
10 Patient choice

Key points

- Each year, millions of Australians are referred by a general practitioner (GP) to a specialist, allied health professional, or pathology or radiology provider.
 - Where patients referred to a specialist go for their initial consultation also determines which hospital they will be admitted to if they require inpatient care.
- Patients' ability to choose which healthcare provider they go to when they receive a referral is limited by:
 - outpatient clinics refusing to see a patient when there is another public clinic closer to the patient's home
 - a common misperception that a named referral for a specialist or allied health professional, or a branded diagnostic request form, cannot be accepted by an alternative provider.
- All patients should be given the opportunity to choose the provider that best meets their needs, after receiving a referral and support from a GP.
 - Giving patients this opportunity would mainly involve removing barriers to patients exercising existing rights to choice, rather than giving them major new entitlements.
- The reforms would lead to more patient-centred care and improve patient wellbeing by:
 - empowering patients to have more control over their care and choose options that better match their preferences, such as a public clinic further from home with shorter waiting times
 - encouraging providers to improve service quality, efficiency, accountability and responsiveness
 - increasing equity of access for patients who are able to choose to access providers other than the one nearest them.
- Patients would have greater choice if the Australian, State and Territory Governments:
 - amended referral regulations to clarify that patients can choose their private specialist
 - required that referrals and diagnostic requests included a clear statement that advises patients of their right to choose their provider
 - directed public outpatient clinics to accept any patient with a referral for a condition that the clinic covers, regardless of where the patient lives
 - continued to give travel assistance to patients in more remote areas based on the cost of travelling to the nearest provider, but allowed this to be used for travel to an alternative provider.
- The Australian Government should also work with professional bodies to develop best practice guidelines on how to support patient choice.
- Under the proposed reforms, GPs would continue to be responsible for making referrals, requesting diagnostic tests, and supporting their patients.

10.1 Introduction

The Commission is proposing reforms to give patients greater ‘referral choice’ over which provider they go to when referred by a GP for more specialised health care (table 10.1). GPs refer patients to specialists, allied health professionals,¹ and pathology or radiology providers (by requesting diagnostic tests). GPs would continue to be responsible for making referrals, requesting tests and supporting their patients, under the reforms.

Increasing patient choice would empower patients and improve service quality by encouraging healthcare providers — including GPs, specialists, allied health professionals, pathology and radiology providers, public outpatient clinics and hospitals — to be more responsive to patient preferences (discussed further in section 10.4).

The Commission developed the proposed reforms with consideration to what effective service provision would look like from the perspective of patients, providers, and governments.

- Patient choice would be supported by GPs and other healthcare providers, and by ongoing improvements in user-oriented information. This support would let patients with differing levels of health literacy exercise choice.
- Providers would be able to attract patients by improving service quality and being more responsive to patient preferences. To facilitate this, providers would be able to benchmark their service quality and efficiency against their peers.
- Governments would help healthcare providers to understand and support patient choice, and would publish comparative information for both patients and providers. Governments would monitor the operation of patient choice to facilitate ongoing improvement and to increase the accountability of providers.

¹ The term ‘specialist’ is used in this report to refer to medical specialists, not including GPs. The term ‘allied health professional’ is used to refer to health professionals other than doctors and nurses, such as dentists, audiologists and optometrists.

Table 10.1 Overview of proposed reforms to patient choice

<i>Proposed reforms</i>	<i>Timeframe</i>	<i>Potential costs and benefits</i>
<i>Increasing choice for referred patients</i>		
Recommendation 10.1 Australian Government to amend referral regulations to make it clear that patients can choose which private specialist they go to when they are referred.	As soon as practicable.	Additional cost of GP time where supporting choice requires longer consultations. Empower patients and support them to make choices that better satisfy their needs and preferences.
Recommendation 10.2 Patients to be informed by GPs and by a clear statement on all referrals that patients can use an alternative to any provider mentioned in a referral.	As soon as practicable.	Cost of changing referral systems and forms to include statement. Inform patients of their existing rights and options.
Recommendation 10.3 Public outpatient clinics to accept any patient with a referral for a condition the clinic covers, regardless of where the patient lives.	As soon as practicable.	Increase choice for public patients. Improve equity of access for patients that can choose an alternative clinic.
Recommendation 10.5 Australian Government to develop, with professional bodies, best-practice guidelines on how to support patient choice, as part of a strategy to help GPs and other providers to implement the proposed choice reforms.	As soon as practicable.	Cost of implementing strategy. Empower patients and support them to make choices that better satisfy their needs and preferences. Make choice work better for patients, GPs, specialists and other providers. Help GPs and other referrers to support patient choice.
<i>More flexible travel assistance</i>		
Recommendation 10.4 Patients who must travel long distances to access specialist medical treatment should be able to access patient travel assistance schemes regardless of which provider they choose to attend.	As soon as practicable.	May be an increase in number of patients accessing the scheme. Increase choice for patients who must travel long distances to access specialist care. Improve equity of access for patients that can choose an alternative provider.
<i>Evaluation of reforms</i>		
Recommendation 10.6 Australian Government to evaluate patient choice reforms.	5 years after implementing reforms.	Cost of evaluation. Identify further beneficial improvements.

10.2 Referral pathways

Patients typically need to visit a GP and obtain a referral before they can access government-funded services from a specialist, or pathology or radiology provider (except in emergency cases). This reflects the central role of GPs in coordinating patient care and referring patients to other providers when more specialised medical or diagnostic services are appropriate. GPs also make referrals to allied health professionals, such as optometrists, although patients may attend an allied health professional without a referral.

In a year, GPs make about:

- 15 million referrals to specialists (at an average rate of almost one specialist referral in every ten GP consultations), most often to orthopaedic surgeons and dermatologists
- 9 million referrals to allied health professionals, chiefly to physiotherapists and psychologists
- 91 million requests for pathology tests and 15 million requests for radiology tests (GPs often request multiple diagnostic tests in a single consultation).²

While this report mainly discusses referrals made by GPs, the same approach also applies to referrals made in outpatient settings by others, such as specialists and allied health professionals.

Patients referred to a specialist can have their initial outpatient consultation with either a specialist working in private practice or one employed in a public outpatient clinic.

There is no charge to see a specialist in the public sector but patients may be placed on a long waiting list for an appointment (box 10.1). Services are largely funded by State and Territory Governments, with a contribution from the Australian Government.

Waiting times are usually shorter for specialist outpatient appointments in private practice. Patients may bear an ‘out-of-pocket’ cost if the price of the consultation is higher than the fixed benefit paid by Medicare. Out-of-pocket costs vary significantly between specialists providing the same service (box 10.2). There can also be out-of-pocket costs for services supplied by allied health professionals, and pathology and radiology providers.

Specialist consultations leading to an elective hospital admission

An initial specialist outpatient consultation may be followed by others, usually at the same public clinic or with the same specialist working in private practice. For many patients the entire course of their treatment occurs in an outpatient setting. However, following one or more outpatient consultations, some patients need to be admitted to hospital for elective care.

² Specialist and allied health referral numbers are for 2016-17; they are Productivity Commission estimates based on data published by the (Australian Government) Department of Health (2017b) and Britt et al. (2016). Pathology and radiology request numbers are for 2015-16, published by the (Australian Government) Department of Health (2016b, 2016c).

Box 10.1 Waiting times for elective care

Public outpatient waiting times

Waiting times for initial public outpatient appointments vary a lot depending on clinic resources and the urgency of the patient's condition. Patients with urgent conditions may be able to make an appointment immediately. Other patients (with less urgent conditions) are placed on a waiting list, and may face very long waiting times (up to several years). For example, of patients attending a public 'general surgery' clinic in the first quarter of 2017 in Queensland, 10 per cent of patients with the *most* urgent conditions had waited longer than 35 days, while 10 per cent of patients with the *least* urgent conditions had waited longer than 438 days (Queensland Health 2017d). The Commission has proposed that all State and Territory Governments publish more useful data on public outpatient clinic waiting times (chapter 11).

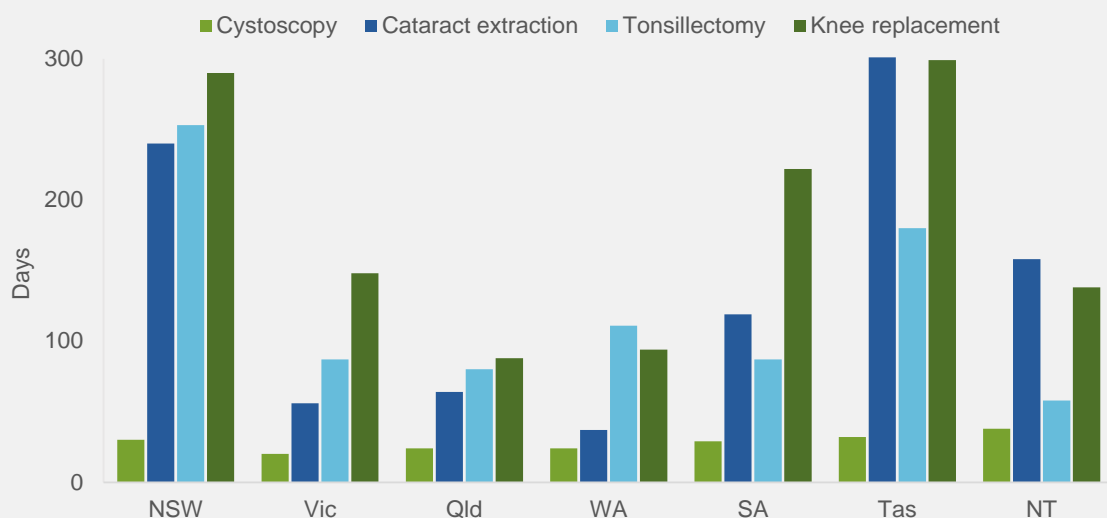
Private outpatient waiting times

Patients may not be able to see a particular private specialist for an outpatient consultation immediately, but waiting times are usually shorter than for public outpatient consultations (especially for less urgent conditions). Private outpatients are more likely to be asked to make an appointment a few weeks or months in the future, rather than being added to a waiting list. There are limited data on waiting times for private outpatient consultations. One study found that patients in Melbourne waited an average of 33 days for a private paediatric outpatient appointment (Kunin et al. 2017).

Elective surgery waiting time for public hospitals

Waiting times for elective surgery at a public hospital also depend on clinical urgency. In 2015-16 the median waiting time was 37 days. However, many patients faced much longer waiting times — 10 per cent waited longer than 260 days (AIHW 2016f). Waiting times varied by procedure and across States and Territories (figure below). The median waiting time for elective surgery in public hospitals is longer for patients residing in more disadvantaged areas (AIHW 2016a). There are limited data on waiting times for elective inpatient care other than surgery.

Median waiting times for common elective surgeries in public hospitals, 2015-16



Source: AIHW (2016f).

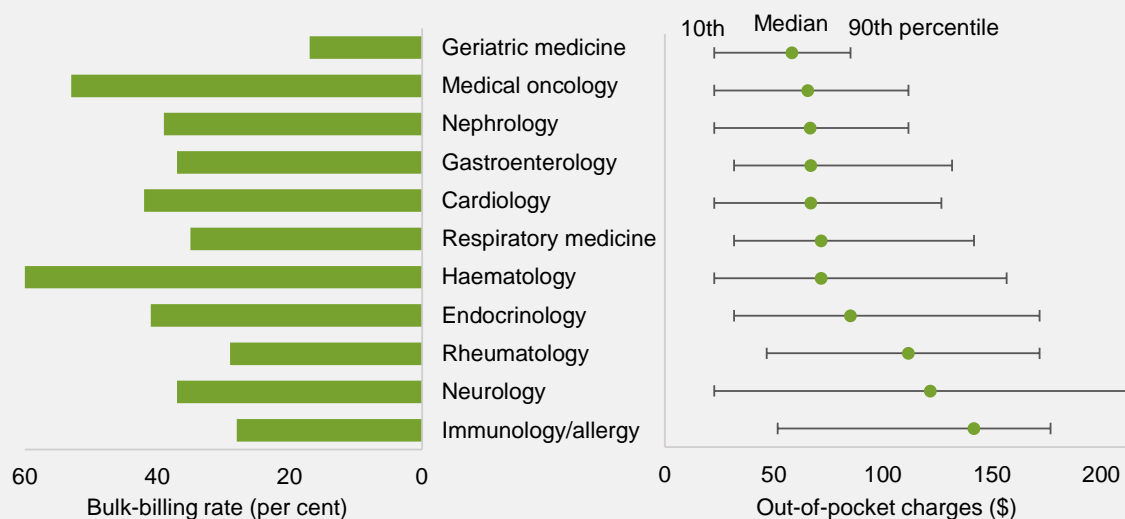
Box 10.2 How much do private outpatients pay for consultations?

Specialists set their own prices for private outpatient consultations, but the Australian Government contributes a fixed Medicare benefit. The benefit is equal to 85 per cent of the ‘schedule fee’ for private outpatients (and 75 per cent for private inpatients). As at October 2017, schedule fees were \$150.90 for an initial consultation with a consultant physician (a non-surgical specialist – item 110) and \$85.55 for an initial consultation with other specialists (item 104) (Department of Health 2017j). Other schedule fees apply to different types of specialist consultations or treatments.

Specialists can set their price equal to the Medicare benefit, so that the patient does not pay a fee (‘bulk-billing’). Alternatively, they can set their price higher than the benefit, in which case the patient must pay the difference (‘out-of-pocket’ charges). Private health insurance cannot be used to pay out-of-pocket charges for *outpatient* services. In 2016-17, about 40 per cent of private specialist outpatient consultations were bulk-billed. Of those that were not bulk-billed, the average patient contribution was about \$75 (Department of Health 2017b).

Bulk-billing rates and out-of-pocket charges vary a lot — between and within specialties (figure below) and between jurisdictions. In 2016-17, the Northern Territory had the highest bulk-billing rate for private specialist outpatient consultations (53 per cent) and Western Australia the lowest (27 per cent). Other jurisdictions had rates between 36 and 46 per cent (Department of Health 2017b). Many specialists charge more to high-income patients than to low-income patients (Johar et al. 2016). The Commission considers that private specialists’ out-of-pocket charges should be published as part of a shift to systematic public reporting on individual specialists (chapter 11).

Bulk billing rates and out-of-pocket charges for initial consultations, 2015^a



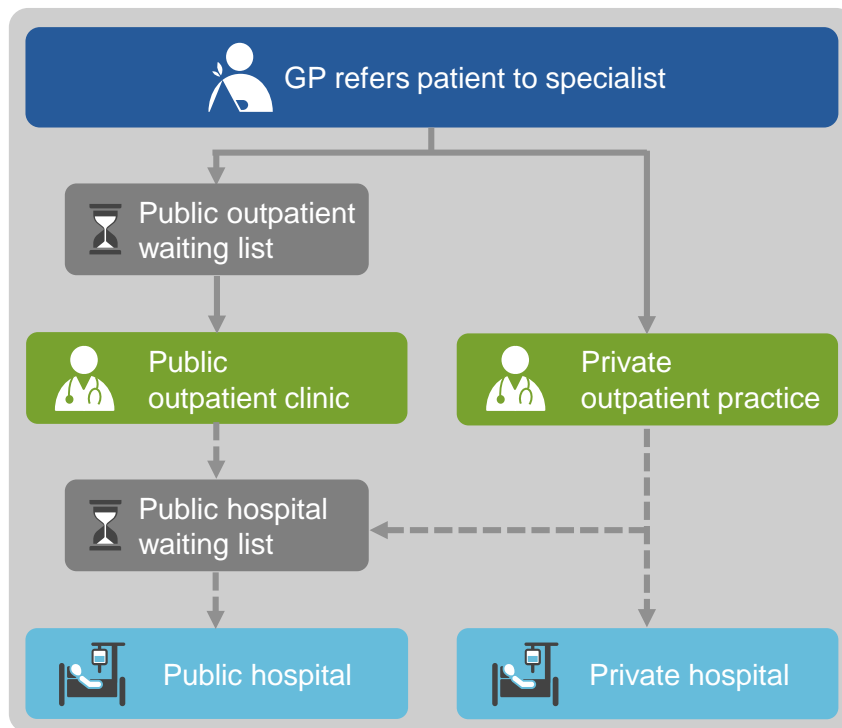
^a Private consultations with a consultant physician. The distribution of out-of-pocket charges excludes (bulk-billed) consultations with no out-of-pocket charge.

Source: Freed and Allen (2017).

There are essentially three pathways from a specialist outpatient consultation to an elective hospital admission (indicated by the dotted lines in figure 10.1):

- public outpatient to public inpatient — public outpatients who need to be admitted are wait-listed at the hospital attached to the public outpatient clinic they attended, unless the hospital is unable to treat the patient
- private outpatient to public inpatient — an outpatient who sees a specialist in private practice can sometimes be admitted as a public inpatient, if their specialist has admitting rights at a public hospital³
- private outpatient to private inpatient — an outpatient who sees a specialist in private practice is usually booked in for admission at a private hospital and treated by the specialist they saw as an outpatient.

Figure 10.1 **Alternative pathways to an elective hospital admission**



The private outpatient to public inpatient pathway raises equity issues. Patients following this pathway are able to access public inpatient services without first queuing on a public outpatient waiting list, although they must usually still join a public *hospital* waiting list. Moreover, access to this pathway can depend on where the patient lives, which GP refers

³ This is restricted in Queensland because patients can only be placed on a public hospital surgery waiting list after they have had a public outpatient consultation (Queensland Government 2015). It is possible in other cases because almost half of all specialists work in both the public and private sectors (about one third work only in the public sector and one fifth only in private practice) (Freed, Turbitt and Allen 2016).

them and whether they are willing to pay any out-of-pocket charges for a private outpatient consultation. The number of people following this pathway varies a lot between jurisdictions but precise numbers are not known. Increasing patient knowledge about this pathway, and supporting patients to make informed choices about which route they wish to follow, would reduce this inequity.

In 2015-16 there were more than 2.4 million admissions to public hospitals for elective care, and more than 3.5 million elective admissions to private hospitals. In the same year, about 700 000 patients were admitted to public hospitals for elective surgery, and about 1.5 million were admitted to private hospitals. The most common elective surgeries were cataract surgery and removal of skin cancers (AIHW 2017a). On average, Australian hospitals perform well against those in comparable countries in terms of quality, equity, efficiency, accountability and responsiveness (AIHW 2016a; Schneider et al. 2017; St Vincent's Health Australia, sub. 207).

10.3 Giving patients greater choice

The Commission proposes that, when a GP refers a patient for an initial specialist consultation, the patient should always be given the opportunity (following support from their GP) to choose either the:

- public outpatient clinic they attend (with the specialist chosen by the clinic)
- individual specialist they see in private practice.

Similarly, when patients are referred to an allied health professional, or pathology or radiology provider, they should always be given the opportunity to choose which one they go to, with support from their GP.

The Commission's proposed reforms (detailed below) would largely remove barriers to patients exercising existing rights to choice (box 10.3) and help GPs to support patient choice, rather than giving patients major new entitlements. The reforms aim to increase patient choice where the benefits are likely to outweigh the costs.

- The Commission is proposing that public patients be given the opportunity to choose the outpatient clinic they attend, although the public clinic (or public hospital, if the patient is admitted) would continue to decide which specialist treats each patient. Specialists and other doctors work in teams in public clinics and hospitals, and allowing them to allocate work within these teams is important for efficiency and the education of trainee doctors.
- Well-established clinical norms dictate that (where possible) public outpatients are admitted to the hospital attached to the public outpatient clinic they attend, and private outpatients are admitted to a (private or public) hospital where the specialist they saw for their outpatient consultation has admitting rights. The Commission does not propose changing these norms, as doing so could impede efficiency and interfere with continuity of care.

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- Patients admitted to (public or private) hospital may subsequently be referred to other specialists within the hospital, have tests ordered or be transferred to another hospital. The benefits of increasing choice for patients after they have been admitted are unlikely to outweigh the costs. Such costs could include a patient occupying a hospital bed while waiting for a bed to become available at their ‘chosen’ hospital.

Helping GPs to support patient choice

GPs are uniquely well placed to advise patients on referral choices. GPs know the circumstances of the patient when they make a referral or request a test, have knowledge of healthcare providers, and they hold a position of trust.

The proposed reforms would strengthen the capacity of GPs to support their patients to get the care they want and need. GPs would continue to be responsible for making referrals and requesting tests; recommending providers to patients (which could include naming a particular provider in a referral or using a branded request form); and directing patients to useful sources of information. The proposed reforms would give GPs additional guidance and information to help them support patient choice.

Box 10.3 Current barriers to patient choice

Patients’ right to choose between private healthcare providers is not well known

Choice of private provider is hindered by a common misperception among patients and providers that a named referral for a specialist or allied health professional, or a branded diagnostic request form, cannot be accepted by an alternative provider. Patients receiving a referral that specifies a provider may not be informed of their right to choose an alternative.

Choice of public outpatient clinic is restricted

Patients wishing to use a referral at a public outpatient clinic are often given no choice but to attend the clinic nearest to their home. This can be due to custom and practice among local GPs, public outpatient clinics having a policy of refusing appointments for people who do not reside in the clinic’s catchment area, or (in Perth) a requirement that referrals be processed through a central booking service which allocates patients to their nearest public clinic.

Travel assistance schemes are inflexible

All State and Territory Governments run patient travel assistance schemes which give financial assistance to patients who must travel long distances to access specialist medical treatment. However in most jurisdictions, patients cannot claim any assistance if they choose to go to a provider other than the nearest one.

Some participants suggested ‘system navigators’ could support patient choice (AHHA, sub. 427; Diana Voss, sub. 450; Tasmanian Government, sub. 485). Such navigators already play a role supporting some patients with cancer or diabetes to make more complex treatment

decisions. However, in the case of referrals and diagnostic requests, they would duplicate a function that GPs are usually better placed to provide.

The level of involvement that patients want in making choices with their GP will vary, but the available evidence indicates that most want at least some involvement. In a recent survey of 1000 Australians aged 50–75 run by the Macquarie University Centre for the Health Economy (MUCHE), 85 per cent of respondents said that if they needed admitted care they would want their GP to discuss which hospitals they could choose from. Only 5 per cent wanted their GP to choose a hospital without any input from the patient (Cutler, Gu and Olin 2017).

It is unclear to what extent GPs currently support patients to make referral choices. The Commission heard that many GPs consistently support their patients to choose (when the patient wants this) but also that some GPs usually make choices on behalf of their patients. Evidence on where most GPs are along the spectrum is scarce. The Royal Australian College of General Practitioners (RACGP) submitted that:

GPs already support patient choice when referring. When a GP refers a patient to another medical specialist, the patient is usually presented with a choice at the time of the referral and consents to the referral once a shared decision has been reached. (sub. DR524, p. 2)

All patients should be given the opportunity to choose their provider with GP support. This includes patients with low health literacy, who may require more support. Patients could still rely on their GP to make referral decisions on their behalf, if they wish.

Patients should also have the option, following support from a GP, to choose their provider independently after leaving the GP's practice. This would enable them to take time to consider their options and to draw on additional sources of information, such as the views of others. The Commission is *not* proposing that patients make referral choices without any GP input.

The RACGP (sub. DR524, p. 4) was concerned that 'if a patient chooses their own medical specialist for a referral and does not inform their GP, the GP may have no way of following up with the specialist for any required action'. However, good patient care requires the provider receiving the referral to inform the GP of the outcome of the consultation or test. The Medical Board of Australia's code of conduct for doctors states:

Good patient care requires coordination between all treating doctors. Good medical practice involves: 1. Communicating all the relevant information in a timely way. 2. Facilitating the central coordinating role of the general practitioner ... (2014, pp. 13–14)

The GP could follow up with the patient if they are not informed by the provider. GPs and other providers should ensure that patients receive good care no matter which providers they choose to use.

To help GPs and other referrers support patient choice, the Australian Government should develop best-practice guidelines, as part of a broader strategy to inform and assist healthcare providers to implement the reforms. This should be developed in collaboration with

professional bodies. The RACGP (sub. DR524) and the Royal Australasian College of Physicians (sub. DR580) expressed interest in providing such input.

In chapter 11, the Commission has proposed reforms to improve the information available to GPs and their patients. The progress of these reforms should not be used as a reason for postponing reforms aimed at increasing patient choice, although better information would amplify the benefits of greater patient choice (section 10.4). GPs are well placed to support patients' referral choices by supplementing the information already available to patients, such as surgery waiting times, with other relevant information such as provider quality.

In England, reforms to patient choice included a national online booking system for patients to arrange their outpatient appointment online, either while in the GP's office or by themselves after receiving a referral. The Commission considered such a system but found the potential costs were not justified at this time. It would likely be expensive and complex to implement across states and territories. The National Health System in England spent £280 million on its 'Choose and Book' system between 2002 and 2012 (Dusheiko and Gravelle 2015). The Queensland Government (2016c) has announced a more modest plan to provide online booking for public outpatient appointments by 2020.

Clarifying existing rights to choose between private providers

Patient choice is limited by a common misperception among patients and healthcare providers that a named referral for a specialist or allied health professional working in private practice, or a branded diagnostic request form, cannot be accepted by an alternative provider. As a result, specialists sometimes refuse to see a patient because a different specialist is named in the referral. The patient must then contact their GP's office to ask them to change the name in the referral.

The Australian Government Department of Health advised the Commission that current regulations for private sector providers give them scope to supply services irrespective of whether they are named in the referral.⁴ This is unclear in the regulations for specialists working in private practice, and so should be amended to clarify the right of patients to exercise choice over specialists in private practice.

A clear patient advisory statement should be included on all referrals to specialists, allied health professionals, and pathology and radiology providers to highlight the right of patients to take the referral to an alternative provider to any that is named. This will involve the amendment of existing regulations, which require such a statement on branded request forms for pathology and radiology tests, but leave scope for the statement to be displayed in a way that limits its effectiveness (box 10.4). The regulations should ensure that the patient

⁴ The requirements are specified in the Health Insurance Regulations 1975 (Cwlth), Health Insurance (Allied Health Services) Determination 2014 (Cwlth) and Health Insurance (Pathology Services) Regulations 1989 (Cwlth).

advisory statement is prominent and easy to understand, to maximise its effectiveness in informing patients about their right to choose a provider.

Box 10.4 Patient advisory statements on branded request forms

GPs requesting pathology or radiology services for patients may print or write the request on a branded form, which carries provider details such as clinic addresses. The Health Insurance Regulations 1975 (Cwlth) require branded request forms to include a patient advisory statement. For radiology, the regulations state that the form must contain:

... a statement that informs the patient that the request may be taken to a diagnostic imaging [radiology] provider of the patient's choice ... (r. 19(1)(d))

To satisfy this, branded radiology request forms typically include a statement like:

Your doctor has recommended you use [name of radiology provider]. You may choose another provider but please discuss this with your doctor first.

For pathology, the regulations require the following statement:

Your doctor has recommended that you use [name of pathology provider]. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor. (r. 18A(1)(a))

The wording of these statements means they do little to support patient choice.

- They tell the patient not to choose a different provider without discussing this with the doctor requesting the test, which may require an additional visit to the GP.
- The pathology statement threatens non-payment if the patient chooses inappropriately. The Australian Government Department of Health advised that it is 'unlikely to ever be necessary' for a GP to insist on a particular pathology provider on clinical grounds because 'accreditation requirements ensure there is consistency in quality between providers' (pers. comm. 14 July 2017).

Moreover the statement is often included on the form in a small font and is usually positioned where the patient could easily miss it.

Requiring patient advisory statements on branded request forms is well intentioned, but as these statements currently appear they are likely to do little to help patients understand their options and exercise choice. This should inform the implementation of the Commission's proposed patient advisory statements.

These reforms would, in addition to support from a GP, help patients understand their options. They would also be consistent with the Australian Charter of Healthcare Rights adopted by all jurisdictions in 2008, which states that patients have a right to be informed about services, treatment, options and costs in a clear and open way (ACSQHC 2008).

The Commission's proposal to clarify patients' rights to choose between private specialists was generally supported by participants, including the Australian Healthcare and Hospitals Association (sub. DR561), Breast Cancer Network Australia (sub. DR534), and the Royal Australasian College of Physicians (sub. DR580). An exception was the RACGP (sub. DR524), which instead proposed that GPs be given discretion to decide whether a patient can take a named referral to an alternative specialist. The Commission does not agree.

This approach would run counter to the current regulations and represents a backwards step for patient choice. There is no compelling reason to remove some patients' rights to choose their provider, given the benefits associated with choice (section 10.4). Rather, existing rights should be clarified to facilitate patient choice.

RECOMMENDATION 10.1

The Australian Government should amend the Health Insurance Regulations 1975 (Cwlth) to make it clearer that patients with a specialist referral can choose to have their initial consultation with any private specialist practising the relevant specialty. This includes clearly specifying that:

- referrals do not need to name a particular specialist
- any specialist practising the relevant specialty can accept a referral, irrespective of whether another person is named as the specialist in the referral.

RECOMMENDATION 10.2

The Australian Government should amend the regulations for referrals and diagnostic requests to require:

- general practitioners and other referrers to advise patients that they can use an alternative to any provider mentioned in a referral or request
- all referrals to specialists and allied health professionals, and requests for pathology and radiology services, to include a prominent and easy to understand statement advising patients that they can use an alternative to any provider mentioned in the referral or request.

Removing restrictions on choice of public outpatient clinic

GPs almost always refer patients to the public outpatient clinic nearest the patient's home (when referring to a public clinic). While most State and Territory Governments do not explicitly require this, public clinics may refuse to see a patient if there is another public clinic nearer their home (Cutler, Gu and Olin 2017). Victorian public clinics, for example, can refuse to see a patient under guidelines that state:

If a referral is received for a service that could be provided at a facility closer to the patient's home, specialist clinic staff may contact the referrer and ask them to redirect the referral. However, ... [p]rovided there are valid reasons why the patient should be seen at the original hospital, the referral should not be refused on the basis of the patient's location. (Victorian Department of Health 2013, p. 13)

Such arrangements create uncertainty about whether a referral will be accepted at any public clinic other than the nearest.

A further barrier to choice in some regions is that GPs send referrals to a local hospital network, rather than a specific clinic in that network. The local hospital network then forwards the referral on to the clinic that it decides to be the most appropriate to see the patient (typically the one nearest to the patient's home). In metropolitan Perth, referrals are centrally administered across more than one local hospital network by the WA Central Referral Service. GPs are required to send referrals to the Central Referral Service, which identifies the catchment area in which the patient lives, and sends the referral on to the clinic for that catchment area.

The scope for patients to choose is also limited by a common practice among GPs of lodging referrals directly with a public clinic (or centrally-administered booking service) to request a consultation (rather than giving the referral to the patient to lodge). Some jurisdictions require this, such as Western Australia for the Central Referral Service. The convenience and certainty of this approach may have value to patients, but this needs to be balanced against the barrier to choice it can create.

The Commission recommends that public outpatient clinics no longer be allowed to refuse consultations based on where a patient lives, or to require referrals to be lodged directly by the patient's GP. Patients should have the option of lodging referrals, allowing them to independently choose which public clinic they go to after discussion with their GP.

Redistribution of demand

Participants raised two broad concerns about how a redistribution of demand among public clinics could reduce access for some patients.

- Greater demand at more popular clinics could lead to longer waiting times (Little Company of Mary Health Care, sub. DR547; Queensland Government, sub. DR592; RACP, sub. DR580; SA Government, sub. DR571; VHA, sub. DR531)
- Lower demand at other clinics, particularly if they are smaller ones in regional or remote areas, could threaten their viability and lead to closure — thereby reducing access for patients in these areas (AHHA, sub. DR561; Queensland Government, sub. DR592; VHA, sub. DR531).

The proposed reforms would likely lead to modest changes in demand and waiting times — with longer waiting times for some services at some public clinics (and hospitals), and shorter waiting times for others. Evidence from other countries suggests that when given choice, many patients will still choose to go to the nearest provider (section 10.4). Additionally, changes in waiting times will discourage a large redistribution of demand — as waiting times increase at more popular clinics they will become less attractive relative to those where waiting times are falling.

The reforms should improve equity of access for patients who are able (with GP support) to choose to access providers other than the one nearest them. Patients whose nearest provider has a relatively long waiting time would no longer be prevented from going elsewhere.

Importantly, across all services, patients with more urgent conditions will continue to receive priority access (box 10.2).

Greater patient choice may lead to falling demand in some locations, including in regional or remote areas. Changing demand provides valuable signals about patients' needs and preferences, and how these match with the services offered. Where demand for a service falls, providers may need to make the service more attractive to patients, such as by improving quality.

State and Territory Governments and local hospital networks should actively monitor changes in demand, and investigate and respond to significant changes in demand. Where demand falls they may need to consider remedial action to improve service quality or reconsider the allocation of resources within the jurisdiction.

In summary, removing restrictions on patients' choice of public clinic would lead to some redistribution of demand. The benefits associated with changes in demand sending a signal to providers and governments, in addition to the broader benefits of allowing patients to choose between public clinics (section 10.4), are likely to outweigh the cost of any resulting reduction in patient access.

Care coordination

Patients should be able to consider care coordination among other provider characteristics when choosing which public clinic to attend. Poor coordination may lead to worse patient outcomes. The Victorian Healthcare Association (sub. DR531) suggested that decoupling surgical care from local post-operative and rehabilitation services could increase the risk of poor health outcomes for patients.

The Victorian Healthcare Association also argued that greater patient choice would increase the costs that hospitals bear to ensure that their services are coordinated with those provided outside the hospital.

... 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. (sub. DR531, p. 5)

However, several participants told the Commission that its recommendations would not require major changes in how hospitals coordinate care. Hospitals already coordinate care for patients not residing nearby, particularly hospitals serving a geographically dispersed population such as those providing highly specialised services (such as transplants) to patients across a whole State.

The treating specialist is usually responsible for providing post-operative care, although a GP may provide it if the patient lives far from the specialist. In August 2017 the Australian Government proposed changes that would fund GPs to provide post-operative care to patients (Department of Health 2017d).

The Commission recognises that local relationships between hospitals and post-operative and rehabilitation services can enhance care. However, providers should respond to patient choice and work to connect patients with services that are appropriate to their needs. Providers should inform patients of any risks associated with receiving care far from their place of residence. However, patients should not be restricted from going to any clinic that covers their health condition.

Public clinics would still have the discretion to reject a referral if they are not able to provide the relevant service. Not all public clinics offer all services. The Royal Australasian College of Physicians (sub. DR580, p. 4) pointed out that some endocrine disorders ‘require management by a multidisciplinary team, and these patients should be directed to those hospitals where such teams are located’.

RECOMMENDATION 10.3

State and Territory Governments should direct their public outpatient clinics to accept any patient with a referral for a condition that the clinic covers, regardless of where the patient lives. Where a local hospital network or the WA Central Referral Service processes referrals, that service should be directed to:

- allow patients to lodge requests for an initial outpatient appointment when they have received a referral
- give patients the option of specifying the public outpatient clinic they will attend.

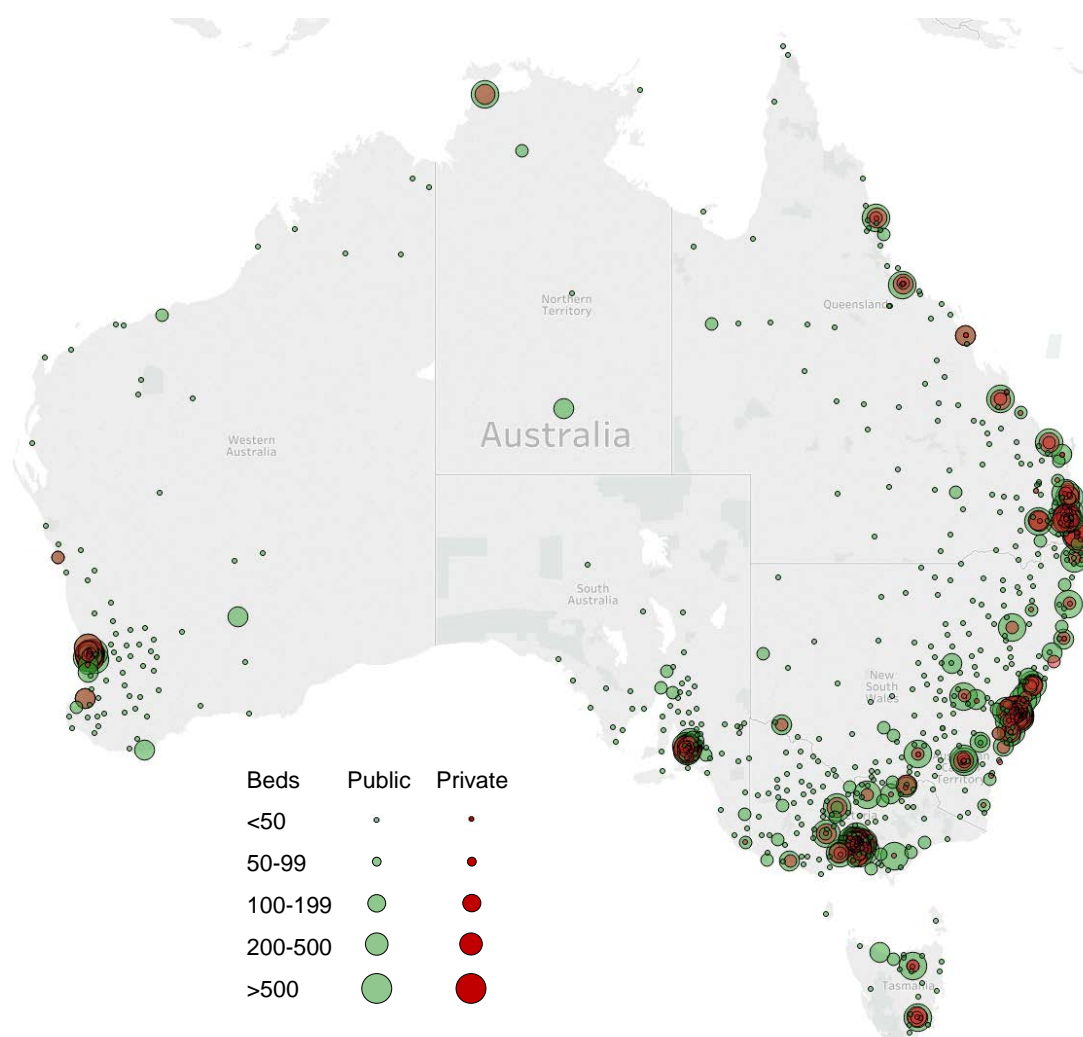
Making patient travel assistance schemes more flexible

Patients living outside major cities tend to have less access to elective care. Over 85 per cent of specialists locate their practice in major cities and only 3 per cent provide services in outer regional, remote and very remote areas (Scott, Yong and Mendez, sub. 87). Hospitals are clustered around major cities (figure 10.2) — particularly larger public and private hospitals, where most elective surgery is performed.

It may be more difficult for patients in regional and remote areas to exercise referral choices, as getting to alternative providers may involve significant travel (with its associated time and financial costs). The Australian Healthcare and Hospitals Association noted that:

For many consumers there is no practical alternative public hospital that can be selected (e.g. if the nearest geographic alternative involves an unreasonable travel burden) ... (sub. 427, p. 5)

Figure 10.2 Location and size of hospitals, 2017^a



^a Data are for September 2017. Bed counts include chairs for same-day admissions.

Sources: AIHW (2017d) and Productivity Commission estimates of bed numbers where AIHW data are not available.

Nonetheless there is evidence that those living in regional and remote areas may be more willing to consider, and travel further to, alternative providers. The MUCHE survey found that respondents living outside major cities were more willing to travel longer distances (up to 60 kilometres) to attend a better quality hospital (Cutler, Gu and Olin 2017). Similarly a survey of more than 2000 English patients found that those living outside of urban centres were more likely to choose to attend a non-local hospital (up to two hours away) (Dixon et al. 2010).

All State and Territory Governments run patient travel assistance schemes which give financial assistance to patients who must travel long distances to access specialist medical treatment (National Rural Health Alliance 2014). The level of assistance is based on the cost

of getting to the nearest provider and in most jurisdictions is only available to patients who go to the nearest provider. As is the case now, only patients who cannot access specialist medical treatment nearby should be able to claim assistance. However, allowing these patients to claim assistance regardless of which healthcare provider they choose to attend, while still basing the level of assistance on the cost of getting to the nearest provider, would increase patients' referral choices without costing governments significantly more.

This reform should improve equity of access for patients in regional and remote areas who would be able to choose to access providers other than the one nearest them. These patients would no longer be penalised for going to an alternative provider when their nearest provider has a relatively long waiting time, or when the alternative provider better meets their preferences.

This reform was supported by participants including the Australian Healthcare and Hospitals Association (sub. DR561), Breast Cancer Network Australia (sub. DR534), the Royal Australasian College of Physicians (sub. DR580) and the Victorian Healthcare Association (sub. DR531). It was not supported by the Queensland Government (sub. DR592) or SA Government (sub. DR571) as they were concerned that it would cause a geographic redistribution of demand that would make it harder to access services in some locations. However, only a fraction of patients access travel assistance, and many of these are still likely choose to go to the nearest service (section 10.4). The aggregate effects on demand for particular services are therefore likely to be slight, and the benefits of more flexible travel assistance are likely to outweigh the costs.

RECOMMENDATION 10.4

State and Territory Governments should change patient travel assistance schemes so that assistance is available to patients who must travel long distances to access specialist medical treatment, regardless of which provider they attend. The level of assistance should continue to be based on the cost of getting to the nearest provider.

RECOMMENDATION 10.5

The Australian Government should develop best-practice guidelines on how general practitioners (GPs) and other referrers should support patient choice when making a referral or diagnostic request. These guidelines should be designed with the relevant professional bodies, and form part of a broader strategy to help GPs and other healthcare providers implement recommendations 10.1 to 10.4.

Monitoring the effects of reforms

Governments should monitor the effects of these reforms to identify where fine tuning is warranted. This could include surveying patients to establish to what extent, and in what

way, GPs are supporting patients' referral choices, and whether patients require other support. The Australian Government could also survey GPs or other providers to establish that they understand the referral guidelines, and whether (and how) the Government should further assist GPs to support patients' referral choices. Wherever possible, monitoring should take advantage of existing data collection to maximise the net benefits to the Australian community.

Five years after introducing the reforms, the Australian Government should undertake a comprehensive evaluation to assess the costs and benefits, and whether further changes are needed. The evaluation should be undertaken in consultation with State and Territory Governments.

RECOMMENDATION 10.6

The Australian Government should undertake an evaluation of the choice reforms proposed in recommendations 10.1 to 10.5, five years after they commence operation.

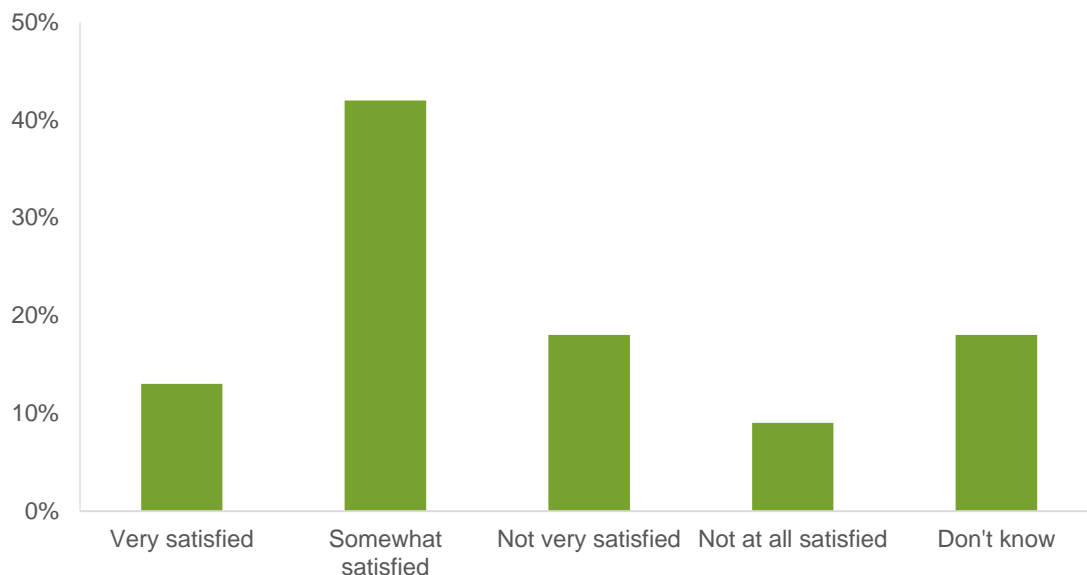
10.4 Key benefits and costs of the reforms

Intrinsic value of choice

Choice has intrinsic value by empowering people to have greater control over their lives (chapter 1). Reviewing choice in the English public health system, Dixon et al. (2010, p. 13) argued that choice of hospital is justified by its intrinsic value, citing a link between providing a choice and 'positive psychological indicators such as perceived control, intrinsic motivation, task performance and life satisfaction'.

Australian evidence suggests that many patients would like more choice. A user survey on the Healthshare website — which has information on healthcare providers, including a directory of private specialists — found that almost 95 per cent of (more than 1500) respondents said they would like to have the option to choose their own specialist when referred by a GP (Healthshare, sub. DR591). The MUCHE survey found that about 70 per cent of respondents were either somewhat satisfied, not very satisfied or not at all satisfied with the amount of choice available in the public hospital system (and a further 18 per cent responded 'don't know') (figure 10.3). These results are comparable to survey results from other countries (Coulter 2004; Dixon et al. 2010). Patients' desire for choice may reflect its intrinsic value or other benefits (discussed below).

Figure 10.3 Satisfaction with choice in the public hospital system^a



^a Based on a survey of one thousand 50- to 75-year-old Australians in December 2016.

Source: Cutler, Gu and Olin (2017).

Choice lets patients satisfy their individual preferences

Patients differ in many ways, including where they live, their ability (or willingness) to pay out-of-pocket charges, and preference over the timing of their care. Providers differ in their locations, performance, waiting times and out-of-pocket charges. Increasing patients' referral choices would allow them to choose providers that better match their individual preferences (box 10.5). The Royal Australasian College of Physicians (sub. DR580, p. 3) suggested that, for example, 'some patients may find it more appropriate to have access to care close to their workplace rather than close to home to reduce travel time to appointments that are within working hours'.

Evidence from other countries suggests that patients tend to choose the nearest hospital, although they may choose an alternative depending on other characteristics such as quality of care and waiting times (Kolstad and Chernew 2009). When patients in England were given more choice in the mid-2000s, the share of patients attending their nearest hospital fell from three-quarters (in 2002-03) to one-half (in 2012-13) (Moscelli et al. 2016). Patients who have had a bad experience at the nearest hospital are more likely to choose one further afield, while patients with poor mobility, such as older or chronically ill patients, are less likely (Dixon et al. 2010).

Box 10.5 (continued)

Adam lives in Thirroul, about 20 minutes' drive north of Wollongong. His GP decides to refer him to a dermatologist. The GP asks Adam whether he has private hospital insurance and discusses Adam's choice to be treated as a public or private outpatient. Adam decides he would like to be treated as a private outpatient as he wants to be seen straight away, although his condition is not urgent. The GP tells Adam there are numerous private dermatologists in Wollongong and offers to discuss a few with Adam, but Adam says he is happy to go to any local dermatologist the GP recommends. The GP gives Adam a referral, and the details of three dermatologists — thinking that at least one will be able to see Adam immediately — for Adam to call to make an appointment.

Through discussion with his GP, Adam has satisfied his preference for an immediate appointment, without being overwhelmed with choice. Without the referral regulations being clarified, Adam may have had to contact the GP's office to get the name of the specialist on the referral changed. Both he and the GP's office have avoided this complication.

John lives in Emerald, in Queensland. His GP decides to refer him to an orthopaedic surgeon for a problem with his elbow. When asked, John tells his GP he does not have private health insurance and prefers to not to go to a specialist who has out-of-pocket charges. John also says that he prefers not to travel more than necessary. The GP explains to John there is no orthopaedic clinic at Emerald Hospital and that, as the nearest orthopaedic surgeon is more than 50 km from Emerald, John qualifies for assistance under Queensland's Patient Travel Subsidy Scheme.

The GP tells John that there are orthopaedic clinics attached to both Rockhampton Hospital (about 3 hours' drive) and Gladstone Hospital (about 4 hours' drive) where John can go and not pay any out-of-pocket charges. The GP gives John her opinion on the two options and explains to John that he can take the referral and go away and think further about the choice before sending the referral to the clinic of his choice — John likes this idea. Over the next few days, John looks up information on each hospital on the MyHospitals website, and speaks to a friend who has recently been to Gladstone Hospital, before choosing to send his referral to the Gladstone clinic.

John has benefited from being able to make an informed choice that meets his needs and receiving travel assistance towards the cost of this attendance. Additionally, he felt empowered in taking control of the decision between the two public clinics.

Holly lives in the Melbourne suburb of Prahran. Her GP suggests she get a precautionary magnetic resonance imaging (MRI) brain scan, although she is not eligible to receive the scan at a public clinic and it will not attract a Medicare benefit. Holly is happy to pay to get the scan. The GP provides her with a branded request form for the scan, which includes a clear statement saying that the request can be taken to an alternative provider. The GP tells Holly that she can take the request form to any MRI provider, gives her the names of three large provider groups and suggests that she look at their websites to choose among the dozens of clinics. After the consultation, Holly uses the websites to find two MRI clinics close to her home, at Cabrini Hospital in Malvern and at The Avenue Hospital in Windsor. She calls each to ask their prices and decides to book an appointment with the less expensive one.

Holly has benefited from being informed of her options and directed to relevant information. She is able to choose the provider that is best for her, based on location and price. If her choice had not been supported, she may have attended a more expensive clinic, further from her home.

Precisely how Australian patients would respond to greater choice is uncertain, given that there is limited information on the service characteristics they value when choosing a provider. In the MUCHE survey, respondents choosing between (hypothetical) hospitals cared most about quality of care — as indicated by average health gains, rates of readmission and adverse events. Respondents' choices indicated they would be willing to travel further and wait longer to access better quality hospitals (Cutler, Gu and Olin 2017).

Patients' choices can drive service improvements

Greater patient choice over which providers they use can drive providers to compete for patients by increasing service quality and becoming more responsive to patients' needs and preferences (such as by improving hospital amenities). This holds for allied health professionals, pathology and radiology providers, specialists, outpatient clinics, and hospitals. Competition for patients can also drive providers to improve efficiency, in order to free up resources that can be used to attract or service more patients. Private providers may reduce out-of-pocket charges to attract patients.

There is limited Australian evidence on the effects of competition between healthcare providers. Two studies of public and private hospitals in Victoria produced mixed findings. Palangkaraya and Yong (2013) found that greater competition was associated with fewer unplanned readmissions for cardiac patients but also a slight increase in mortality. Chua, Palangkaraya and Yong (2011) found an ambiguous relationship between competition and hospital efficiency. A recent study of Australian GPs — who, like other private providers, set their own prices — found that more competition leads to more bulk-billing and lower out-of-pocket charges, without affecting consultation length (which is associated with quality of care) (Gravelle et al. 2016).

There is extensive evidence from other countries (mostly from England and the United States) on the effects of competition between hospitals. Where hospitals are not able to set prices — as with public clinics and public hospitals in Australia — greater competition among hospitals is generally associated with higher quality (box 10.6; Gaynor 2006). There is limited evidence on the effects of competition between specialists, allied health professionals, or pathology or radiology providers.

Considering the available evidence, and the structure of Australia's health system, the Commission considers it unlikely that the proposed choice reforms would alone drive dramatic service improvements. However, these reforms are likely to sharpen the incentives to providers to establish or maintain a good reputation, to be responsive and provide high-quality care to patients, and (for those setting prices) to keep their prices competitive.

Box 10.6 Patient choice in England

A range of reforms were introduced in England from 2006 to increase patient choice. Prior to 2006, GPs referred public patients needing elective care to a clinic at the nearest hospital. In 2006, patients were given some choice over which hospital they attended, and from 2008 they have been able to choose any public or private hospital covered by the English National Health Service. Patients also have access to a useful website to compare alternatives (chapter 11) and an online booking service (Choose and Book).

Quantitative studies have found that following these reforms:

- patients sought out better performing providers — hospitals with lower pre-reform mortality rates and waiting times had a greater increase in elective patients post reform than those with higher mortality rates and waiting times (Gaynor, Moreno-Serra and Propper 2013). Among people seeking a coronary artery bypass graft, choices made by sicker patients were more sensitive to reported mortality rates (Gaynor, Propper and Seiler 2012)
- hospitals in more competitive locations generally improved service quality the most — death rates for patients admitted after a heart attack fell the most in hospitals that had more nearby competitors (Cooper et al. 2011). Hospitals located in more competitive areas also had larger declines in mortality from other causes and lower lengths of stay for elective surgery (Gaynor, Moreno-Serra and Propper 2013). However, one study found that the reforms increased emergency readmissions for patients who had hip or knee replacements, and had no effect on hospital quality for coronary bypass patients (Moscelli, Gravelle and Siciliani 2016).

The cost of GPs' time to support patient choice

The Australian Government, through Medicare, broadly funds GP consultations according to the time they take — including time supporting patient choice. Both the RACGP (sub. PFR337) and the Australian Medical Association (sub. 481) stated that giving patients more choice would increase the length of some GP consultations and hence their cost. The Commission agrees. GPs who take more time to support choice would receive additional funding under the existing Medicare Benefits Schedule, as some consultations that go longer would be eligible for a higher benefit (table 10.2).

Patients paid out-of-pocket charges for about 15 per cent of GP consultations in 2016-17 (Department of Health 2017b). Some GPs have higher out-of-pocket charges for longer consultations. They would need to advise their patients about the possibility of additional out-of-pocket charges before taking time to support choice.

The Commission has estimated that, under the proposed reforms, the additional costs of longer GP consultations would be relatively small for both the Australian Government and patients as a group (box 10.7). These costs are likely to be outweighed by the benefits discussed above.

Table 10.2 Medicare Benefits Schedule for GP consultations

<i>Consultation type</i>	<i>Current benefit^a</i>	<i>Per cent of consultations^b</i>	<i>Definition^c</i>
Level A	\$16.95	2.9	Consultation for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
Level B	\$37.05	80.4	Consultation lasting less than 20 minutes , including any of the following that are clinically relevant: taking a patient history ; performing a clinical examination; arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; in relation to one or more health-related issues, with appropriate documentation.
Level C	\$71.70	15.3	Consultation lasting at least 20 minutes , including any of the following that are clinically relevant: taking a detailed patient history ; performing a clinical examination; arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; in relation to one or more health-related issues, with appropriate documentation.
Level D	\$105.55	1.5	Consultation lasting at least 40 minutes , including any of the following that are clinically relevant: taking an extensive patient history ; performing a clinical examination; arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; in relation to one or more health-related issues, with appropriate documentation.

^a As at October 2017. Benefits shown are for consultations at consulting rooms. Other benefits apply for consultations in nursing homes or elsewhere. ^b In 2016-17. ^c Bold added to highlight differences between definitions for Level B, C and D type consultations.

Sources: Department of Health (2017i); DHS (2017).

Box 10.7 The cost of funding additional GP time to support choice

The Commission estimated the cost of funding additional GP time to support patient choice, relative to a base case that represents the status quo. The base case was constructed using survey data from the Bettering the Evaluation and Care of Health (BEACH) program on the time distribution of GP consultations and the proportion involving a referral or diagnostic request. Data from Medicare and the Department of Veterans' Affairs were used to generate population estimates from these survey results.

No data are available on the extent to which GPs already support choice. The share of base case consultations that would increase in length, and by how much, under the reforms is also uncertain. Reflecting this uncertainty, the Commission estimated the cost of additional GP time under a range of alternative assumptions. It was assumed that between 10 and 40 per cent of consultations with a referral, and between 5 and 20 per cent of consultations with a diagnostic request, would go longer due to the reforms.

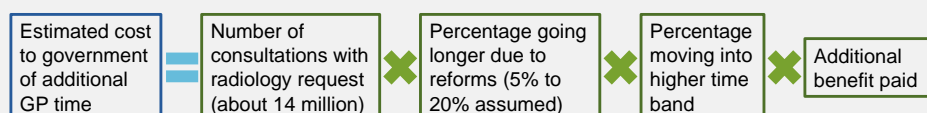
How much extra time would be taken in such cases (and hence the likelihood of attracting a higher Medicare benefit) was also varied in the cost estimates. A higher upper bound was set on the

(continued next page)

Box 10.7 (continued)

assumed additional time needed for referrals compared with diagnostic requests. As per the Medicare Benefits Schedule (table 10.2), a consultation would only attract a higher benefit when its duration increased enough to move it into a higher time band.

Approximation of government cost equation for radiology requests



The resulting estimates suggest that the additional cost to the Australian Government would be in the range of \$6 million to \$24 million per year (equivalent to 0.08 per cent to 0.32 per cent of Medicare spending on GP services).

This comprised:

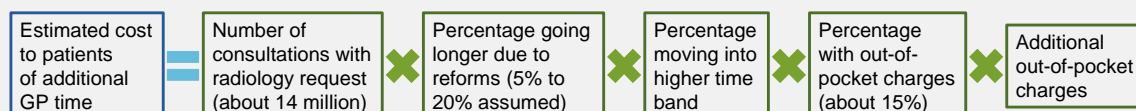
- for **specialist referrals**, \$2.5 million (if 10 per cent of consultations take more time) to \$10.0 million (if 40 per cent of consultations take more time)
- for **referrals to allied health professionals**, \$1.1 million (if 10 per cent) to \$4.5 million (if 40 per cent)
- for **pathology requests**, \$1.4 million (if 5 per cent) to \$5.7 million (if 20 per cent)
- for **radiology requests**, \$800 000 (if 5 per cent) to \$3.4 million (if 20 per cent).

These cost ranges are in direct proportion to the percentage of consultations that go longer due to the reforms. If GPs spend time supporting many more patients to make referral choices, then the costs of funding additional GP time could be toward the upper bound estimates, but the benefits will be proportionately higher. The estimates equate to an average cost to the Australian Government of about \$1.50 for each consultation that goes longer due to the reforms.

In previous years, roughly 40 per cent of consultations were charged at a lower rate than they could be, given their length (those that go longer than 20 minutes but are charged as Level B, or longer than 40 minutes but are charged as Level C). This is not accounted for in the cost estimates. To the extent that this continues, it would reduce the cost estimates commensurately.

Incorporating data on GPs' out-of-pocket charges, and assumptions about how these charges vary with consultation length, the Commission estimated the increase in aggregate out-of-pocket charges due to the reforms.

Approximation of patient cost equation for radiology requests



Counting GP time to support all types of referrals and requests, additional out-of-pocket charges were estimated to be between \$260 000 and \$1 million per year (equivalent to 0.3 per cent to 1.2 per cent of total patient spending on GP out-of-pocket charges). Again this range is in direct proportion to the percentage of consultations that were assumed to go longer due to the reform.

Sources: Productivity Commission estimates based on Britt et al. (2004, 2016), Britt, Valenti and Miller (2014), Department of Health (2017b, 2017i), and Department of Veterans' Affairs (pers. comm. 17 October 2017).

Would the private health system be affected?

Some participants argued that increasing choices for public patients could reduce demand for private health insurance, and increase the burden on the public health system (for example, AMA, sub. 481; NRHA, sub. 428). Catholic Health Australia noted that:

... offering choice of provider may risk undermining one of the key benefits of private health insurance – which could ultimately lead to adding further demand on the public hospital system. (sub. 440, p. 5)

The effect of the proposed reforms on the private health system depends on their effect on both the decision to take out private hospital insurance (on which there are some data), and the decision to access private outpatient or hospital services (on which data are limited).

Just under half of all Australians held private hospital insurance in June 2017 (APRA 2017). A 2014-15 ABS survey found that, on average, people had private hospital insurance for three or four reasons. The most commonly cited reasons were security or protection or peace of mind; to allow treatment as private patient in hospital; and shorter waiting times. About one-third of those with private hospital cover gave ‘choice of doctor’ as one of their reasons (ABS 2016d).

The proposed reforms are unlikely to have a significant effect on the take up of private hospital insurance, or on the private–public balance of hospital services in Australia. People have private hospital insurance for many (and multiple different) reasons, and choice is far from the most common. The proposed reforms would not affect the advantages of attending a private specialist or private hospital (instead of a public outpatient clinic or public hospital), such as being able to choose the treating specialist and avoid a waiting list.

11 Information to support patient choice and provider self-improvement

Key points

- Better public information about hospital and clinician performance would support patient choice and encourage self-improvement by health providers.
- Patients can already draw on some information. However, more information should be publicly reported to facilitate comparisons between providers, including on clinical outcomes and the wide variation in out-of-pocket charges between specialists working in private practice.
- Other countries have shown that it is possible to publish more information on individual providers to help empower patients and assist general practitioners to support patient choice. There is also evidence that publishing more information would prompt providers to engage in greater self-improvement activity.
- To better inform patients and their GPs, and encourage more self-improvement by providers, the Australian, State and Territory Governments should, as part of their health funding arrangements, commit to:
 - releasing all data they hold on individual hospitals (including outpatient clinics), specialists and allied health professionals unless it would clearly harm the interests of patients or breach privacy protections
 - disseminating the information nationally through an improved MyHospitals website
 - allowing non-government organisations to use the data in advisory services they provide
 - phasing-in public reporting on individual specialists and allied health professionals, possibly beginning with registration details, followed by process data (such as location, levels of activity and out-of-pocket charges) and, in the longer term, whether the clinical outcomes of procedural specialists are within an acceptable range.
- Progress in implementing these reforms should be reviewed by the Australian, State and Territory Governments three years after the new health funding arrangements come into force.
- The Commission's 2017 inquiry on data availability and use recommended a package of broader reforms to make data already gathered by governments and others more accessible. These would complement the healthcare-specific information reforms proposed in this report.
- This report does not propose changes to make health care provided to public patients in hospitals more contestable than currently. Governments are already able to commission non-government providers when they are satisfied that it is possible to sufficiently codify and enforce the performance required by an external contractor.

The Commission proposes a number of reforms to improve published information on individual hospitals (including outpatient clinics), specialists and allied health professionals (table 11.1).¹

Table 11.1 Overview of proposed health information reforms

<i>Proposed reforms</i>	<i>Timeframe</i>	<i>Potential costs and benefits</i>
Strengthened government commitment to public reporting		
Recommendation 11.1		
Australian, State and Territory Governments to adopt a general policy of publicly releasing any data they hold on individual hospitals (including outpatient clinics), specialists and allied health professionals, unless clearly demonstrated that it would harm the interests of patients or breach privacy protections.	12 months ^a	Cost of renegotiating relevant parts of health funding agreement between governments, but publishing more information would support choice and improve patient outcomes by encouraging self-improvement by healthcare providers.
Australian, State and Territory Governments to make data on individual hospitals, specialists and allied health professionals available in a format that other organisations can readily include in advisory services they provide.	As soon as practicable	Wider dissemination of information that supports choice and facilitates provider self-improvement.
Australian Government to require specialists to participate in public information provision in return for being eligible to provide any service that attracts a Medicare benefit.	12 months ^a	Cost of amending legislation. Extra compliance costs for specialists but will facilitate self-improvement and support choice.
State and Territory Governments to require all specialists serving public patients to participate in public information provision.	12 months ^a	Extra compliance costs for specialists and data processing costs for governments, but would facilitate patient choice and provider self-improvement.
Improve the MyHospitals website		
Recommendation 11.2		
Australian Institute of Health and Welfare to transform the MyHospitals website into a vehicle that better supports choice by patients, and encourages self-improvement by individual hospitals, specialists and allied health professionals. Australian, State and Territory Governments to provide relevant data and other assistance.	Phase-in as soon as practicable	Cost of data development and website redesign. Better informed patients and will encourage provider self-improvement.
Review progress of reforms		
Recommendation 11.3		
Australian, State and Territory Governments to review above reforms after three years.	Three years	Cost of review but may lead to reporting that is more effective in supporting choice and self-improvement.

^a Adoption of the recommended policy or requirement would be followed by the phasing-in of public reporting over more than 12 months, where needed to develop and collect comparable data in collaboration with jurisdictions, service providers, consumer groups and other interested parties.

¹ The term ‘specialist’ is used in this report to refer to medical specialists, not including general practitioners. ‘Allied health professional’ refers to health professionals other than doctors and nurses (such as dentists, audiologists and optometrists).

The proposed changes have merit in their own right and would increase the benefits of recommendations made in chapter 10 to give patients greater choice over where they receive health services accessed through a referral. The information reforms would also encourage self-improvement by providers of referred health services. Central to the reforms is strengthening and expanding the commitment to public reporting that the Australian, State and Territory Governments made in the 2011 National Health Reform Agreement (NHRA).

The reforms proposed in this chapter would complement broader recommendations made in the Commission's recent inquiry on data availability and use, which called for a number of changes to improve access to, and utilisation of, data across the economy (PC 2017a). This included a new Data Sharing and Release Act, National Data Custodian, and sectoral Accredited Release Authorities to streamline access to datasets.

11.1 Introduction

This chapter considers how reforming published information on individual hospitals, specialists and allied health professionals could support greater patient choice, provider self-improvement, and contestability. There is a case for information provision in health care because suppliers typically have a significant information asymmetry over the patients they serve and governments that regulate and fund them (Arrow 1963).

Information provision is particularly important for contestability because governments should only contemplate a contestable model for publicly-funded services in cases where they are able to codify and measure required performance. It is also necessary to publish the collected information to make service commissioners and individual providers more accountable.

Publishing information on individual providers could prompt improved outcomes through two additional channels:

- patient choice (informed patients seeking out better performing providers)
- self-improvement by providers (through benchmarking against their peers).

Much of the research on the effects of publishing information on individual healthcare providers has focused on performance indicators — such as mortality rates — which are often not presented in a consumer-oriented format, cover only a small subset of service characteristics that patients value, and may not be sufficiently specific to a particular illness or treatment to be seen as relevant by individual patients.

This could explain why studies typically find that published performance indicators have rarely influenced choices made by patients (Devlin and Appleby 2010; Dixon et al. 2010; Faber et al. 2009; Fung et al. 2008; Marshall and McLoughlin 2010; NZHQSC 2016a; Totten et al. 2012; Werner and Asch 2005). Other information sources have tended to be more widely used by patients, such as the views of their general practitioner (GP), friends and family (Day and South 2016; Victoor et al. 2012). Further research is required on

whether there are more consumer-oriented approaches to public reporting which would encourage patients to make greater use of performance indicators (Boyce et al. 2010; Hibbard 2003). There could also be scope to make indicators more specific to the circumstances of individual patients and provide better support to interpret the information.

There is evidence that public reporting encourages health care providers to engage in self-improvement activity, particularly at the hospital level, possibly because of a peer-pressure effect (Bevan 2013; Cacace et al. 2011; Campanella et al. 2016; Chen 2010; Fung et al. 2008; Lamb et al. 2013; Smith et al. 2009; Totten et al. 2012). This suggests that, even if patients do not use performance indicators, it is in the interests of patients to publish the data to encourage providers to deliver more effective services in terms of quality and efficiency, as well as to make them more responsive and accountable.

11.2 What information would support choice, provider self-improvement and contestability?

To support greater patient choice, provider self-improvement and contestability, public information has to describe service characteristics that are valued by patients (as consumers) and governments (as system stewards). Its usefulness will also depend on whether the amount of information, and its presentation, is tailored to the varying capacity and willingness of patients, their supporting GPs, health care providers and governments to use it.

This section gives a broad overview of the types of information that would support greater choice, provider self-improvement and contestability. It is not intended to be a detailed guide or to nominate specific indicators for a particular service characteristic.

Supporting patient choice

GPs would continue to play an important role in supporting patients under the choice model recommended in chapter 10, and so information needs to be accessible and useful to both groups. In some cases, patients may wish to rely solely on their GP to access and interpret the information but patients should, after an initial discussion with their GP, have the option of using available information to make choices independently.

The Commission's proposed choice model would, for referrals to a specialist or allied health professional, facilitate patient choice over either a public outpatient clinic (which in most cases also determines the public hospital a patient is admitted to, if needed) or a health professional working in private practice. To support this model, information would therefore be needed on both individual hospitals and health professionals.

There are many service characteristics that patients can value, including:

- convenience (such as opening hours and distance from a patient's home)

-
- waiting time to receive the service
 - out-of-pocket charges (for health professionals working in private practice)
 - courtesy of staff, specialists and allied health professionals
 - amenity of facilities
 - clinical outcomes.

Studies of hospital choice have found that distance from home is a major determinant of which provider is chosen, with patients tending to select the nearest hospital by default (Boyce and Browne 2013; Dixon et al. 2010; Kolstad and Chernew 2009). However, there is also evidence that patients will bypass the nearest hospital when its clinical or other outcomes are significantly worse than other providers (Beckert, Christensen and Collyer 2012; Gaynor, Propper and Seiler 2012; Moscelli et al. 2016).

Patients have bypassed hospitals with worse outcomes despite (as noted above) rarely making choices based on published performance indicators. Studies have found that patients instead tend to rely on their own experience (particularly a bad experience with the nearest hospital), that of friends and family, and the advice of their GP (Day and South 2016; Dixon et al. 2010). In Australia, these sources can provide information that is more relevant to a given patient's illness or treatment options than the (limited) performance indicators that governments currently publish (detailed below). A recent survey showed that Australians have less trust in the information published by governments compared to their own experiences, those of family and friends, and a GP's opinion (Cutler, Gu and Olin 2017).

Patients may wish to trade off different characteristics, such as choosing a closer facility with lower amenity, which suggests that they should be given information on as many traits as possible. However, there is a risk that the amount of information could far exceed what patients are able or willing to process, possibly facilitating indecision rather than choice. A balance therefore has to be struck that provides information with sufficient breadth and detail to assist patients but does not overwhelm them.

A further challenge is to accommodate the possibility of marked differences between patients in their ability and willingness to use information, including because of differences in health literacy (ACSQHC 2014b; Barber et al. 2009; RACGP, sub. DR524; Tasmanian Government, sub. 485; Victorian Healthcare Association, sub. DR531). As noted above, making the information accessible and useful to GPs will help them to support patients to choose.

One way of accommodating the varying ability and willingness among patients to use information is to have an interactive website (or mobile application) that has a limited number of headline indicators, possibly with visual aids such as infographics, but with the ability to drill deeper into the data as desired by an individual patient or their supporting GP. As detailed below, there are already websites in Australia that provide some information on individual hospitals, specialists and allied health professionals but they have significant limitations in their current form.

Supporting provider self-improvement

The service characteristics reported for the purpose of encouraging provider self-improvement should be largely the same as those for supporting choice, to ensure provider alignment with patient preferences. The key difference is in how the information should be presented, with providers requiring detailed data to benchmark effectively, rather than more consumer-oriented summary measures. As noted above, consumer-oriented measures and the underlying data could be built into a single website (or mobile application), but this is not essential. What is critical is that the data intended for benchmarking are publicly available, rather than being restricted to service providers, and that they name individual providers so as to maximise the incentive to undertake self-improvement.

Supporting contestability

Compared to information that supports user choice, contestability will tend to require greater emphasis on performance indicators that measure clinical and other outcomes, so that governments can monitor whether policy objectives are being met. The indicators are likely to need to be more detailed and technical than those designed for consumers. Timely reporting is also more important so that governments can intervene promptly when underperformance occurs.

A further difference is that governments are more interested than patients in accountability measures, such as levels of expenditure, to understand how well resources are being used to deliver health outcomes. As noted above, patients are largely influenced by convenience (particularly distance from home) but clinical and other outcomes are also influential when the nearest provider is considered to be significantly worse than more distant options.

The next section of this chapter identifies weaknesses in how State and Territory Governments currently monitor a range of performance indicators in their role as system stewards, and give providers access to the data to encourage self-improvement.

11.3 How well does current reporting support choice, provider self-improvement and contestability?

The Commission's inquiry on data availability and use detailed how a large amount of information is collected on the health system for a variety of purposes, including to track activity and expenditure, process insurance claims and maintain electronic patient records (PC 2017a). The Commission has also previously found that the collected data often have limited usefulness due to deficiencies in collection methods, restrictions on who can access the data, and because useful types of information are missing (PC 2015a). As a result, many potential benefits from health data are being forgone (table 11.2).

This section focuses on health data that are relevant to patient choice, provider self-improvement and contestability. Recent reviews of such data in Australia (discussed

below) have found that the large amount of information gathered from hospitals does not always give patients the information they need to be fully informed about choices, service providers to engage in self-improvement, and governments to undertake timely monitoring. An international comparison of health care transparency by KPMG International (2017) suggests that this problem is not unique to Australia.

Table 11.2 Types of health data, users, benefits and gaps

<i>Type of information</i>	<i>Potential users and benefits</i>	<i>Key gaps</i>
Performance of individual health care organisations and health professionals (quality, safety, outcomes, costs).	<p>Helps consumers to choose where to obtain treatment.</p> <p>Enables governments, taxpayers and insurers to assess value for money and hold providers to account.</p> <p>Encourages providers to compete to improve performance.</p> <p>Helps organisations to identify good practices and ways to improve quality or reduce costs.</p>	<p>Cost data and quality measures are not reported for all hospitals.</p> <p>Measures of patient experience in hospitals vary across jurisdictions, and are not always timely or comprehensive</p> <p>No performance data currently reported for health professionals.</p> <p>Information on the characteristics of patients treated is not always complete.</p>
Patient health records.	<p>Improves the coordination of care by allowing health professionals to access and share data on individual patients.</p> <p>Reduces risk of medical errors or duplicated testing.</p> <p>Facilitates clinical and epidemiological research (using de-identified data).</p>	<p>Take up of national electronic health records has been modest, in part due to concerns over quality of included information.</p>
Other administrative data.	<p>Facilitates clinical and epidemiological research (using de-identified data).</p> <p>Enables research into policy effects.</p> <p>Supports development of an evidence base for improving medical practice, developing clinical guidelines or evaluating health treatments and technologies.</p>	<p>Many data are collected, but it has been difficult for researchers to access or link datasets.</p>

Source: PC (2015a).

National reporting by governments

At a national level, patients can access information on individual specialists and allied health professionals on a website maintained by the Australian Health Practitioner Regulation Agency (AHPRA). However, the website is essentially confined to providing registration details so that patients can check that they are dealing with a licensed professional.

There is a significant amount of national reporting on public hospitals, typically under the auspices of the Council of Australian Governments (COAG), but it is not well suited to supporting patient choice, provider self-improvement or contestability. Few of the reported indicators measure patient outcomes, and what is reported is often not disaggregated below state or territory level.

A further problem is that it is difficult to navigate the data because they are built on a complex system of frameworks and reports. There are currently three main reporting frameworks:

- National Health Performance Framework (NHPF)
- Performance and Accountability Framework (PAF)
- Report on Government Services (ROGS).

A recent review undertaken for the Australian Health Ministers' Advisory Council called for reporting arrangements to be rationalised because the purposes of current frameworks are unclear and overlap (Nous Group 2017). The review recommended a single overarching framework based on the NHPF, with elements of the PAF incorporated as appropriate. Other existing frameworks would be linked and subordinate to the overarching framework.

The review also recommended a shift in emphasis to reporting outcomes because:

Many of the current indicators focus on throughput or output rather than measuring the change or improvement of patient's experience or clinical outcome. This does not provide insight to the effectiveness of the health system at either a patient or population level. (Nous Group 2017, p. 11)

The current specification for the PAF already includes a large number of outcome indicators but many of these are not actually reported due to ongoing data and methodological problems. The PAF is also unusual in being designed to allow reporting at the level of individual hospitals (but not specialists or allied health professionals). For this reason, it was the framework adopted for the MyHospitals website, which is supposed to be a national vehicle for informing patients (box 11.1). In reality, the limited number of indicators currently reported under the PAF has meant that MyHospitals is largely confined to reporting waiting times and other process measures for public hospitals (table 11.3). MyHospitals is even more limited in the information it provides on private hospitals due to their participation being voluntary and, for those that do participate, fewer indicators tend to be reported than by public hospitals.

Box 11.1 The MyHospitals website

MyHospitals was established in late 2010 by the Australian Institute of Health and Welfare (AIHW) to provide greater public access to information on hospital performance. The Australian, State and Territory Governments had committed to set up the website as part of the National Health and Hospitals Network Agreement. Their commitment to this initiative was reiterated in the succeeding National Health Reform Agreement in 2011, which described the website as a vehicle for patients to compare available services and performance at different hospitals. It could also be used by GPs to help patients choose a hospital.

The AIHW (sub. DR508, p. 11) noted that 'the website is not solely focused on patient choice and can attract a broad audience, including consumers, clinicians, hospital administrators, researchers/academics, policy makers and journalists'.

(continued next page)

Box 11.1 (continued)

The website currently has information on more than 1000 public and private hospitals. Users can search for a hospital by state or postcode, view the hospital's profile and the services it offers, see data for some performance indicators, and compare to other hospitals. All public hospitals are listed on the website but only around half of all private hospitals are covered (about 300 establishments) because their participation is voluntary.

In late 2011, COAG endorsed the Performance and Accountability Framework as the basis for performance reporting on individual hospitals. The framework has 17 performance indicators for hospitals but only seven of these are currently reported on MyHospitals (table 11.3). The indicators that are reported largely concern waiting times and other process measures. There is almost no information on the outcomes from specific treatments, apart from average length of stay in hospital for a few conditions. Private hospitals listed on the website tend to report even fewer indicators than public hospitals.

In February 2016, a progress report on two of the indicators not yet reported by public hospitals — the hospital standardised mortality ratio and in-hospital mortality rate for specific conditions — stated that it would not be meaningful or helpful to report them until there was greater national consistency in the data. The report identified inconsistent coding practices between hospitals, differences in admission policies between jurisdictions, and an inability to track patients who are transferred between hospitals. It noted that resolving the problems would require a concerted effort by agencies such as the Australian Commission on Safety and Quality in Health Care, and the AIHW, working with national committees responsible for coding standards, and also with state and territory system managers to align coding practices with national standards.

Sources: AIHW (2016h; sub. DR508); NHPA (2012, 2016).

Table 11.3 MyHospitals does not report every indicator it is meant to

<i>Indicator</i>	<i>Reported on MyHospitals?^a</i>
Safety and quality	
1. Hospital Standardised Mortality Ratio	✘
2. Deaths in low-mortality Diagnostic Related Groups	✘
3. In-hospital mortality rate for selected conditions ^b	✘
4. Unplanned readmission rate for selected conditions ^c	✘
5. Healthcare-associated <i>Staphylococcus aureus</i> infections	✓
6. Healthcare-associated <i>Clostridium difficile</i> infections	✘
7. Rate of community follow-up within 7 days of discharge from psychiatric admission	✘
Patient experience	
8. Measures of patient experience with hospital services	✘

(continued next page)

Table 11.3 (continued)

<i>Indicator</i>	<i>Reported on MyHospitals?^a</i>
Access	
9. Access to services by type of service compared to need	x
10. Emergency Department waiting times by urgency category	✓
11. Percentage of Emergency Department patients transferred to a ward or discharged within 4 hours, by triage category	✓
12. Elective surgery patient waiting times by urgency category	✓
13. Waiting times for cancer care	✓
Efficiency and financial performance	
14. Relative Stay Index for multi-day stay patients	✓
15. Day of surgery admission rates for non-emergency multi-day stay patients	x
16. Cost per weighted separation and total case weighted separations	✓
17. Financial performance against activity-funded budget	x

^a Indicators reported by public hospitals. Private hospitals listed on the website tend to report fewer indicators than public hospitals. ^b Acute myocardial infarction, stroke, fractured neck or femur, and pneumonia. ^c Acute myocardial infarction, knee and hip replacements, depression, schizophrenia, and paediatric tonsillectomy and adenoidectomy.

Reporting at a state and territory level

The hospital indicators published at a national level are typically derived from detailed information that State and Territory Governments gather to fulfil their responsibility to oversee the provision of public hospital services.²

Among other things, public hospitals are required to report on a large number of performance indicators embedded in service agreements and associated performance frameworks. Targets are set for many of the indicators, which if not met can lead to a graduated system of intervention by the relevant health department (for example, NSW Ministry of Health 2013, 2016b).

State and Territory Governments sometimes give public hospitals access to data gathered from their peers to encourage self-improvement. An example of this is an activity-based management ‘portal’ developed by NSW Health (Damato 2015). In Queensland, public hospitals have access to a graphical tool — termed variable life adjustment displays — which plots differences in actual and predicted outcomes for various clinical indicators and

² The data that State and Territory Governments supply for national reporting are specified in a series of national minimum datasets, with the data provided to the Australian Institute of Health and Welfare. This is done in accordance with the National Health Information Agreement, which also specifies a nationally agreed set of performance indicators to be reported. The agreement also commits State and Territory Governments to providing various datasets to the Independent Hospital Pricing Authority to assist its calculation of the Australian Government’s funding contribution for public hospitals.

compares to the statewide average (adjusted for patient characteristics) to flag when internal review is required (Duckett, Coory and Sketcher-Baker 2007; Queensland Health 2016d). Moreover, some public hospitals have access to international benchmarking data from the health care analysis company Dr Foster.

Governments contribute to the funding of some clinical quality registries, which gather outcomes data on a specific illness or treatment to facilitate improved practice (box 11.2). The Australian Government Department of Health (sub. DR569, p. 4) noted that clinical quality registries are ‘playing a significant role in changing the culture and fear [among specialists] around public reporting’.

Box 11.2 Clinical quality registries

Clinical quality registries are organisations that systematically monitor the quality of health care within specific clinical domains by routinely collecting and analysing health-related information. They use the data to identify benchmarks and variation in clinical outcomes and feed this information back to specialists for self-improvement. Reports may also be provided to hospital management, health care funders, clinical colleges and researchers.

There is significant heterogeneity across registries. Some monitor the quality of care for a specific service, such as blood transfusions or cardiac surgery, while others focus on a particular disease, such as lung or prostate cancer, and some target a range of conditions and services, such as those associated with major trauma. Reporting arrangements vary, with participation sometimes voluntary and coverage limited to a single state or subset of hospitals, while others cover both Australia and New Zealand. Some registries are partly funded by governments but most are managed by a non-government organisation.

There is evidence that clinical registries can facilitate improved quality and safety by both providing feedback to service providers and by publishing performance data on individual providers. Publication is likely to create additional impetus for providers to engage in self-improvement, rather than prompting consumers to seek out higher-performing providers, given that the information generated by registries can be difficult for patients to interpret.

Publishing performance data can encourage self-improvement by not only hospitals and specialists but also providers of prosthetic devices. Catholic Health Australia (sub. PFR350) noted that outcomes published by the National Joint Replacement Registry have often prompted suppliers to withdraw poorer performing devices from the market, even though consumers do not base their choices on the performance data.

Registry data could also be a useful resource for State and Territory Government monitoring of service quality and safety. However, the data are not routinely included in datasets assembled by governments as part of their stewardship role. For example, a 2016 review of hospital safety and quality assurance in Victoria found that many registries did not provide their data to the state health department, even in cases where the registry was partly funded by the Victorian Government. The review recommended that the Victorian Government make its funding of registries conditional on all performance metrics being provided to the state health department and relevant hospital management at the same time as they are fed back to clinical units.

Sources: ACSQHC (2014a, 2016); AIHW (2016m); Duckett, Cuddihy and Newnham (2016); Larsson (2012).

Data collection on individual specialists also occurs as part of self-improvement initiatives in particular specialities. For example, the Royal Australasian College of Surgeons (2017; sub. PFR374) facilitates ongoing improvement through audits of surgical mortality in each jurisdiction in collaboration with the relevant State or Territory Government. Medibank Private and the Royal Australasian College of Surgeons (2016a, 2016b, 2016c, 2016d, 2016e, 2017) have used data on services provided to private patients to inform surgeons about variation in surgical practice and out-of-pocket charges.

Some jurisdictions have been developing patient-reported outcome measures (PROMs), which are emerging as a useful addition to indicators traditionally used to monitor the performance of health care providers (box 11.3).

Box 11.3 Patient-reported experience and outcome measures

Public hospital patients have been surveyed about their experiences for many years, with varying approaches and transparency across jurisdictions. For example, the NSW Bureau of Health Information regularly publishes results for emergency departments, admitted services, outpatient clinics, small hospitals and maternity units. In Victoria, public hospitals are given survey results each quarter. Providers in Queensland have in recent years been given survey results for emergency departments, small hospitals, maternity units and orthopaedic outpatient clinics.

A drawback of patient experience surveys is that they focus on processes rather than health outcomes. There is an emerging trend to address this by using patient-reported outcome measures (PROMs), which ask patients about their health and health-related quality of life. They are the only way to measure some symptoms (such as pain and nausea) and a patient's judgment of their functioning. They can therefore be a useful complement to clinical outcome measures reported by service providers, such as readmission and mortality rates.

The countries most advanced in implementing PROMs at a systemwide level are England, the Netherlands, Sweden and United States. England was a leader in 2009 when it began to require routine collection and publication of PROMs for patients before and after varicose vein, groin hernia, and hip and knee replacement surgery. In the United States, the focus has been on a number of chronic conditions. In the Netherlands and Sweden, PROMs collection is undertaken as part of clinical registries for specific diseases or conditions.

In Australia, the NSW Agency for Clinical Innovation and the Cancer Institute NSW have been leaders in PROMs. Several NSW local health districts have implemented demonstration projects that include small-scale PROMs collections. In Victoria, some providers already collect PROMs and the Agency for Health Information is developing a pilot for a statewide collection. There is also a trend for clinical registries to use PROMs as part of their measurement of outcomes.

To date, evidence on the benefits of PROMs is mixed. Studies have found strong evidence that PROMs have improved patient-provider communication and patient satisfaction but have yet to be widely used by providers as a tool to improve clinical outcomes.

Sources: ACSQHC (2012); Boyce and Browne (2013); Chen (2015); Chen, Ou and Hollis (2013); Devlin and Appleby (2010); Duckett, Cuddihy and Newnham (2016); Kyte et al. (2016); NSW BHI (2016); Queensland Health (2016b); Thompson et al. (2016); Victorian DHHS (2016a, 2017d); Williams et al. (2016).

State and Territory Governments do not publish much of the data they gather, particularly on clinical outcomes at the level of individual hospitals, specialists or allied health

professionals. However, some jurisdictions do release more information than available nationally. For example, the NSW Government regularly publishes hospital-level data online for elective surgery, emergency departments and patient experience (NSW BHI 2017; box 11.3). Similarly, the Queensland Government maintains a website that provides more information on its public hospitals (Queensland Health 2017b). The Victorian, SA and WA Governments also make some hospital-level information available online (SA Health 2017; Victorian DHHS 2017a; WA Department of Health 2017).

The data that State Governments do publish have similar limitations to information on the MyHospitals website, particularly an almost exclusive focus on process measures such as throughput and waiting times for emergency departments and elective surgery. For public outpatient clinics, even the reporting of process measures is very limited, giving patients little information on differences in waiting times between clinics.

The Queensland Government recently released a discussion paper inviting feedback on how it could expand public reporting of quality and safety to drive ongoing improvements in health care (Queensland Health 2017a). A specific policy proposal will be developed after the feedback period ends in October 2017, followed by targeted consultations on the proposal with affected stakeholders.

Non-government initiatives to inform choice

Patients have always been able to draw on the experiences of family and friends when considering alternative providers of health care. As a trusted source of advice, this can have a significant influence on choice. The advent of the internet has created an opportunity for individuals to broaden this to drawing on the experiences of a wider group, although consumers should not rely solely on this source due to the possibility of being misled by fake reviews and websites that give a biased impression by deleting unfavourable posts.³

Patient Opinion Australia (POA) operates a website where individuals can search reviews that others have posted on the care they have received at a local health service.⁴ The relevant health service can post a response, and this may be followed by a published dialogue between the patient and provider. The website is moderated by POA to ensure published material is not defamatory. If patient feedback is very critical, POA may contact the individual to check that it is sent in good faith.

The POA website was established in 2012 and is modelled on a similar UK website that has operated since 2005. POA is run on a not-for-profit basis. It earns revenue by offering a

³ Section 29(1) of the *Competition and Consumer Act 2010* (Cwlth) prohibits false or misleading representations through testimonials but this depends on timely detection of the behaviour. The ACCC (2013) has published a guide on how businesses and review platforms can comply with the law.

⁴ It is illegal for user ratings and reviews to be used to advertise regulated health services. However, testimonials are generally allowed on consumer information sharing websites which invite public reviews because they are intended to help consumers make more informed decisions and are not considered advertising (AHPRA 2014).

subscription service to service providers, which gives them access to tools and support to help staff make the most of patient feedback. Subscribers can also compare how they are doing and generate reports. Over 150 organisations subscribe to POA.

In 2013, health insurer NIB established a website, called Whitecoat, where people can compare local specialists and allied health professionals based on user ratings and reviews. A number of other insurers now also contribute to the website and an online booking service has been introduced. Reviews are sourced from Whitecoat users and clients of affiliated health insurers. Before reviews are published they are moderated, including to ensure that they do not assess a provider's expertise or quality of clinical care. Unlike the POA website, Whitecoat does not include responses from service providers.

Health insurers have also partnered with Healthshare, which facilitates choice through:

- a website where patients can search by location for specialists and allied health professionals working in private practice. The resulting information can include a health professional's special interests, practice locations, hospital affiliations and whether there are out-of-pocket charges for clients of a particular health insurer
- an add-on to the software used by many GP practices which, in addition to a search function similar to the Healthshare website, enables GPs to automatically populate referral letters with patient and specialist details
- a free online service called Specialist Now, which assists patients to find earlier appointments with specialists working in private practice.

Weaknesses in reporting limit the case for greater contestability

In the study report for this inquiry, the Commission observed that there may be scope for State and Territory Governments to use more contestable approaches to commissioning health care that hospitals provide to public patients (PC 2016a). This could be for an individual health service, subset of services, or an entire public hospital.

State and Territory Governments are already able to utilise private sector providers when they wish to. For example, governments sometimes commission private hospitals to reduce elective surgery waiting lists for public patients (Tasmanian Government, sub. 485). Government-operated public hospitals use private providers for pathology and radiology testing.

Governments also have a long history of funding not-for-profit organisations to provide entire public hospitals.⁵ The commissioning of for-profit operators to provide public hospitals is rarer, following a series of failed attempts to do so in the 1990s (Australian Council of Trade Unions, sub. 100; Duckett 2013; Illawarra Forum, sub. 444; NSW Nurses

⁵ This includes major public hospitals such as St Vincent's Hospital (Sydney); Mercy Hospital for Women (Melbourne); Mater Adult, Children's and Mothers' Hospitals (Brisbane); St John of God Midland Public Hospital (Perth); and Calvary Public Hospital (Canberra).

and Midwives' Association, sub. 247; Queensland Nurses' Union, sub. 405).⁶ Governments found it difficult to sufficiently codify required performance across the many services provided by an entire hospital, leading to conflicts with operators over contract requirements.

Since the 1990s, governments have developed more robust systems for monitoring levels of hospital activity and expenditure, particularly for acute in-patient services. However, safety and quality remains challenging to codify and enforce in a timely way as part of a service agreement. While there are methodologies to measure some aspects of safety and quality, they require an investment of time and resources to develop and maintain. Examples include efforts to measure mortality rates (box 11.1) and survey patients using PROMs (box 11.3).

The findings of a 2016 review of hospital safety and quality assurance in Victoria suggest that State and Territory Governments have a lot more work to do before they can be confident that performance monitoring in their own hospitals, let alone that of external contractors, is as effective as possible.

... most states monitor only a narrow range of safety indicators, and over-rely on individual incident reports rather than analysing trends. As a result, many health departments in Australia do not know the true rate of complications in their hospitals, how safety varies across the different hospitals they oversee, or whether safety is improving over time. They mostly lack the information required to identify concentrated risks to patient safety, and even the knowledge of whether their existing safety policies are working. (Duckett, Cuddihy and Newnham 2016, p. 8)

Compared to public hospitals, there are currently less extensive reporting requirements for private hospitals, and so State and Territory Governments can be even less well informed about their safety and quality (Australian Healthcare and Hospitals Association, sub. 427; Duckett, Cuddihy and Newnham 2016; Tasmanian Government, sub. 485).

While there is scope for more effective performance reporting by both public and private hospitals, it is unrealistic to expect that it will ever be possible to fully codify and measure every aspect of hospital safety and quality that is valued by the community. Governments will therefore continue to face the prospect that, when commissioning services from an external provider, they will be entering into an incomplete contract in the sense that required performance cannot be fully specified.

Governments are already able to commission non-government providers when they are satisfied that it is possible to sufficiently codify and enforce the performance required by an external contractor. Given this, and in light of the above, the Commission is not proposing changes to make public hospital services more contestable than currently.

⁶ Apart from Joondalup Health Campus in Perth, the few public hospitals currently run by for-profit operators tend to be relatively small facilities located outside capital cities. This includes Mildura Base Hospital, Peel Health Campus, Noosa Hospital and Albury Border Cancer Hospital (Australian Private Hospitals Association, sub. PFR381).

11.4 Proposed reforms

Improving public reporting on individual hospitals, specialists and allied health professionals would support patient choice and encourage self-improvement by service providers. Current gaps in available data can leave consumers (and their GPs) in the dark about what they are choosing. Health care providers and governments can be unaware of prolonged safety breaches — such as occurred at Djerriwarrh Health Services in Bacchus Marsh, Victoria — due to gaps in performance data needed to undertake timely monitoring and give feedback to hospital managers, specialists and allied health professionals (ACSQHC 2015c; Duckett, Cuddihy and Newnham 2016).

The Commission considers that the case for better public information provision is strong. More user-oriented reporting (including, on out-of-pocket charges, courtesy of staff and health professionals, amenity of facilities, experiences of other patients, and clinical outcomes) would further empower consumers and bring additional benefits from the patient choice recommendations in chapter 10. Development of better information should occur concurrently, and not delay, patient choice reforms. More broadly, information provision would be in the interests of patients, facilitate more self-improvement by service providers, and help to strengthen State and Territory Government oversight of service provision.

Many inquiry participants supported publishing more information.

CHA [Catholic Health Australia] supports greater provision and transparency of appropriately risk-adjusted performance information. In doing so, we note that the publication of such information often prompts providers to compare their performance with their peers which results in performance improvement — even where consumers themselves do not change provider in response to the provision of performance information. (Catholic Health Australia, sub. 440, p. 4)

AHHA [the Australian Healthcare and Hospitals Association] in general supports reform recommendations that improve transparency in the health care system to support patient choice and enhance system accountability and efficiency ... AHHA strongly supports the reporting of clinical outcomes data ... (AHHA, sub. DR561, p. 3)

... 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. (Health Consumers' Council (WA), sub. 447, p. 2)

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. (Jeanette Sheridan, sub. 451, p. 6)

CHERE [the Centre for Health Economics Research and Evaluation] agrees with the Commission's recommendations for the increased availability of currently collected data and the extension of data collections to include more information on clinical and patient-reported outcomes. (CHERE, sub. DR516, p. 5)

The Tasmanian Government supports the proposal to make more information on hospital services available to the public. To gain most advantage from this expanded reporting effort, this initiative

should be facilitated through the Australian Health Ministers Advisory Council (AHMAC) and devolved to the Australian Institute of Health and Welfare (AIHW) and its policy and data development committee structure. (Tasmanian Government, sub. DR590, p. 23)

... [Alzheimer's Australia is] supportive of the proposed information reforms in strengthening and expanding the commitment to public reporting. A jurisdictional move to a general policy of publishing all data on individual hospitals and specialists, unless it would clearly harm the interests of patients, will be a big step towards transparency and informed decision making for all consumers. (Alzheimer's Australia, sub. DR521, p. 3)

Better information provision would also be consistent with the Australian Charter of Healthcare Rights, which all jurisdictions adopted in 2008 to explicitly acknowledge that patients 'have a right to be informed about services, treatment, options and costs in a clear and open way' (ACSQHC 2008, p. 1).

Some stakeholders raised concerns about specific issues that would arise in shifting to greater public reporting, including privacy constraints and the potential for reported data to provide a misleading impression of relative performance. These issues are discussed further below.

Strengthen cross-jurisdiction commitment to public reporting

The system of national reporting for individual hospitals outlined above is based on commitments made by the Australian, State and Territory Governments in the NHRA. Specifically, as part of their funding agreement for health care, the governments committed to a national system of public performance reporting on every individual public hospital, to use the MyHospitals website as the online vehicle for such reporting, and for the website to allow performance to be compared between hospitals.

The hospital-level data are provided by State and Territory Governments to the Australian Institute of Health and Welfare (AIHW) to process and publicly report an agreed set of indicators. A number of other agreements and technical documents, and cross-jurisdiction committees, support the reporting arrangements. This includes the previously mentioned Performance and Accountability Framework, which details the indicators that jurisdictions have agreed will be reported (listed in table 11.3 above).

The NHRA provides the broad architecture through which the Australian, State and Territory Governments could agree to improve information provision to support greater patient choice and provider self-improvement. There is an opportunity for this to occur as part of broader negotiations for a successor to the NHRA, which the Australian Government Department of Health (sub. DR569) expected to begin before the end of 2017 and lead to a new agreement being finalised in 2018.

Make data available to other information providers

In addition to publishing information through existing channels, including the MyHospitals website, the Australian, State and Territory Governments should commit to making published data available in a format that enables other organisations to readily incorporate it into advisory services they provide.

For example, to help GPs support patient choice during a consultation, the information could be incorporated into software used by GP clinics, similar to the above-mentioned searchable directory of specialists provided by Healthshare. There may also be scope to include the information in regional Health Pathways services, which are web-based portals being developed to help GPs and other health professionals identify the best pathway for a particular patient, including guidance on referring patients to local specialists. Mobile applications are another potential channel for disseminating information to GPs, as well as directly to patients.

Publicly release as much data as possible

As a general principle, the Australian, State and Territory Governments should commit to publishing the data they hold on individual hospitals, specialists and allied health professionals, unless it is clearly demonstrated that releasing the data would harm the interests of patients. This would also be subject to satisfying protections on privacy, which require the consent of individual people and organisations to release information that identifies them (box 11.4).

As noted above, some states already publish a large number of process measures online for individual hospitals, such as waiting times and number of services provided for elective surgery. In New South Wales, this is done centrally by the Bureau for Health Information, with the data presented in a user-oriented format online with a search facility. The central website could be expanded to publish all hospital-specific performance data gathered by the NSW Government.

It may be less straightforward to do this in other jurisdictions because they do not have as well-developed arrangements for publishing information on individual health care providers. The SA Government noted that:

Many of the existing consumer information dashboards [in South Australia] were initially designed to assist hospital management, clinicians and staff to monitor and manage the flow of patients in emergency departments and inpatient units. It would take a targeted engagement, design and build strategy to re-engineer them to be truly customer focused. (sub. DR571, p. 5)

The MyHospitals website is likely to be a more cost-effective vehicle for disseminating the information across all jurisdictions and so should be used for this purpose.

Box 11.4 Privacy protections for health information

Commonwealth legislation

The *Privacy Act 1988* (Cwlth) specifies how and when personal information can be collected and disclosed by Australian Government agencies and private sector organisations (including private sector providers of health care). Personal information is defined as information or an opinion about an identified, or reasonably identifiable, individual. Such information can generally only be collected if it is reasonably necessary for, or directly related to, one or more of the collecting entity's functions or activities. The information cannot be used or disclosed for a secondary purpose unless a certain condition is met, such as consent from the relevant individual, to comply with a court order, or it is allowed under a public interest determination made by the Australian Information Commissioner.

More stringent privacy protections apply to information held by the AIHW. It is subject to both the Privacy Act and additional requirements in its own legislation — the *Australian Institute of Health and Welfare Act 1987* (Cwlth) — which prohibit the AIHW from releasing information concerning a person — which is defined more broadly than the Privacy Act to include deceased persons and bodies corporate — unless one of the following exceptions applies.

- The data provider has given written permission to release the information to a specific party.
- The AIHW Ethics Committee has approved release of the information and it would be consistent with the terms set by the data provider.
- Release is in the form of publications containing de-identified statistics, information and conclusions.

The AIHW cannot be forced to divulge information protected by its legislation, even by a court of law. Such information is also exempt from the *Freedom of Information Act 1982* (Cwlth).

Audits of surgical mortality have been declared a quality assurance activity under Part VC of the *Health Insurance Act 1973* (Cwlth). This provides a form of qualified privilege which protects audit data on individual surgeons from being disclosed for purposes other than the audit, even to a court, without the surgeon's consent. There is an exception for the Commonwealth Minister of Health to authorise disclosure if it relates to conduct that is a serious offence against a state or territory law. Audit data are also protected by state-based declarations in some jurisdictions.

State and territory requirements

The Commonwealth Privacy Act does not apply to State and Territory Government agencies, such as public hospitals. Instead, most states and all territories have enacted their own legislation specifically to protect the privacy of health information they hold. An exception is South Australia, which has incorporated some privacy requirements into broader health legislation and issued administrative directions and codes for its agencies to follow. Similarly, Western Australia does not have a legislated privacy regime but government agencies are subject to various confidentiality requirements, and privacy principles are provided for in freedom of information legislation.

Sources: ANZASM (2016); (Australian Government) Department of Health (2014); AIHW (2011, 2014b, 2014c; sub. DR508); OAIC (2014, 2017); Royal Australasian College of Surgeons (sub. DR595).

Improve the MyHospitals website

The Commission supports the concept of a national website to inform patients and their GPs about individual providers of health care.⁷ It could also be a source of information for hospitals, specialists and allied health professionals to benchmark themselves for self-improvement.

A national website should not exclude the development of alternative information services, such as those targeted at GPs (for example, Healthshare's add-on to software used by GP practices) or patients (including through mobile applications), given the Commission's above proposal that governments make their data available in a format that other organisations can readily incorporate in advisory services they provide.

The current national website, MyHospitals, should be seen as a work-in-progress with significant potential for improvement. The breadth of information available to patients in England through the National Health Service (NHS) website, and its consumer-oriented presentation, provides an example of what to aim for (box 11.5).

MyHospitals has been active for more than six years, so now is an opportune time for the AIHW to consider how to improve it. This should include market research on who uses the website currently, who might in the future, their varying needs and health literacy, what indicators are useful to them, and best-practice approaches to presenting health information online.

There may be potential to redesign the website so that it is more user-friendly and intuitive, providing a small number of headline indicators in a format such as infographics but with scope for patients, their GPs and others to drill much deeper into the data as they wish. The AIHW could draw on lessons learned with the NHS website and other overseas examples of information provision (for example, Boyce et al. 2010; Dixon et al. 2010; Gigerenzer et al. 2008; Hibbard and Peters 2003; Kumpunen, Trigg and Rodrigues 2014).

As noted in chapter 4, the Commission has concluded that Australian public reporting on individual hospitals should include ratings for the quality of end-of-life care, similar to those published by England's Care Quality Commission. Quality ratings for other hospital services should also be reported, as occurs in England.

Another characteristic that should be reported is waiting times at individual public outpatient clinics, which governments have rarely published to date. The Queensland Government (sub. DR592, p. 13) was concerned that a significant investment would be required to report waiting times in 'real-time'. However, this is not essential. A similar approach to that already used to report elective surgery waiting times would be a major improvement. For example, governments could use historical data over a recent period to report median, 10th and 90th percentile waiting times by specialty and urgency.

⁷ For patients who are blind or vision impaired, information would also have to be accessible in a format such as audio, large print or braille (Australian Blindness Forum, sub. 412; Vision Australia, sub. 421).

Box 11.5 Information provision in England

In England, a large amount of consumer-oriented information about health care providers has been made available online. Patients are able to search the National Health Service website for hospitals and health professionals in their area, and compare performance indicators for individual:

- hospitals, divided into various reporting categories (including key facts, efficiency, safety, food, friends and family test, patient-reported outcome measures, reporting culture, cleanliness and infection control, complaints and parking facilities)
- consultants in 14 specialities, with the number of indicators varying between speciality (they can include mortality rates, readmissions, average number of days that patients stay in hospital, and number of procedures performed in the past year).

Indicators are often presented in an easy-to-understand format, such as a tick or star rating, but with scope to drill down into the data to see quantitative results, definitions and data sources.

To give a broader perspective on performance, the hospital indicators include information reported by staff (such as whether they would recommend the facility) and patients (including their perceived health improvement, user ratings and written reviews, and whether they would recommend the hospital to friends and family).

Patients can also see an overall rating that England's health care regulator — the Care Quality Commission (CQC) — has given to individual hospitals. On the CQC website, this can be disaggregated into ratings for individual objectives (safety, effectiveness, caring, responsiveness or well-led) and specific service areas (such as surgery or end-of-life care). By law, hospitals must display their ratings where patients can easily see them (such as the main entrance) and on their website (if they have one).

There are also other websites that patients can turn to for information, including one hosted by the Society for Cardiothoracic Surgery in Great Britain and Ireland, which provides additional detail on the performance of individual surgeons and surgical units.

The AIHW (sub. DR508) and other inquiry participants agreed that it would be worthwhile to consider how to improve the MyHospitals website (Australian Healthcare and Hospitals Association, sub. DR561; Royal Australasian College of Physicians, sub. DR580). The AIHW stated that:

Further research and analysis would be useful in understanding how the website is used by different sections of the public, and how its usefulness may be improved ... The AIHW supports investigating the approaches taken and the measured results achieved by overseas websites, such as the UK's National Health Service (NHS) website, to improve and enhance the MyHospitals website, to further encourage performance improvement. (sub. DR508, p. 11)

The AIHW should, in consultation with governments and other stakeholders, identify gaps in the indicators currently available on MyHospitals and how to address them. Future information provision could include PROMs and results from staff surveys. The lack of progress in reporting clinical outcome measures, such as mortality rates, would also have to be addressed.

Phase-in public reporting on individual specialists and allied health professionals

The choice model proposed in chapter 10 would give patients the option of choosing a specialist or allied health professional who works in private practice. Governments and private health insurers already collect some data on health professionals but patients are denied access to all but the most basic information. This is in contrast to England, where patients can access a single government website to search for a specialist or allied health professional working in a particular discipline near the patient's home and, for some professions, view various performance indicators (box 11.5).

In Australia, the MyHospitals website should be expanded to include reporting on individual specialists and allied health professionals, similar to what already occurs in England. The data could also be made available to non-government bodies to incorporate in information services they provide.

The AIHW should consult with governments, health professionals, consumers and other interested parties on what information to report on the MyHospitals website for individual professionals. The arrangements should be underpinned by a joint Australian, State and Territory Government commitment in the (soon to be negotiated) successor to NHRA that there will be public reporting on individual professionals. Reporting would have to be phased-in as specific indicators are developed and associated data assembled and processed by the AIHW. Box 11.6 outlines a potential sequence for doing this.

Box 11.6 **How reporting on individual health professionals might be phased-in on the MyHospitals website**

Reporting on individual specialists and allied health professionals on the MyHospitals website could be phased-in as follows.

- Provide registration details using information currently published by the Australian Health Practitioner Regulation Agency — including where and when they trained, and any conditions, undertakings or reprimands attached to their registration — but with a search function that makes it easy for patients to search in their region by speciality.
- Add process data on each specialist and allied health professional, such as:
 - location, contact details, opening hours and available parking where they practice
 - out-of-pocket charges (for health professionals working in private practice)
 - number of relevant procedures performed
 - hospitals where they have admission rights.
- In the longer term, report clinical outcomes achieved by individual specialists, such as whether patient-reported outcome measures, mortality, revision and unplanned readmission rates are within an acceptable range. Priority should be given to reporting on procedural specialists where variation in clinical performance can have a large effect on a patient's quality of life.

A longer-term goal should be to release risk-adjusted information on the clinical outcomes achieved by individual specialists, such as their mortality, revision and unplanned readmission rates. This future work should include development and reporting on PROMs. Priority should be given to reporting on procedural specialists where variation in clinical performance can have a large effect on a patient's quality of life. Governments and professional bodies are best placed to facilitate the collection of comparable data on clinical outcomes. This is not a straightforward task and, if poorly implemented, could mislead consumers and efforts by specialists to improve (discussed further below).

The choice model proposed by the Commission would not enable patients who use the public health system to choose which specialist or allied health professional provides their health care. However, it could still be worthwhile for governments to report on professionals working in the public health system to encourage their self-improvement. Moreover, there is overlap in the workforce for the public and private health sectors, with some specialists treating both public and private patients.

User ratings and reviews for specialists and allied health professionals

In the draft report for this inquiry, the Commission proposed that the MyHospitals website include user ratings and reviews for individual health professionals. The AIHW (sub. DR508, p. 11) cautioned that this would 'not necessarily align with data quality and other standards' which, as a statistical agency, it is required to adhere to for its traditional performance reporting.

While there are some advantages in well-managed user ratings being linked to clinical information, it is not essential for the AIHW or any other government body to take on this role. Unlike clinical outcome measures (including patient-reported ones) and administrative data (such as waiting times), there is not a strong case for governments to be involved in setting a methodology for user ratings and reviews, or gathering and publishing the information.⁸ Non-government bodies such as POA and Whitecoat have already shown capacity to publish user ratings and reviews. Furthermore, these bodies are affiliated with health insurers, which have shown a strong interest in supporting further improvements to better inform consumers.

A small number of participants had more general concerns about user ratings and reviews.

The AMA [Australian Medical Association] is ... opposed to user ratings because they ... risk unwarranted damage to a specialist's reputation [and] ... it is not clear how [the] AIHW could access the patient's clinical records to ensure specialists are not criticised for aspects of treatment they are not responsible for. It is noteworthy the Supreme Court of NSW awarded a medical practitioner close to half a million dollars after being defamed by a discontented former patient in a targeted social media campaign. (AMA, sub. DR589, p. 2)

⁸ User ratings and reviews should not include an assessment of clinical outcomes. That is the role of patient-reported outcome measures (PROMs), where there is a strong case for government involvement.

User ratings and reviews have the potential to be highly unreliable as performance indicators, insofar as they create opportunities for the reporting of vexatious or vindictive feedback. (Royal Australasian College of Physicians, sub. DR580, p. 7)

... 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 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. 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. (Victorian Healthcare Association, sub. DR531, pp. 6–7)

The Commission recognises that a poorly managed system of user ratings and reviews could be abused in ways that are not in the interests of patients or health professionals. The evidence suggests, however, that these risks can be managed. For example, POA and Whitecoat have shown that it is possible to moderate comments and give providers a right of reply, which can help to ensure that user ratings and reviews provide useful information to patients and feedback to professionals that is not captured by other forms of reporting.

Address concerns about reporting clinical outcomes for specialists

As noted above, the Commission proposes that the AIHW phase-in public reporting of clinical outcomes for specialists in collaboration with the relevant professions. Submissions from professional bodies (Australian Medical Association, sub. DR589; Royal Australasian College of Physicians, sub. 473, DR580; Royal Australasian College of Surgeons, sub. PFR374) indicated that their support would be conditional on:

- public reporting being effective in facilitating better outcomes
- data being risk-adjusted to control for casemix differences between specialists
- reported differences in performance being statistically significant
- recognition that teamwork can influence clinical outcomes.

The Commission considers that these concerns can be addressed, as outlined below. The concerns should not be used to deny Australians access to clinical outcomes data that have been available to patients in other comparable countries for many years. Several US states have publicly reported the performance of individual cardiac surgeons since the early 1990s.

⁹ This comment by the VHA (sub. DR531) was based on results from a US survey by Zgierska, Rabago and Miller (2014), which may have been distorted by sample-selection bias, given that there was a low response rate (4 per cent of targeted doctors in a state-level medical society) and emergency-department clinicians were over-represented in responses (57 per cent of respondents). Moreover, the authors noted that they were unable to control for other factors that may influence doctors' perceptions and decision making, such as malpractice concerns.

In England, the mortality rates of individual cardiac surgeons have been publicly reported since 2005. Reporting has since expanded on the NHS website to include a range of indicators for individual consultants in 14 specialities.

Effectiveness of public reporting in facilitating better outcomes

Like hospital-level reporting, available evidence indicates that public reporting on individual specialists would encourage them to engage in greater self-improvement activity.

Most studies on the effects of public reporting focus on the US experience with reporting on cardiac surgeons, particularly a significant decline in risk-adjusted mortality following the introduction of the New York State Cardiac Surgery Reporting System (NYSCSRS). The extent to which this decline can be attributed to public reporting, rather than a general trend of improving outcomes from cardiac surgery, has been the subject of much debate. However, there is evidence that the overall decline in mortality rates in New York was partly due to the NYSCSRS (Jha and Epstein 2006; Oakley 2011; Peterson et al. 1998; Smith et al. 2009). Moreover, exposing the mortality data to public scrutiny prompted efforts to address major deficiencies in collection and reporting methods, which would have facilitated more effective stewardship (Harlan 2001).

There has also been a downward trend in risk-adjusted mortality for cardiac patients in England since the introduction of public reporting on individual surgeons (Bridgewater et al. 2007; Shaw, Taylor and Dix 2015). Like the US experience, publishing the data highlighted deficiencies in collection and reporting methods, thereby adding impetus to strengthen information also relevant to stewardship (Bridgewater et al. 2013; Radford et al. 2015; Williams 2013a).

The benefits from specialist-level reporting need to be weighed against the cost associated with collecting and publishing the data. However, much of the data are already collected in Australia, or should be, for stewardship purposes, and so the additional cost of public reporting could be relatively small. For example, audits of surgical mortality already gather data on surgeons in each state and territory of Australia (RACS 2017; sub. PFR374). Publishing the data could, like in other countries, also generate a benefit by giving added impetus to address data deficiencies which hamper the stewardship role of governments.

Data are risk-adjusted to control for casemix differences between specialists

A common concern about specialist-level reporting is that it could encourage specialists to cherry pick low-risk patients and avoid more complex cases, thereby resulting in inequitable access to care (Australian Medical Association, sub. DR589; Chen 2010; Chou et al. 2015; Hannan et al. 1997; Pearse and Mazevska 2010; Radford et al. 2015; Royal Australasian College of Physicians, sub. DR580; Royal Australasian College of Surgeons, sub. PFR374; Werner and Asch 2005). Most research on this topic is based on surveys of specialists, who sometimes stated that they were more reluctant to treat high-risk cases following the

introduction of public reporting (Bridgewater et al. 2007; Narins et al. 2005; Schneider and Epstein 1996; Smith et al. 2009; Walker et al. 2013). However, there is little evidence of reporting actually resulting in avoidance of high-risk patients.

It is now common for clinical outcomes to be reported in risk-adjusted terms, which controls for differences in the mix of treated patients and largely removes the incentive for cherry picking. Risk adjustment also addresses the concerns that some inquiry participants had about consumers being misled by clinical outcomes data (for example, Royal Australasian College of Physicians, sub. DR580). The risk-adjustment approach is now well established in England and implemented in collaboration with the professions (box 11.7). The NYSCSRS also publishes risk-adjusted data for individual specialists (NY DOH 2016).

Box 11.7 The journey to risk-adjusted reporting in England

England began a shift to publicly reporting risk-adjusted clinical outcomes for individual specialists in the mid-2000s. Specialists had previously opposed public reporting, partly due to concerns that like-for-like comparisons were not possible. Professor Andrew Street (Centre for Health Economics, University of York) observed that this argument became outdated with the development of risk-adjustment techniques, which in England are now being implemented in collaboration with specialists, but the argument is still used to resist public reporting in Australia.

The excuse no longer holds: like-for-like comparisons are now perfectly possible, as recent experience in England testifies ... The Society for Cardiothoracic Surgery in Great Britain and Ireland led this initiative, collecting data about individual surgeons and devising its own approach to adjusting risk between surgeons ... The Society also evaluated what happened next. Doctors weren't forgoing more risky operations to protect their outcome data, because they were confident the risk-adjustment was correct. And survival rates following surgery improved across the board because doctors compared and questioned their performance relative to their peers. They've published the data annually for hospitals and individuals ever since ... Following this experience, publication of performance data has since been rolled out across the NHS, starting in 2013 with the publication of activity and death rates for hospital doctors in ten specialities ... (Street 2016)

The Royal College of Surgeons of England shifted its position to supporting the release of surgeon-level data from 2013 and stated that:

The objective of publishing the data is to drive forward improvements in care and enable patients to understand far more about the nature of a surgeon's work and their recovery after an operation ... It is believed that, by revealing what others have achieved in their clinical area, surgeons are more likely to reflect on their practice and be inspired to improve while providing patients with accurate information on their surgeon's outcomes. (RCS 2017)

The President of the Royal College of Surgeons from 2011 to 2014, Professor Norman Williams (2013b, p. 1), backed the change because patients 'have a right to know of doctors who are not meeting the standards expected of them' and observed that almost all surgeons in England had consented to releasing their surgical audit data.

This occurred despite many misgivings concerning the accuracy of the risk adjustment, team versus individual performance, risk-averse behaviour ... Despite the drawbacks and the criticisms I have no doubt that the exercise has been a success ... this was a watershed moment for the profession and I am sure that in years to come we will all look back with great pride that we ... adopt[ed] this transparency agenda as a means to drive up standards and inform the public ... Transparency is a potent means of driving up standards for both delivery of care and training ... (Williams 2013a, pp. 250–1)

As detailed in box 11.8 for mortality rates, risk-adjustment methodologies are already used in Australia to monitor clinical outcomes but the resulting performance indicators are almost never published. The box also illustrates how funnel plots can be used to present risk-adjusted data in a way that facilitates accurate interpretation. The NHS website in England uses an alternative, more consumer-oriented, approach to address concerns about how the data could be misinterpreted. Mortality, revision and unplanned readmission rates are simply presented as being ‘OK’ if they are within an acceptable range, rather than publishing precise rates which may differ between specialists but not by so much as to be statistically significant. The underlying data are available for those who are interested.¹⁰

Box 11.8 Measuring risk-adjusted mortality rates

Mortality rates are often used as a measure of clinical performance because there is a clear outcome (death) to measure. However, without risk adjustment, much of the variation in this indicator over time and between providers could be due to differences in patient characteristics, rather than the performance of service providers.

Risk-adjusted mortality rates are now regularly calculated in several jurisdictions using routinely collected data, including Queensland, Canada, England, the Netherlands, and Scotland. Moreover, the Australian Commission on Safety and Quality in Health Care has developed national coefficients to assist jurisdictions within Australia to risk-adjust two measures of mortality (the hospital standardised mortality ratio and condition-specific mortality for four conditions). However, mortality rates are rarely published at a service provider level in Australia.

A key step in risk adjustment is to use a logistic regression model to estimate coefficients for various risk factors — such as patient age, gender, comorbidities and type of admission — that quantify how the probability of mortality has varied with each factor across a population of service providers. The results are then used to estimate an *expected mortality rate* for each provider, based on the characteristics of its patients.

The risk-adjusted mortality rate for each provider is often presented as the ratio of its actual to expected deaths. In essence, this ratio compares actual outcomes for the provider’s set of patients with the outcomes expected if its patients had been treated by the average provider. Hence, each provider is compared with a hypothetical average provider treating the same patients, not another actual provider that treated different patients. For this reason, it can be misleading to compare risk-adjusted rates between providers.

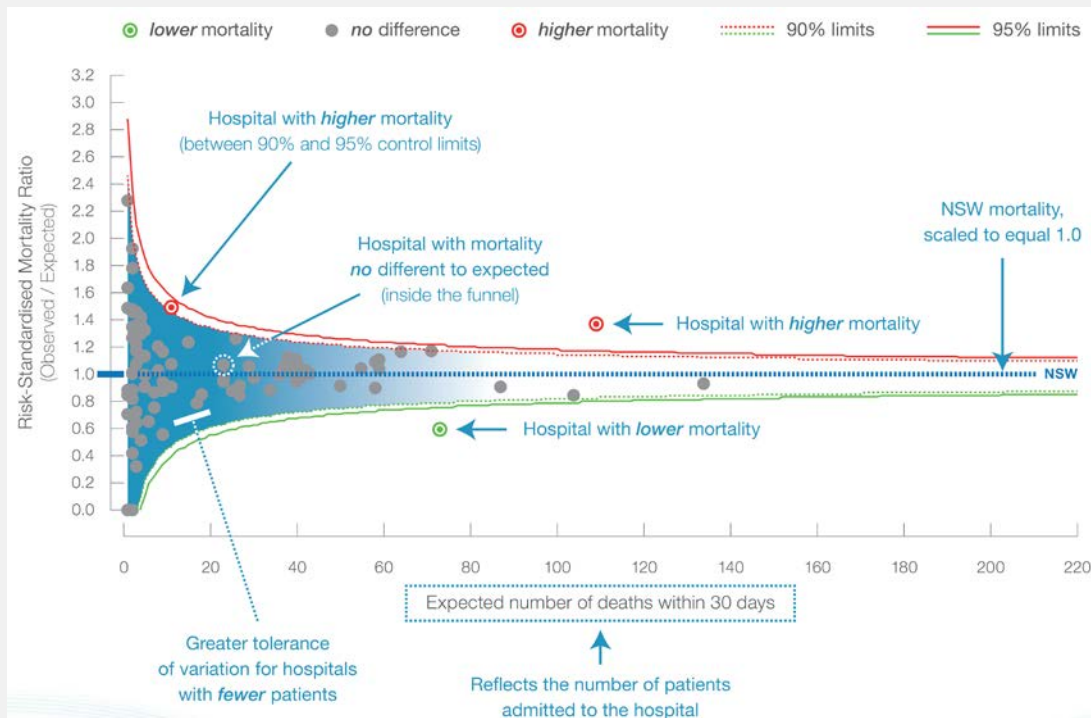
An Australian example is the 30-day risk-standardised mortality ratio published by the NSW Bureau of Health Information for hospitals treating five clinical conditions (acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, pneumonia and hip-fracture surgery). If this ratio is less than one, it indicates that a hospital has lower than expected mortality compared to the hypothetical average NSW hospital that treated the same group of patients. However, small deviations from one are not considered to be meaningful.

(continued next page)

¹⁰ In contrast, the US Hospital Compare website only publishes a qualitative rating for (hospital-level) mortality (possible ratings are worse than, no different than, or better than the national average). Joynt et al. (2016) noted that this limits the peer-pressure effect of public reporting (especially because few hospitals are rated as different from the national average) and so could explain why a downward trend in mortality rates did not accelerate after public reporting began in 2008.

Box 11.8 (continued)

Funnel plots (illustrated below) are used to show when there is a high level of confidence that a hospital's mortality ratio is greater than expected.



Hospitals with fewer patients (appearing towards the left-hand side of the figure) tend to have greater variability in deaths simply by chance and so the funnel's 90 and 95 per cent confidence limits are wider. A mortality ratio above the 90 per cent limit of the funnel is interpreted as the hospital having higher than expected mortality, based on the patients it treated. If a hospital is outside the 95 per cent limits, there is greater confidence about its outlier status.

Sources: ACSQHC (2014c, 2015b); AHRQ (2014); Ben-Tovim et al. (2009); Brand et al. (2013); CMS (2017a, 2017b); Dr Foster (2014); Flowers et al. (2010); NHPA (2012, 2016); NHS Digital (2016); NHS Scotland (2011, 2016a, 2016b); NSW BHI (2013, 2015b); NY DOH (2016); Taylor and Aylin (2014); YNHSC and CORE (2017).

No risk-adjustment methodology is perfect because it can only control for risk factors that are measured and depends on the quality of data and modelling (AHRQ 2014). However, as the support of specialists and their associations in England demonstrates, public reporting of risk-adjusted indicators has gained acceptance over time as publication has driven improvements in methodologies and associated data.

Another essential element in gaining the support of specialists, and ensuring that reporting is not misleading, is to give specialists an opportunity to review and comment on their performance data prior to release. The Royal Australasian College of Physicians (sub. DR580) noted that data currently gathered by Australian jurisdictions are not generally made available to the relevant specialist and there is no opportunity for them to provide a rationale for any disparity, variation or poor outcome.

Reported differences in performance are statistically significant

In some cases, a specialist's reported performance may differ from the average for his or her peers, but not by a sufficiently large amount to be statistically significant in the sense that there is a high probability that the difference is due to more than chance. To identify performance differences that are statistically significant, it is common to publish a confidence interval around the peer average, beyond which there is a high probability (usually 90 or 95 per cent) that a provider's performance is truly above or below the peer average. An example is illustrated in box 11.8 for hospital-level reporting of mortality rates.

For specialists, the confidence interval will tend to narrow as the frequency of the relevant procedure (such as cardiac surgery) and measured outcome (such as mortality) rises, thereby increasing the indicator's statistical power to identify genuine differences in performance.

The Royal Australasian College of Surgeons (sub. PFR374) noted that a 2016 NZ Government review had decided not to support specialist-level reporting partly because overseas experience had shown that the typical caseload of specialists is unlikely to be sufficiently large to provide the statistical power needed to identify real differences in performance (NZHQSC 2016b).

This conclusion was largely based on a study by Walker et al. (2013), which analysed the statistical power of mortality rates for four types of surgery in England.¹¹ However, in the case of cardiac surgery, the authors concluded that the number of procedures undertaken by individual surgeons was 'sufficient to allow the process of detection [of poor performance] to operate with reasonable statistical power' (Walker et al. 2013, p. 3), although this was based on a relatively low bar for defining poor performance and an acceptable rate of detection.¹² A similar result was found for hip-fracture surgery but the likelihood of identifying poor mortality rates in the other two types of surgery was much lower. To achieve an acceptable level of statistical power, the authors recommended:

- using data for a longer period (such as three years) to increase the number of procedures for a given specialist, although this reduces the timeliness of reporting
- measuring only outcomes that occur frequently for the relevant procedure
- only reporting at a team or hospital level when the detection rate for individual surgeons with poor performance would be less than 60 per cent.

The mortality rates reported for cardiac surgeons in England and New York are based on data over three years. Moreover, Walker et al. (2013) concluded that mortality is sufficiently common to be a useful indicator for cardiac surgery. This is not always the case for other

¹¹ The four types of surgery were adult cardiac surgery; oesophagectomy or gastrectomy for oesophagogastric cancer; bowel cancer resection; and hip-fracture surgery. The Victorian Healthcare Association (sub. DR531) also cited Walker et al. (2013) as evidence that small caseloads hinder meaningful reporting.

¹² Poor performance was defined as a 95 per cent probability that the surgeon's mortality rate was twice the national level. It was estimated that 69 per cent of cardiac surgeons did enough procedures over a three-year period to be detected in seven out of ten cases when they truly met this definition of poor performance.

specialities and so consideration would have to be given to measuring other outcomes. Indeed, the specialist-level performance indicators published in England vary between the 14 specialities where reporting occurs. Whether reporting would have insufficient statistical power even after pooling data over a longer period and measuring more frequent outcomes is a matter that can be judged on a case-by-case basis for individual specialities.

Recognition that teamwork can influence clinical outcomes

The Royal Australasian College of Surgeons (sub. PFR374) said that it supported the release of performance data at the team level, but not individual specialists, because medical interventions in public hospitals are provided by teams and serious failures in health care are often related to systemic issues rather than individual competence. The NZ Government review that the Royal Australasian College of Surgeons referred to went further by arguing that publishing the results of individual surgeons seems likely to promote individualistic behaviour and that, if it is team-based medicine that is to be encouraged, it does not seem sensible to publish data based on one team member (NZHQSC 2016b). Similarly, the Royal Australasian College of Physicians (sub. DR580, p. 7) argued that reporting outcomes for individual specialists would ‘disrupt the team work environment by incentivising people to act in a ‘tick the box’ fashion to satisfy indicators even if this is at the expense of collaboration’.

The Commission agrees that clinical outcomes in hospitals are often the result of teamwork which can include, among others, surgeons, anaesthetists and nurses. Moreover, there may be value in reporting performance at a team or unit level, particularly when the caseload of individual specialists in a particular speciality is too low to provide much statistical power. However, claims that specialist-level reporting conveys no useful information and undermines teamwork are overstated.

The Commission has not seen any evidence that specialist-level reporting in England, the United States or other countries has led to a systemic problem with individualistic behaviour undermining teamwork. The fact that such reporting is supported by the Royal College of Surgeons of England and the Society for Cardiothoracic Surgery in Great Britain and Ireland (box 11.7) suggests that the benefits far outweigh the negative effects, if any, on teamwork. In Australia, the audits of surgical mortality that the Royal Australasian College of Surgeons oversees in each jurisdiction in collaboration with State or Territory Governments gather information on the outcomes of surgeons and provide feedback to them on their performance.

Facilitate progress in improving reporting

Progress in improving reporting, especially on clinical outcomes, has often been slow, as illustrated by the prolonged development and indefinite timeframe to publish the safety and quality indicators that are supposed to be on the MyHospitals website (box 11.1 and table 11.3). Too often it has taken the exposure of a major safety incident to provide the impetus to reform reporting. A recent example was an announcement by the Victorian

Government (2016) that, following safety breaches at Djerriwarrh Health Services in Bacchus Marsh, it would implement a significant package of improvements to the collection, use and publication of data on health service delivery.

While slow progress in improving reporting can sometimes be explained by the complexities of measuring outcomes, another barrier has been a reluctance among governments, hospitals and health professionals to be exposed to greater public scrutiny. This is despite clear evidence showing that it is in patients' interests for performance data to be published because of its positive effect on provider self-improvement. Paternalism can also be a barrier to improved reporting, with patients seen as being incapable of interpreting information if they were allowed to see it (Mead 2017). A further barrier can be data perfectionism, where the default position is that any information which is less than perfect must be withheld from the public because they would be easily misled.

The Commission's above proposal to strengthen the cross-jurisdiction commitment to public reporting in the successor to the NHRA, including to release as much data as possible, should convey a clear expectation to all stakeholders that reporting must be improved. However, the Commission recognises that this will not guarantee progress, given past resistance to change. It is therefore also recommended that there be a review of progress in improving reporting three years after the successor to the NHRA comes into force.

In the case of specialists, it should, as noted above, be possible to address their concerns about how clinical outcomes are measured and reported. Nevertheless, overseas experience suggests that they may still be reluctant to be exposed to greater transparency. In England, resistance to releasing data on individual surgeons was eventually overcome by the combination of a 2001 public inquiry, which highlighted a lack of transparency regarding a notorious case of malpractice in cardiac surgery, and the subsequent introduction of freedom-of-information legislation enabling *The Guardian* to force the release of mortality data for individual heart surgeons in 2005 (Bridgewater et al. 2007; Guardian 2005; Kennedy et al. 2001; NZHQSC 2016a, 2016b; Street 2016; UK Department of Health 2002). Similarly, the longest-running US reporting program — the NYSCSRS — was forced to begin releasing data on individual surgeons in 1991 when it lost a freedom-of-information lawsuit initiated by the publication *Newsday* (Barua and Esmail 2011; Harlan 2001; NZHQSC 2016a, 2016b).

In Australia, public reporting on the performance of individual specialists would, as proposed above, have to be developed and implemented in collaboration with the relevant professions to ensure the data are useful and that privacy protections are respected. However, this should be accompanied by a clear expectation from governments that there would be widespread participation by specialists in information provision. In particular:

- the Australian Government should require specialists in private practice to participate in public information provision in order to be eligible to provide any service that attracts a Medicare benefit¹³

¹³ It would be impractical to limit this eligibility test to only private outpatient services that lead to an elective hospital admission as a public patient. As the Australian Medical Association (sub. DR589) noted, that would be difficult for Medicare to administer, increase billing complexity for specialists, and create uncertainty for patients.

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- State and Territory Governments should require specialists treating public patients to participate in public information provision.

RECOMMENDATION 11.1

The Australian, State and Territory Governments should strengthen and expand their commitment to public reporting in the (soon to be negotiated) successor to the National Health Reform Agreement, with the aim of better supporting patients and their general practitioners to exercise patient choice, and encouraging performance improvement by service providers. This should include a commitment by all jurisdictions to:

- provide data and other assistance to the Australian Institute of Health and Welfare to enable it to strengthen the MyHospitals website as a vehicle for supporting patient choice and provider self-improvement, as detailed in recommendation 11.2
- adopt a general policy of publicly releasing any data that a jurisdiction holds on individual hospitals (including outpatient clinics), specialists and allied health professionals, unless it is clearly demonstrated that releasing the data would harm the interests of patients or breach requirements to protect privacy
- make the information that a jurisdiction publicly releases on hospitals, specialists and allied health professionals available in a format that other organisations can readily incorporate in advisory services they provide.

To facilitate reporting on individual specialists, there should also be a commitment by:

- the Australian Government to amend the *Health Insurance Act 1973* (Cwlth) so that specialists are required to participate in public information provision in order to be eligible to provide any service that attracts a Medicare benefit
- the State and Territory Governments to oblige all specialists serving public patients in their jurisdiction to participate in public information provision.

RECOMMENDATION 11.2

The Australian Government should, in consultation with State and Territory Governments, direct the Australian Institute of Health and Welfare to transform the MyHospitals website into a vehicle that better supports choice by patients and encourages self-improvement by hospitals, specialists and allied health professionals. The changes should:

- draw on lessons from overseas examples of information provision, including the National Health Service website used to inform patients in England
- be based on market research on who would use an improved MyHospitals website, how their needs and health literacy vary, what indicators are useful to them, and how they could be informed by using best-practice approaches to presenting health information online
- put greater emphasis on reporting outcomes, such as by publishing patient-reported outcome measures and clinical outcomes such as readmission rates
- include reporting on waiting times at individual public outpatient clinics and ratings for the quality of end-of-life care and other services in hospitals (similar to ratings published by England's Care Quality Commission)
- phase-in reporting on individual specialists and allied health professionals as data become available, possibly beginning with registration details, followed by process data (such as location, levels of activity and out-of-pocket charges) and, in the longer term, whether the clinical outcomes of procedural specialists are within an acceptable range.

RECOMMENDATION 11.3

The reforms detailed in recommendations 11.1 and 11.2 should be reviewed by the Australian, State and Territory Governments three years after the successor to the current National Health Reform Agreement comes into force.