

Scope: This paper comments on the Productivity Commission’s proposal to apply the principles of competition, contestability and informed user choice to reform of the public hospital system.

Summary: The paper starts by reiterating the importance of the health of the population to social and economic development. It then reviews the applicability of competition, contestability and informed user choice to public hospitals, and concludes that their inappropriateness is likely severely to limit their contribution to reform of public hospitals. It identifies the political origin of this unproductive approach to reform.

1. Good health is important

The Commission’s Report ¹ acknowledges that: *“Access to high-quality human services, such as health and housing, underpins economic and social participation.”*

It has long been understood that good health is important to the population. Benjamin Disraeli ² observed: *“The health of the people is really the foundation upon which all their happiness and all their powers as a state depend.”*

More recently, the World Health Assembly ³ resolved: *“... in the coming decades the main social target of Governments and WHO should be: “ the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.”*

Thus good health is not merely a goal for individuals; a healthy population is an essential prerequisite for social and economic development.

2. What sort of market do public hospitals constitute?

The Productivity Commission’s Issues Paper: Reforms to Human Services (December 2016), asks whether the effectiveness of human services could be improved by introducing greater competition, contestability and informed user choice. These attributes - competition, contestability and informed user choice - are three fundamental characteristics of a free market, in the classical Adam Smith sense, and must all be demonstrably present for a system to qualify as a market, and to operate as one. If these attributes are not present in a system, the system will not operate as a market; tinkering with them will be ineffective, and possibly even counter-productive, if it results in the consumption of more taxpayers’ money with no improvement in outcomes.

The extent to which the public hospital system possesses these attributes will now be examined.

The description of **competition** on page 8 of the Issues Paper claims that competition already exists and thrives in human services, but the example given, of GP services, is irrelevant in a discussion of publicly-funded health services: GP services are part of the private health sector, which are subsidised to a variable extent by Medicare, and are not equitable if the practice does not bulk-bill.

¹ Productivity Commission Study Report, November 2016. Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, p. 2.

² Benjamin Disraeli (1804 – 1881)

³ Thirtieth World Health Assembly, 1977. Resolution WHA 30.43

(This example should remind us of the fact that a substantial proportion of hospital admissions are to private hospitals, and the effect of any adjustment of the arrangements for public hospitals cannot be considered in isolation, but their impact on the balance between public and private hospital services must be predicted accurately if unintended consequences are to be avoided.)

The notion of public hospitals striving against one another to attract service users ignores the reality of the constraints on public hospitals, such as attracting and retaining health professionals, and the distribution of health professionals across the State's public hospitals. The long waiting lists for elective procedures in most NSW hospitals, and the prevalence of extended waiting times for access to Emergency Departments, are clear evidence of insufficient capacity, which does not suggest that these hospitals would be able to provide an effective service for the larger numbers of patients which would be attracted by a hospital which was competing effectively in a market.

The strategy of providing budgets or entitlements to users of services has potential merit, but will run up against the same hurdle of limited capacity if users are able to identify a service that meets their needs better. Most public hospitals in NSW are already running at close to their full bed occupancy, and do not have the flexibility to accommodate rapid variations in the demand for their services, as is shown by the frequency with which planned elective surgeries are postponed on account of unplanned emergency admissions to the hospital.

Public hospitals do not fulfil the definition of **contestability** given on page 8 of the Issues Paper; there are substantial capital and human resource barriers to their starting to provide a new service *de novo*. The definition then focuses largely on the threat of replacement of the managers of public providers if they "underperform". This fails to recognise the reality: most expenditure in hospitals arises from decisions made by clinicians. Clinicians decide which patients are admitted to hospital, what investigations are undertaken, what treatment is provided, how long patients stay in hospital, and when they are discharged. Thus the proposal to identify and replace underperforming hospital managers misses the point, and will not fix the problem. The metrics which are used to determine underperformance are not specified, but the Key Performance Indicators which are currently used to assess the performance of NSW public hospitals are couched in terms of finance, patient throughput and the avoidance of adverse events – essentially process measures; positive clinical outcomes are rarely if ever measured and recorded.

Indeed, the Issues Paper itself acknowledges (page 22) the need for "*more user-oriented information than is currently available, particularly on the clinical outcomes achieved by individual hospitals and doctors.*" It becomes clear that more information and analysis of the clinical outcomes of medical interventions is essential before contestability can become more than another catch-cry.

The sentence quoted in the previous paragraph is part of a discussion on **informed user choice**, the third attribute of a market. The Commission's Report ⁴ (page 84) admits that "*Equitable access is an ongoing concern for some groups, particularly those in remote areas. Public patients are offered little choice, which constrains responsiveness to user preferences*", again reflecting the reality that choice of alternative providers is often limited, even in metropolitan areas. The Paper goes on to suggest "*that many public hospitals could increase their service quality and efficiency by matching best practice among their domestic peers*" – ignoring the fact that, even within a hospital, there is substantial variation, not only in the extent to which Clinical Guidelines are followed, but also between the practices of different clinicians within the same hospital. The required changes would

⁴ Productivity Commission Study Report, November 2016. Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform.

impact severely on the jealously-guarded autonomy of individual clinicians' decision-making, and would not be easy to implement.

In addition, however, the notion of the *informed user* requires exploration. While the general public is now better-informed than ever through the ready availability of medical information through the internet, their capacity to evaluate the quality of this information, and their ability to apply it to their own clinical circumstances, lag behind. More telling, though, is the power differential between doctor and patient, and the implied pressure experienced by patients to “do as Doctor says”. Under these circumstances, the goal of informed user choice is a very long way off.

In the literature cited in the Commission's Report ⁵, the majority of the references describe the impact (not always positive) of competition on process measures, such as waiting times, infection rates, readmission rates, and admission levels for various procedures. Clinical outcomes rarely feature: the most commonly-quoted is mortality from acute myocardial infarction, hospital admission for which is hardly likely to be influenced much by “informed user choice”.

Thus the failure of the public hospital system to demonstrate possession of the attributes of a classical free market suggests that it cannot be regarded as one, and that the introduction of increased competition, contestability, and allowing informed user choice, are unlikely to achieve the stated goal of improvements in “*quality, equity, efficiency, responsiveness and accountability of service provision*” (Issues Paper, page 7).

In fact, there is general acknowledgment that the health system (or illness system, as it is perhaps more accurately named), does not possess the attributes of a free market, and is, in the terminology of economics, a “failed market”, which can only operate when restrained by substantial government regulation, as is currently the case. This fact is implicit in the discussion on page 11, where the euphemism “stewardship” is used to soften the image of bureaucratic control.

3. The source of these attributes as the basis for this inquiry

This leads back to consideration of the choice of these attributes of a free market as the basis for the Commission's exploration of these attributes as the starting point for change in the delivery of human services.

The website of the Australian Government Productivity Commission⁶ describes the first two stages of its inquiry into Human Services as follows:

⁵ Productivity Commission Study Report, November 2016. Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, p. 92.

⁶ <http://www.pc.gov.au/inquiries/current/human-services>, accessed 28 December 2016.

Identifying Sectors for Reform

The first stage of the Human Services inquiry is now complete. It has delivered an initial study report identifying services within the human services sector that are best suited to increased application of competition, contestability and informed user choice.

Reforms to Human Services

The second stage of the Human Services inquiry will make recommendations on how to apply increased competition, contestability and user choice to the human services that were identified in the inquiry's first stage report.

The starting point of this inquiry - the market attributes of competition, contestability and informed user choice – was determined, not by the “independent” Productivity Commission, but by the federal Treasurer, Scott Morrison. Thus the starting point for reform has been determined by the neo-liberal philosophy of the government.

A more rational approach would have been to identify the problems confronting the human services sector (or components thereof), and then to canvass solutions to these problems, which could certainly include, but should not be limited to, attempts to modify these market attributes.

The approach adopted by the inquiry, however, has been to select a set of solutions, based on political ideology, and then to look for the human services that are most likely to be susceptible to this limited set of solutions, whose success in improving the services is by no means guaranteed, and whose potential unintended consequences have yet to be explored.

It is as though the Treasurer's car keeps running out of petrol, and his solution is to build more filling stations (because they provide tax revenue), rather than asking a competent mechanic to look at why the fuel consumption of his car is increasing.

Thus we find ourselves in the position of the farmer in the middle of Ireland who, when asked for directions by the driver of a passing car, said: Sure, I'll tell you the way to Dublin; but if I were you, I wouldn't start from here.”

In its Issues Paper, the Commission asks for information on a whole range of questions. But it also acknowledges that respondents should not feel that they are restricted to responding to the questions raised in the issues paper. This response is submitted in that light.

Professor Rufus Clarke