public Hospital Services

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The responsiveness of public hospitals to patients' needs and preferences

The Health Consumers' Council (WA) Inc advocates for a patient-centred health care system which is responsive to patients' needs and preferencesⁱ. The reality of health care services is that they are usually inward looking and have the service's needs more at the centre of planning rather than patient needs. The need to improve patient experience is recognised nationally.ⁱⁱ

Services are stretched with funding constraints and are not always able to accommodate every preference. It would be disingenuous to suggest that all preferences are to be met while not providing adequate funding to safely do so. The community are aware that services are finite and expect to be given realistic expectations of what they can hope to receive from our health system.

With regard to **Culturally and Linguistically Diverse (CaLD) populations** and, in particular, members of new and emerging communities, public hospitals provide what are seen as excellent services for the most part. However, there are areas where hospitals could expand to better support cultural diversity. Suggestions include:

- The use of universal health symbols to assist those whose level of English is low or non-existent
- Ensuring interpreters are used throughout the patient journey
- Training staff in ways to ask questions of patients to gain better responses to questions – many people will not answer direct questions with much more than a 'yes' or a 'no', or may come from a culture where asking questions or expressing your own wants/preferences is frowned upon.

The equity of access to public hospital services

Culture is key challenge facing our health system. There is evidence of systemic racism in our health servicesⁱⁱⁱ, and the experience of Aboriginal consumers will often differ from other consumers. The negative assumption of alcohol and drug usage were appallingly highlighted in the recent case of Miss Dhu in WA and Gurrumul in Northern Territory.

In relation to CaLD consumers, some of the above suggestions will assist with providing greater equity of access. Signs that are universally understood, interpreters and translated material, staff who have developed skills in cultural competence all support greater equity in accessing health care and public hospital care.

the quality and efficiency of public hospital services, and how this differs across regions and jurisdictions

The recent excellent work by the Australian Commission on Safety and Quality in Health Care on the Atlas of Variation in healthcare shows that there is a significant and at times concerning variation in the safety, quality and access to health services across our different states, and certainly within them. In particular, the experience and health outcomes for country consumers in this vast state of WA is very different from that of metropolitan health consumers. The difficulties WA faces in delivering equitable access to health services across Australia is on a different scale altogether than that faced by, say Victoria or Tasmania.

the scope to improve accountability through more public reporting, including on clinical outcomes and cost effectiveness

The Consumers Health Forum statement in response to the ACSQHS Atlas of Variation highlights the vital place of transparent reporting in driving accountability and patient safety; “These data will shake that assumption and spearhead further demand for more publically available information on the performance of hospitals and surgeons. The disclosure of these big differences demand a vigorous response from the medical profession and health administrators.”^{iv}

The reality remains that most health consumer choices are made in a vacuum of relevant and important data. Consumers are just not appropriately supported to make data driven health choices.

Transparent data drives culture change, and culture change is at the heart of all the intransigence in the health sector to delivering patient-centred care.

How greater competition, contestability and user choice could place users at the heart of service delivery and improve the quality, equity, efficiency, responsiveness and accountability of public hospital services

It might seem counter-intuitive that a consumer advocacy agency is not completely in favour of greater competition, contestability and user choice. However, there are significant concerns for patient safety when profit is linked with delivery of health services. Australia does not aspire to a health system like that in America where patients are forced to make the commercial choice of which severed finger to save, within the constraints of their insurance.^v America’s health system is more expensive and less effective than ours. The many perverse incentives in both systems for doctors to “do something” in order to be paid is not a path towards effective health services. This is not even addressing the profit motives of pharmaceutical and medical device companies who seek to create demand for products. The current public concerns around use of urogynaecological mesh is a case in point. Medical device companies can in some cases provide the training for medical specialists to insert the device and there is again an obvious conflict inherent within this transaction.

Also, specifically in relation to CaLD populations and people who are not able to read and/or understand English, they require adequate support to avoid confusion when there is more user choice. Again, there would need to be support provided by way of explanation and appropriate language use. A suggestion would be for hospitals to develop strategies around greater engagement of bi-lingual bicultural staff with appropriate recompense provided for their time. Alternatively, Patient Liaison Officers from diverse cultural backgrounds could be employed specifically to engage with this cohort.

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The Commission is seeking information on which types of public hospital services and patient populations are suited to greater:

- user choice over clinician or hospital
- competition between clinicians or hospitals
- contestability

as well as the benefits and costs of implementing such reforms, and who would capture the benefits and bear the costs.

A key consideration here is that the care is patient-centred. Much of this question centres on how the system may or may not be able to accommodate this. It would be more useful to think about non-cost based changes such as asking patients “what matters to you” and designing care based around their goals, rather than providing one size fits all care.

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- what decisions patients should be given choice over (for example, the individual clinician or clinician-led team that treats them, and/or the hospital in which they are treated)

The short answer, is as many as the system will allow.

- at what point(s) patients should be given a choice (for example, when a GP refers a patient to a specialist)

From as soon as possible. It needs to be a partnership. There needs to be clearer strategies for an effective wayfinding for consumers from the primary sector into tertiary, e.g. use of HealthPathways. Prior to the visit would be ideal, with patients able to access transparently available data on hospital and surgeon performance (see point

- what support should be offered to patients in making choices and who should provide it (for example, GPs or independent advocates)

Online patient information from sources such as the ACSHS would greatly enhance the independence and effectiveness of patients making informed choice. There is an inherent difficulty in relying on one health professional to be across all choices. A key example is maternity, when a woman attends her GP to confirm the pregnancy. The GP will usually ask “do you have health insurance?” If yes, “which obstetrician would you like?” In this typical exchange the consumer is not being given all information about evidence-based maternity care which includes midwifery led care for low risk pregnancies. If we rely on the GP to be across all this information, then we need to support them with tools like HealthPathways, with associated consumer resources which can be easily downloaded.

For newly arrived people it would be relevant and useful to have independent advocates providing support. There are several reasons for this including:

- Newly arrived people who have come as refugees have access to settlement services. They have usually developed a rapport with the service provider/staff member (who can be the independent advocate) who will be able to assist the client/patient and the hospital staff.

- Use of such a strategy will ensure interpreter services are utilised and that the patient has a clear understanding of the choices available to them
- The settlement service provider staff member will be able to explain what making choices is all about and also explain options to the patient

- [who should bear the costs of greater user choice](#)

HealthPathways for example should be funded through the federal government via the Primary Health Networks. The ACSQHS could continue to develop unbiased resources which could be localised if necessary.

- [whether existing consumer protections are sufficient and, if not, how to address this](#)

There is no way consumer protections can be sufficient when people are not able to make data driven decisions. Access to data is key to consumer protection.

- [how to deliver choice to patients in regional or remote areas with few nearby providers \(for example, by funding patient travel to better-served areas\)](#)

The Patient Assisted Travel Scheme has always been woefully underfunded. The difficulty for rural patients is immense, and it is a credit to their low expectations and general

- [likely changes in the use of other parts of the health system \(including services for private patients\) and how to minimise unintended consequences](#)

A key answer to many of the issues in relation to service planning is to involve the consumer in the design discussion. Involve, not inform. This will entail loss of power which is a significant barrier to appropriate involvement.

- [whether there should be policy trials to test alternative approaches to introducing greater user choice, and a phased implementation of reforms](#)

Any trials need to include people from CaLD backgrounds/new and emerging communities to test not only the content but the efficacy of the approach.

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What information patients would need to make informed choices about public hospital services, how it should be presented and how this should vary for different patient populations.

- what information patients would need to make informed choices about public hospital services, how it should be presented and how this should vary for different patient populations (for example, people who are unable to access information provided on the internet or in English)
- what level(s) of information should be available to patients (for example, information could be provided at the level of individual clinicians, clinician-led teams or hospitals)
- how the information patients need to make informed choices differs from what is currently available publicly (including through the MyHospitals website), and what changes are required to address this

The mechanisms for assembling and communicating data to patients (for example, through the use of application programming interfaces, the MyGov website and mobile phone apps).

A variety of forms is the simple answer. Most people under 60 will actually have a smart phone and the options to have information accessible on these devices is obvious. My Health Record could play a key role here in offering links to reputable websites to inform choice, e.g. ACSQHS website.

Aboriginal and Torres Strait Islander Patients

The Aboriginal Liaison Officer support is a good strategy but is underfunded and not always available to those who need it. The opportunities for better links with Aboriginal Medical Services is obvious. One regional AMS in WA trialled having a staff member located in a Perth-based AMS and the links back and forth between the hospital have been very beneficial for consumers. Culture remains a key barrier to effective care for Aboriginal and Torres Strait Islander patients.

Culturally and Linguistically Diverse Populations

Uptake of interpreters remains low in WA. For new and emerging communities and people from CaLD backgrounds with little or no English will require interpreters and, for some information in a language they are literate in. Some have not had access to education in the past and are not literate in their first language, any information provision will need to be verbal in these instances.

If people are not computer literate strategies must be in place to ensure equity in information distribution. This cohort may include the aged, new populations, Aboriginal people in remote regions and the homeless.

What to put on MyHospitals etc websites – the short answer is ask consumers! Are they really that interested in financial performance of hospitals? No, they are more interested in

knowing if they will come out better than they went in. They need information about individual surgeons etc. – how many of these procedures have they done? What has been the revision rate? Etc – again as previously mentioned, consumers have to make the choice in a vacuum of information.

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In addition to the information patients need to make informed choices, the Commission is seeking input on what further data should be published to facilitate improvements in public hospital services through benchmarking, including:

- what additional performance indicators to publish
- how this information would support more effective public hospital services by improving quality, equity, efficiency, responsiveness and accountability
- who should be responsible for collecting and managing this information, and who should bear the costs.

The tool Patient Opinion has been publicly supported in WA by the Health Consumers' Council of WA. This is because it makes the conversations between hospitals and patients transparent, highlights when there is a positive culture, able to receive and act on feedback, or not.

This model works well with the health services purchasing the service from the not for profit organisation which has developed this website along the same very successful lines at Patient Opinion in the UK.

Other key indicators such as surgeon performance have already been highlighted in this paper -the short answer is that we have a long way to go when it comes to using data to drive our health decisions. Patients are usually unable to access the data, or unaggregated data, despite the fact it is their data, about their bodies, paid for by their taxes.

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Again the Health Consumers' Council would counsel the involvement of consumers in the planning, purchasing and review of health services.

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Consider a Patient Reported Outcomes/ Patient Experience score to benchmark

Facilitating co-ordination between primary and hospital is a vital priority for the federal government, and will continue to support a more consumer-centred healthcare system.

ⁱ https://www.safetyandquality.gov.au/wp-content/uploads/2012/03/PCC_Paper_August.pdf page ii

ⁱⁱ https://www.safetyandquality.gov.au/wp-content/uploads/2012/03/PCC_Paper_August.pdf p.32

ⁱⁱⁱ <https://www.mja.com.au/journal/2004/180/10/institutional-racism-australian-healthcare-plea-decency>

^{iv} <https://www.safetyandquality.gov.au/wp-content/uploads/2016/02/Consumer-Health-Forum-Atlas-media-release-26-Nov-2015.pdf>

^v <https://www.theguardian.com/film/2007/sep/24/health.politics>