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AMA Submission on the Productivity Commission Issues Paper: Reforms to Human Services, in relation to public hospital services

General Comments

The AMA has a direct and significant interest in public hospitals and public hospital services as a critical element in the overall functioning of the health system. AMA policy includes strong support for the contributions of both the public and private sectors to the funding and provision of health care.

Public hospitals and the health system

While the AMA believes there is clearly potential to improve outcomes of public hospital services, there are significant characteristics of Australia's public hospitals that must be taken into account in considering the application of increased competition, contestability and informed user choice, and the extent to which these can improve outcomes.

In order to manage the demand side for health care (in this case hospital services), there is either rationing of services through waitlists based on acuity of need, or a price signal (private hospital services).

Public hospitals work on a waiting list basis, usually defined by acuity of need, to manage demand for public hospital services. Private hospital services typically use price signals. There is limited scope to apply mechanisms for patient choice (such as choice of treating doctor) to access arrangements in public hospitals that are governed by waiting lists.

Health care is not simply a product in the same sense as some other goods and services. Because health care depends on actions by the patient as well as the provider, and has consequences for the patient (and the economy/community) well beyond the point of service delivery (including capacity to participate in the workforce and the community), there is a community investment in the effectiveness of health care.

Similarly, public hospitals are not the same as a business entity that has full or substantial autonomy over their customers and other inputs, processes, outputs, quality attributes, and outcomes.

Public hospitals do not have the capacity to generate ongoing efficiencies year on year. Pressure to do so will lead to diminishing morale and satisfaction of staff, and reduced

capacity to attract and engage in R&D, with a downwards spiral of performance and quality.

Public hospitals operate within a highly developed framework of industrial entitlements for medical practitioners which are tightly integrated with state/territory employment arrangements. These encourage recruitment and retention of medical practitioners to the public sector, offering stable employment conditions, continuity of service and portability of entitlements. They support teaching, training and research in the public sector as well as service delivery

A move to mandate greater competition in service delivery would be very disruptive with potentially serious implications. There is no guarantee that public sector conditions would be maintained or that entitlements would be protected - even though services might be auspiced by the relevant state or territory government. It would potentially give rise to more insecure employment arrangements, impacting particularly on women in the medical workforce who would potentially find it much more difficult to access entitlements such as paid maternity leave.

Similarly, public hospitals shoulder the majority of responsibility for teaching and training the next generation of medical practitioners. This is a critical part of the culture and fundamental purpose of public hospitals, relying on getting the right balance between service delivery and training. Structures to support teaching and training, such as networked training arrangements, have been established over many years in the public hospital system, and linkages have been put in place with medical schools, post graduate medical education councils and medical colleges. Ill-considered reforms that simply aim to increase competition would disrupt this environment and be likely to undermine Australia's ability to train its future medical workforce - both in terms of quality and efforts to address community need.

As a mix of public and private, Commonwealth and State elements, Australia's health system is unique. Changes to one element of the system will have direct implications and impacts across other elements of the system, as well as a range of unanticipated impacts.

A deliberate (or accidental) over-emphasis on simplistic concepts of efficiency through increased competition will be detrimental to the operation of public hospitals and the overall health system.

The AMA is not convinced that a focus on increased competition will solve the problems faced by public hospitals.

In particular, competition will not solve the overarching source of these problems; the lack of sufficient and certain funding for public hospitals.

Medicare principles

The operation of Australia's public hospitals system is predicated on the Medicare principles, including in particular that the States will provide health and emergency services through the public hospital system, based on the following:

- a. eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals;
- b. access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and
- c. arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

The freedom to choose between public and private hospital care, and the degree of choice available to patients in public hospitals as distinct from private patients, is an integral part of maintaining Australia's balanced health care system.

The broad distinction between public and private health care is generally understood by the community as a basic feature of the health system and part of Medicare arrangements, even though detailed understanding of how this operates, including what they are actually covered for in specific situations, is often lacking for many people.

Introducing private choice and competition elements into public hospital care will tend to blur the distinction between public and private health care, and reduce the perceived value of choice as a key part of the incentive framework for people choosing private health care.

Choice in hospital services

Differences in the scope and degree of choice are core to the separation of public and private treatment and a key part of the incentive framework for choosing private health care.

Increased choice of who provides treatment and where for public patients is not feasible other than at the margins of hospital services. Efforts to introduce greater choice that would undermine the distinction between public and private care are misguided and a distraction from the central and underlying problem facing public hospitals: sufficient and certain funding.

Rationales for increased competition

The AMA does not accept there is a strong connection between other problems posited in the Issues Paper and the 'solution' of increased competition, contestability and user choice. When it comes to public hospitals, the case has not been made as to how increased competition will solve the problems identified in the report of performance, access and patient outcomes.

Equitable access for groups including in remote areas, benchmarking and matching of best practice, and greater accountability for performance, are all worthwhile and

important objectives in their own right. As such, they are already the focus of a range of initiatives.

Public hospitals are already subject to a range of measures and requirements that address the same ends of improved efficiency, effectiveness and patient outcomes. Significant gains in these areas are being made or expected to be made by:

- Hospital pricing, now supported by a comprehensive, rigorous framework of activity based funding and the National Efficient Price;
- Safety and quality, supported by continuously developing standards, guidelines and reporting, including current initiatives to incorporate into pricing mechanisms;
- Improved data collection and feedback on performance including support for peer-based comparison.

The single biggest factor that will increase the returns from such initiatives, and accelerate progress towards the objectives, is the provision of sufficient and certain funding.

Public hospital performance

The AMA has always welcomed *bona fide* efforts to improve public hospital services, provided they are genuinely focused on supporting better care for patients and not simply used as a cover for reduced funding.

The AMA has devoted its own resources to monitoring the performance of public hospitals year-on-year. The AMA's Public Hospital Report Card has documented that public hospitals are not meeting targets for treatment and waiting times in emergency care and elective surgery. What is needed, it says, is sufficient funding for the capacity required to meet public demand for hospital services.

While there is always scope to intelligently consider reforms that may assist in hospital performance, this should not divert attention from the main game, which is sufficient funding.

Such reforms should not be theoretical exercises driven by economic concepts with no understanding of the reality of service provision in public hospitals. As acknowledged by the Productivity Commission, competitive tendering is not a magic bullet, and must be accompanied by 'strong government stewardship'. The AMA is concerned that such stewardship is not in wide abundance, based on the track records of governments in health policy and administration over recent years.

Specific comments

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Other than public information through government reports and websites such as the myhospitals site, information on the effectiveness of public hospital services at the individual hospital or Local Hospital Network level is not available to the AMA.

The AMA monitors and reports on the information published by national government agencies related to efficiency and effectiveness of public hospitals in the *AMA Public Hospital Report Card*.

Sensible, well-considered efforts to improve accountability and transparency would be welcome, provided they are integrated into the work of hospital staff, align with clinical and other work unit objectives, and do not involve excessive compliance, overhead or red tape costs.

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See general comments above – the benefits of increased user choice, competition and contestability in public hospitals are less significant than suggested, while the costs and negative impacts are more significant.

The proposed benefits do not address the problems facing public hospitals, as posited in the issues paper.

The basic economics of the model proposed in the issues paper are unclear. Each of the proposed initiatives - increased user choice, competition and contestability in public hospitals – will involve substantial costs to implement and operate. How these costs will be funded, and from where, is opaque.

A reasonable conclusion is that at the end of the day public hospital funding will actually be reduced, in order to fund initiatives that will not address the identified problems hospitals face.

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Increasing patient choice should not be considered as an abstract concept. It must be considered in the specific context of the service to which it will apply, and with explicit regard to the capacity of patients to consider and make a choice, the consequences of making a choice for access to the services ‘at stake’, and the need to provide a safety net where choice doesn’t deliver. Comparisons with overseas health systems are of strictly limited value, considering the inter-relatedness and uniqueness of the Australian system.

Patient choice works least well for those who have the least resources and skills to make informed choices. The need for assistance in making informed choices is under-recognised and currently operates across a spectrum of needs in a relatively patchy and inconsistent way. There are some tools for care coordination type services but their design, match to purpose and uptake are lacking and uneven. The care planning MBS items were targeted at high end/high need patients with chronic conditions and complex care needs. This is only a part of the spectrum. Overall, GPs are not currently funded or equipped to provide the types of services and information needed to make the full range of patients health literate, informed and skilled to make their own choices.

How does a patient compare doctors or hospitals? Do most patients actually have the ability to choose between different providers and hospitals? Based on the experience of clinicians working in and out of hospitals, the clear answer is no. The reality is that:

- a. Emergency patients are taken by ambulance to the nearest ED
- b. Patients referred to public hospitals by GPs almost always go to the nearest public hospital clinic
- c. State services (eg HIV, Cystic Fibrosis etc) are pre-determined at specific sites

Outside of these, few patients actually have the volition or capacity to choose between hospitals.

Who should help patients to achieve the capacity to make choices? Requiring a patient's GP to do this will add significantly to the time and cost of GP consultations, for conveying information which the GP does not hold at first hand and would have themselves to obtain. Establishing a new bureaucracy of independent advocates to undertake this function would also be expensive and likely ineffective.

How would GPs, advocates or others choose what clinicians, teams, or hospitals to recommend? There would be no clear, predetermined basis for recommending clinician or hospitals, yet an increasingly 'accountable' attribute to such recommendations. The lack of a basis for recommendations would undermine the whole rationale of (purported) patient choice. Alternatively, a vast framework of ratings would need to be developed to provide some semi-rational basis for making or assisting patients to make choices.

Increased user choice would starkly highlight any situations where there is no effective choice, including (but not only) for patients in rural and regional areas. There is no simple solution to this newly-enhanced problem – funding travel to better-serviced areas would be particularly counter-productive, as it would directly increase and hasten the depletion of services in the affected areas.

Increased user choice for public hospital services would have a major effect on the operation and attractiveness of private health services, causing significant tension and distortion to the current balance of public and private health care.

For these reasons, there is clearly no net value in policy trials to test these approaches. What is required is the provision of sufficient and certain funding for public hospitals.

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Given the points made elsewhere in this submission, there is no value or point in describing specifications for information in a model that is not justified or supported.

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The AMA notes Australia's health system performance information and reporting frameworks are currently being reviewed. Any new indicators will no doubt be captured

in this review. These frameworks are ultimately the responsibility of government (provided they listen to stakeholder input and ‘get the frameworks right’).

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Refer to comments above.

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