

Doctors Reform Society of Australia

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Submission to the Productivity Commission regarding the public inquiry into the increased application of competition, contestability and informed user choice to human services

Thank you for the opportunity to provide a submission.

The Doctors Reform Society is an organisation of doctors and medical students whose aim is to have a health system and a society which optimises the health of Australians. Affordable timely access to high quality culturally appropriate health care is one key to that.

As is stated in the Background of the Terms of Reference, a key intention is to 'ensure that high quality service provision is affordable for all Australians and leads to improved outcomes for the economy and individuals'.

Affordability and Access

Australia ranks 9th out of 11 OECD countries with respect to cost related access to health care (1). Those countries which have more public provision of care tend to have less cost barriers to access to care. The cost barriers to care in Australia do not exist in the public hospital system either for inpatients or outpatients. Competition between providers already exists in general practice. Competition is one of the factors which contributes to reduced out of pocket costs for GP access. In rural areas where there is a relative lack of GPs out of pocket costs tend to be higher.

Competition between specialists has little if any effect on out of pocket costs. The market fails to work in this area. Patients usually do not choose their specialist and referrals are seldom based on cost consideration, but depend more on word of mouth amongst doctors and is based more on who the referring GP knows or knows of.

Since 1996 there has been a marked increase in elective surgery in private hospitals, such that now 60% of such surgery is performed in private hospitals. This is as a result of a relative decrease in public hospital funding by the Federal Government (50% down to 38%) compared to State Government, and the Federal Government's support of the private health and hospital industry, mainly through the legislated changes to community rating with respect to private health insurance. The situation now is that those patients who can afford to pay for private care have a choice. They can wait for several years on a public hospital waiting list or they can go privately and be treated within months. Those patients who can't afford private hospital care have no choice. They must wait. This is not the 'service provision is affordable for all Australians' suggested in the Terms of Reference. It is hard to imagine how increased private provision of services in this area can improve this situation.

This goes to timely access to care, clearly intertwined with affordable access. Australia ranks 6th out of 11 OECD countries with respect to timeliness of care(1). Once again, in areas well supplied with

GPs, competition is likely to improve timely access. But for private specialist care where competition is minimal, this is not much of an issue probably because out of pocket costs limit demand. Decreasing (or not growing adequately) public hospital service provision and increasing private provision of specialist services may improve timeliness of care for those who can afford the copayments but will reduce timeliness for those left dependant on the public system as specialists spend more time servicing the private patients. Repeated studies have shown that the relative growth of private specialist services has not led to improved timeliness of care in the public system.

Another area of our health care system which is being considered for increased private involvement is the provision of non GP controlled primary health care. The involvement of private health insurance (PHI) to help fund various innovative models of care has been increasing since the introduction of the Broader Health Cover legislation in 2007. Various chronic disease management programs have been made available through PHI. The basic problem with such an approach is that such programs are not available to non members. This care is not 'affordable for all Australians'.

It would appear that countries which have a strong public health system and limited privatised provision of care do better in terms of affordability and timeliness of care. Australia's gradual move away from a strong public system has already led to decreased affordability and timeliness of care.

Innovation and Cost Effectiveness

Innovation needs to be encouraged. This can happen in both the public and private sectors. Some suggest that the private sector is more suited to innovation but in fact much of the innovation in health care which has emerged over the last few decades has begun in the public sector and adopted by the private sector. This is partly due to economies of scale but also reflects the completely different environment in eg a public hospital where there is a team of specialists sharing the workload, seeing patients as they come rather than 'owning' their own patients, working with academics with university affiliations, and working with trainee specialists. This fosters a questioning attitude to treatment, and an interest in analysis of the benefits of innovations. This is not to suggest public hospitals are perfect but the private sector struggles to do these things as well. There are certainly some private centres affiliated with universities and looking at innovative technologies. But patients in the private sector 'belong' to individual practitioners and any treatments are decided upon by individual doctors. The emphasis on a team of specialists is much less than in a public setting. In addition, there must be a return on investment. The return on investment of innovative transplant surgery for example, is not the kind of thing that one would look for in a private hospital in Australia. A public hospital unit would however, see the issue quite differently, as a financial return would not be a priority.

An example of innovation in the private sector is the myriad new injection therapies for osteoarthritis. This is a very common condition and there is limited evidence for the worth of most treatments in this condition. For years orthopaedic surgeons have been performing arthroscopic debridement for this condition and claiming considerable benefit. Trials have now been done which through serious doubt on the efficacy of such treatment in most situations. Indeed the first significant trial involved a sham procedure under anaesthetic and the response in patients who had nothing done except having a hole in their skin under anaesthetic was the same as those who had the real procedure. This highlights the problem of assessing new therapy. An injection of whatever compound may be associated with an improvement in symptoms but it may simply be a placebo

effect. The explosion in the injection therapies for osteoarthritis has occurred in the private sector. Such treatments are hardly done in the public sector. Patients may improve but often pay \$900 for the treatment and there is also often a cost to the taxpayer through Medicare rebate for a visit or radiology. But these injections may be as limited in efficacy as arthroscopy. The first problem is to get proper research done. Such research is difficult enough in the public sector but most of these injections are done in the private sector by individual doctors and it is even more difficult in that disparate sector to assess the real benefits. This is grossly inefficient and potentially dangerous to patients.

There is currently an assessment of MBS items to find out which treatments and tests should be defunded because they don't work or are not valuable. The Australian Rheumatology Association has recently recommended that arthroscopic debridement be considered for defunding or changed funding. Our reliance on private fee for service medicine however makes implementing change extremely difficult. In a public hospital the team of doctors can adopt an evidence based approach and change protocols according to the evidence. Changing individual doctors' behaviour in the private sector is much more difficult. If we move to even more emphasis on private provision of services, it is very likely even more money will be spent through taxes and patient payments without appropriate analysis of health benefit.

Choice

One of the key drivers for privatisation appears to be the provision of choice. At the GP level this allows people to select a GP or practice which best suits their needs. We know that most patients tend to stay with the one team if they have chronic diseases. The idea of the Health Care Home is designed to build on that. For patients in areas where GP numbers are adequate, choice is already a reality.

Choice of specialist is generally not one of importance to patients. They rely on their GP to refer appropriately. Choice of hospitals is also not usually important, partly because it is dependent on the specialist, but partly because the patient's knowledge of the hospital will usually be limited. Geographical proximity is generally much more important than anything else.

Choice with respect to treatment is so limited by the huge information inequality except in some chronic disease settings. More reliance on privatised services may even make such choice more of a problem as marketing becomes more prominent and patients are attracted by such marketing despite no gains, and possibly some losses, in quality of service which the patient can't detect.

Choices offered by private health insurance are limited only to those who can afford the choice. This is totally inequitable and will not lead to 'improved outcomes for the economy' (Terms of Reference) as it prevents individuals from accessing services which could make them more productive and/or less needful of taxpayer support.

Conclusion

Doctors and the many other professionals in our health care system generally work in a co-operative way. Competition to establish a presence is common, but most of us who see patients on a daily basis want to work with others, not compete. We wish to get the best outcome for

our patients. This doesn't necessarily apply to those health professionals who are running large business enterprises. They may enjoy competition, but their interests are different from health care professionals at the front line. What we need is more help in co-operating with others. That would enhance the efficiency of the health system and lead to better health outcomes for all our patients irrespective of capacity to access privatised services.

The evidence from across the world indicates that in countries with more reliance on privatisation of health care delivery health expenditure tends to be higher and there are greater levels of inequality of health care outcomes. Increased privatisation of our health care system will mean less equity and less efficiency.

1. Mirror Mirror On The Wall 2014 Update: Commonwealth Fund accessed 24/07/2016
<http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>

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