Productivity Commission Human Services Inquiry

Identifying Sectors for Reform

July 2016

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1. Overview

The Australian Healthcare and Hospitals Association (AHHA) is pleased to provide this submission to the Productivity Commission inquiry on *Human Services: Identifying Sectors for Reform*.

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

While this Productivity Commission enquiry has a broad perspective on human services, including health, education and community services, this submission only addresses competition considerations as they relate to health components of human services.

From the outset, it is vital to recognise the complexity of the healthcare sector in Australia and that it should not be simplistically viewed as a market that can operate in all ways according to classic economic principles. The delivery of healthcare services often involves contact with multiple providers who are remunerated from a variety of funding mechanisms and who respond to patient needs across a diverse range of settings and circumstances. The healthcare sector in Australia is also often characterised as a set of silos where service delivery and funding responsibilities can be spread across different levels of government and multiple third party agents. There is also a high degree of information asymmetry between providers of healthcare services and their patients, with an associated high degree of trust placed in the principal-agent relationship that is necessary between a consumer and their healthcare practitioners.

The AHHA supports the principle of competition and informed user choice in the delivery of healthcare. But the AHHA is also concerned that any changes intended to further these objectives do not assume unrealistic or stylised economic responses from patients, healthcare professionals and related organisations. Nor should competition undermine universal healthcare principles which are strongly supported by Australians, and which go beyond a safety net approach, to ensure all Australians have access to high quality affordable healthcare. The overriding objective for any change that may be considered must be the impact on individual and population level health outcomes. Technical efficiency is important to maximise the amount of healthcare services that can be provided for a given level of resources provided by governments or directly from consumers. But recognition of the variety of circumstances, contexts and policy objectives in which healthcare needs are to be satisfied requires that any competition changes must be carefully structured and targeted in recognition of these varied settings and health policy objectives.

To demonstrate some of the complexities of these interrelationships within the Australian health sector, the Australian Government summarised in the *Reform of the Federation White Paper – Roles and Responsibilities in Health* the complicated mix of roles and responsibilities between levels of government across thirteen health policy domains, with similar complexities in the funding flows in Australia's healthcare arrangements also shown.[1] Missing from these diagrams is the proliferation of non-government sector agents and healthcare practitioners. Also missing is how alternative settings impact on how (or even if) healthcare can be delivered such as in urban compared to non-urban settings and the particular healthcare needs of disadvantaged groups such as Aboriginal and Torres

[1] *Reform of the Federation Issues Paper 3 – Roles and Responsivities in Health*, Figures 1-3 (available at https://federation.dpmc.gov.au/issues-paper-3).

Strait Islanders. These diagrams also demonstrate some of the significant interdependences that are present within the health sector.

In the responses that follow in this submission to the Requests for Information for this Inquiry, the AHHA urges the Productivity Commission to respect the following general principles as necessary pre-conditions when examining the scope for effective increased competition in human services in the health sector:

- Increased competition can only be realised with appropriate **transparency**. This includes transparency related to both individual health practitioners and provider groups with respect to:
  - Appropriate alternatives for the provision of needed healthcare
  - Pricing practices and costs
  - Health outcomes achieved
  - Quality of healthcare provided across appropriate dimensions
  - Prospective delays in receiving treatment

- Increased competition can only be realised with appropriate consumer **health literacy**. This includes:
  - Access to relevant authoritative health information
  - The individual having the capacity to understand and act appropriately with this information, and noting that this will be different for different people and in different circumstances
  - The existence of an appropriate principal-agent relationship between the patient and their healthcare provider with expert guidance to properly enable informed consumer choice

- Relevant individual healthcare **data is portable** to enable alternative healthcare practitioners and providers to feasibly provide a competitive alternative. Characteristics of portable data include:
  - Data structures are compatible across vendor applications and use common clinical coding systems
  - Individual health data is maintained in real time
  - Appropriate safeguards are in place to ensure patient confidentiality and health care data security

- The varying **context** in which otherwise similar healthcare is needed means that a change in competition settings will not always work the same way in different settings eg what is feasible in urban settings may not be feasible in non-urban settings implying the need for regionally tailored approaches to competition settings

- There is currently a wide recognition within the health sector of the importance of **integrated healthcare** in achieving better health outcomes, and better use of resources and competition policy should not create perverse or short-term incentives that work against this objective

- Individually short-term rational decisions should not be at the expense of long-term **sustainable health outcomes** or broader **whole-of-system technical efficiency**

- **Funding mechanisms** influence what healthcare services are provided and where they can be provided

- Any increase in competition should not cause an increase in **health inequalities** through perverse incentives or otherwise unintended consequences

- The impact of entrenched professional cultures that prevents clinically safe **expanded scope of practice** consistent with inter-disciplinary competencies must be addressed

2. Request for Information 1: What constitutes improved human services?

> The Commission is seeking participants' views on what constitutes improved human services. Do the concepts of quality, equity, efficiency, responsiveness and accountability cover the most important attributes of human services? If these are the most important attributes, how should they be measured or assessed?

While the attributes listed by the Productivity Commission are all relevant and important, the attributes of accessibility, safety and sustainability are also very important policy objectives in the delivery of healthcare services.

Access relates to both the availability of a particular service or product and the timeliness with which it can be accessed. Market failure often occurs in rural and remote areas where the provision of a particular service or product is not economically feasible. However, accessibility can also arise in well serviced areas as demonstrated by delays in being able to see a doctor and with hospital waiting lists.

Safety relates to the manner in which healthcare and products are delivered, and the frameworks for ensuring healthcare errors are prevented or minimised. The Australian Commission on Safety and Quality in Health Care has produced the Australian Safety and Quality Framework for Health Care that addresses these concerns.[2]

Sustainability relates to both the sustainability of individual and population level health outcomes, and sustainability of the health system itself. The former requires an integrated approach to healthcare delivery and a simultaneous short and long term perspective. The latter relates to retaining capacity within the healthcare system across all time horizons, geographic settings and healthcare markets, and not just minimising short term costs.

It is also important to recognise that data on both the cost and quality of health services is often difficult to obtain, particularly for care that is provided outside of a hospital. Healthcare data is rarely standardised, often fragmented, or generated in legacy IT systems with incompatible formats.[3,4] Without high quality health data, it is impossible to fully assess the adequacy of health services, recognise problems, shift system resources, or identify and disseminate best practices.[5] Comparable, portable and real-time data is a pre-condition for effective competition in the provision of healthcare.

Governments are focusing on building strong integrated primary health care in order to be both effective in improving patient outcomes and experiences, and efficient at delivering appropriate services where they are needed most. However, standardised approaches for reporting activity and outcomes, as well as addressing professional and organisational barriers to sharing information as part of a wider quality improvement program, are needed.[6] This will include requiring a national, cohesive approach to developing and implementing standards for general practice electronic health records.[7] It

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[2] See http://www.safetyandquality.gov.au/national-priorities/australian-safety-and-quality-framework-for-health-care/.

[3] Raghupathi W, Raghupathu V. Big data analytics in healthcare: promise and potential. Health Information Science and Systems 2014;2(3).

[4] Gordon J, Miller G and Britt H. Reality check - reliable national data from general practice electronic health records. Health Policy Issues Brief No 18. Deeble Institute for Health Policy Research; 2016. (Available from https://ahha.asn.au/publication/issue-briefs).

[5] Dash P, Meredith M. When and how provider competition can improve health care delivery. London: McKinsey & Co; 2010.

[6] Pay for performance: Australian landscape, international efforts, and impact on practice; June 2016. At: http://www.phcris.org.au/publications/researchroundup/issues/47.php

[7] Gordon J, Miller G, Britt H, op cit, p 3.

would be counterproductive to increase competitive market conditions in the absence of comprehensive and portable personal health data.

Accreditation schemes with the intention of assuring safety and quality are in place in primary care, e.g. for general practices and pharmacies. However, these have not been established for as long in hospitals, and while improved processes can be demonstrated, there is no clear evidence that compliance with accreditation leads to increased safety and quality.[8,9] Without more robust evidence, dependence on accreditation schemes as a measure of quality would not be supported.

Until progress is made in developing outcome measures and their systematic collection and reporting, particularly in the primary and community health care environment, attention needs to be paid to the information that is currently available. However, the time lag between data collection, analysis and reporting needs to be addressed. Further, the attributes of health services should not be considered in isolation of each other, nor in isolation of the attributes of users of those services. Given the complexity of the data, it is critical that the measurement or assessment of the various attributes of health services be transparent and timely, and that it be interpreted with collaborative input from a broad range of stakeholders to assist understanding.

The AHHA recommends that:

- A comprehensive and transparent approach to assessing and monitoring health services be used to drive improvements in quality, equity and efficiency.
- Work be done to enable systematic measurement and benchmarking of healthcare, but more importantly health outcomes, in the primary, acute and community care environment.
- Real-time data flow, reporting and analysis is the 'gold standard'.
- Patient health data be portable to enable individual consumers to move between providers.

Case example: an effective approach to assessing and reporting on health service attributes

The *Australian Atlas of Healthcare Variation*[10], published for the first time in November 2015 by the Australian Commission on Safety and Quality in Health Care, facilitates an understanding of variation in healthcare across six clinical areas in terms of quality, value and appropriateness.

Data from the Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) and Admitted Patient Care National Minimum Data Set (APC NMDS) have all been used to explore variation across different healthcare settings. However, it was interpretation of this data through collaborative input from the Australian, state and territory governments, specialist medical colleges, clinicians and consumer representatives that assists the understanding of where variation is unwarranted that is critical.

The variation demonstrated also highlights the impact of socioeconomic and environmental factors that influence health, patient need and issues of access to services. It reinforces the importance of being able to interpret data in the context of data about these socioeconomic and environmental factors as well.

[8] Literature review – General Practice Accreditation Report; October 2014. At: http://www.safetyandquality.gov.au/wp-content/uploads/2014/12/Literature-Review-General-Practice-Accreditation-Report-October-2014.pdf

[9] Hinchcliff R. Accreditation of health services: is it money and time well spent? Deeble Institute Evidence Brief. Canberra: Australian Healthcare and Hospitals Association; 2013.

[10] Australian Atlas of Healthcare Variation; November 2015. At: http://www.safetyandquality.gov.au/atlas/

Case example: an ineffective approach to assessing and reporting on health service attributes

Over time there have been objections raised to pharmacy ownership and location rules, with a number of subsequent reviews. The most recent review published did not provide adequate transparency in the findings that supported its conclusions, leaving it open to criticism that the review had not, for example:

- Acknowledged the influence of health care structures (e.g. when making international comparisons);
- Assessed the extent to which the rules contributed (or not) to their original purpose/intent in achieving the objectives of the National Medicines Policy;
- Provided a comparison of alternative mechanisms for achieving the objectives of the National Medicines Policy.

It is hoped that the current review of pharmacy remuneration and regulation (it is understood that the release of the associated discussion paper is imminent) adequately addresses these criticisms of previous reviews so that there can be informed consideration of whether the location and ownership rules work for Australia's public interest, including increased access to community pharmacies for consumers in rural and remote areas of Australia.

3. Request for Information 2: Human services best suited to increased competition contestability and informed user choice

The Commission is seeking feedback on whether the factors presented in figure 2 reflect those that should be considered when identifying human services best suited to the increased application of competition, contestability and informed user choice.

When considering which health services may be best suited to the increased application of competition, contestability and informed choice, there must be recognition that competition should be an instrument for achieving health policy goals, and not an ideological goal in its own right.[11] Investment in examining reforms to increase competition, contestability and user choice for health services must first ensure there is an understanding of how the services contribute to and achieve policy goals and society's broader objectives, as well as alternative mechanisms to competition for contributing to these policy goals and society objectives. Reforms may not be able to achieve all goals at the same time, and trade-offs may need to be made. Expectations for impacts, both positive and negative, need to be transparent.

As a policy goal to improve the technical efficiency within the health sector, it is important to recognise where the incidence of any cost savings from increased competition may accrue and the impact this could have on broader health policy. As an example, trials by private health insurers to improve their members' access to primary healthcare risk improving health care and outcomes for one group (those insured with the particular health fund) at the expense of reduced access and higher costs for all others.[12] This highlights the tension between increased competition and the negative externality of increased health inequalities.

While related, patient choice should not be considered equivalent to competition. Encouraging patient choice does not automatically imply a need to strengthen or introduce competition. Competition between healthcare providers will only be possible where there is choice on the demand side, and in healthcare this is often not the case e.g. due to geographic location or funder restrictions.[13] Competition through the entry of alternative providers can also be inhibited by a lack of harmonization of health regulations across jurisdictional boundaries.[14]

Consideration is also needed about whether the focus is in competition among providers for patients, or competition among providers for payor contracts. Information asymmetry (including uncertainty in need for services and moral hazard) may be much greater between providers and patients,[15] favouring a focus on competition among providers for payor contracts. However there may be a tension between the right of patients to choose health care providers and the right of payers to select the health care providers whose services they are willing to finance.[16] Further, capacity constraints (organisational and workforce) may be used, implicitly or explicitly, as a mechanism for rationing care to patients for those providing funding (e.g. through waiting lists) and cannot be ignored when considering the introduction of increased competition.[17]

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[11] Expert panel on effective ways of investing in health. Competition among health care providers. Investigating policy options in the European Union. Brussels: European Commission; May 2015.

[12] Biggs A. Private health insurance in primary care: overview of issues. Parliamentary Library, Commonwealth of Australia; 2015.

[13] Expert panel on effective ways of investing in health, op cit, p 6.

[14] Novak J, Berg C and Wilson T. The Impact and Cost of Health Sector Regulation. Australian Centre for Health Research; 2007.

[15] Dash P, Meredith M. When and how provider competition can improve health care delivery. London: McKinsey & Co; 2010.

[16] Expert panel on effective ways of investing in health, op cit, p 6.

[17] Expert panel on effective ways of investing in health, op cit, p 6.

While identifying factors that influence the potential benefits of increased competition are important, it is crucial to identify whether there is a problem, and where benefits of having increased competition (under appropriate conditions) may be expected. These have been summarised as:

- When health care providers have, and are exercising, market power;
- When health care providers have market power and inefficiencies in their operations;
- When health care providers are not (sufficiently) responsive to key decision-makers preferences; and
- When there is a lack of innovation, in both product and process.[18]

However, there must also be recognition that:

- Information about healthcare is imperfect. Where there is an inability to measure quality of care, the specification of quality objectives, and competition based on quality or quality-based payments is not possible.
- The level of competition that is appropriate may vary considerably in different clinical settings and locations, largely (but not entirely) because of minimum economic and clinical scales needed to ensure high-quality, efficient delivery of care. It is thought that healthcare markets that are less specialised and less reliant on expensive infrastructure may better support an increasing number of providers.[19]
- 'Traditionally less integrated health care systems, which also tend to allow more provider choice, seem to exhibit historically high expenditures.'[20, page 15] Integrated, patient-centred care delivery requires collaboration and co-ordination between healthcare providers. 'Co-creating and co-designing systems of care around the expressed needs of local populations involves a sharing of ideas and collective action between healthcare stakeholders. This has been the approach taken by many successful multi-site, multi-disciplinary quality improvement collaboratives in recent decades.'[21] Any consideration of increasing competition must examine the impact on achieving collaborative and co-ordinated patient-centred care.
- Social determinants of health influence user characteristics, as well as the current and future drivers of supply and demand of health services. For some population groups, the drivers of poor health outcomes fall outside the remit of health policymakers and healthcare providers.
- There are regional differences in healthcare that may be best addressed by regional solutions. Any application of competition should be done with consideration of allowing flexibility in the design and delivery of health services to best suit regional needs.

[18] Expert panel on effective ways of investing in health, op cit.

[19] Dash P, Meredith M. When and how provider competition can improve health care delivery. London: McKinsey & co; 2010.

[20] Costa-Font J, Zigante V. Are health care 'choice and competition' reforms really efficacy driven? The London School of Economics and Political Science. Working paper No 26/2012.

[21] Leeder S, Russell L, Doggett J and Scott I. More competition in health care? Hasten slowly or not at all. October 2015. At: https://croakey.org/more-competition-in-health-care-hasten-slowly-or-not-at-all/

4. Request for Information 3: Human services with the greatest scope for improved outcomes from increased competition, contestability and user choice

Request for Information 4: Case studies applying the principles of competition, contestability and user choice to the provision of human services

The Commission is seeking participants' views on which human services have the greatest scope for improved outcomes from the increased application of competition, contestability and user choice. Where possible, this should be supported by evidence from performance indicators and other information to show the extent to which:

- Current and expected future outcomes — measured in terms of service quality, efficiency, equity, accountability and responsiveness — are below best practice
- Competition, contestability and user choice do not exist under current policy settings, or are not as effective as they could be in meeting the goals of quality, equity, efficiency, accountability and responsiveness.

The Commission welcomes participants' views on how best to improve performance data and information in the human services sector.

Participants are invited to submit case studies of where policy settings have applied the principles of competition, contestability and user choice to the provision of a specific human service. Such case studies could describe an existing example or past policy trial in Australia or overseas. Participants should include information on the:

- Pathway taken to achieve the reform
- Effectiveness of the policy in achieving best-practice outcomes for quality, equity, efficiency, responsiveness and accountability
- Applicability of the case study to the provision of human services in Australia if it is an overseas example.

It is challenging to provide a simple response to this question, given the many variables that influence the appropriate level of competition that have been discussed in response to previous questions. However, an area that is likely to provide improved outcomes from increased competition, contestability and user choice is within the healthcare workforce, in particular the legislation and regulation of scopes of practice, together with funding models for specific services, which restrict competition and innovation.

The Australian healthcare workforce is large and diverse, ranging from highly qualified and specialised health professionals to workers with limited or no qualifications providing in-home care and support services. 'There is evidence that the current organisation of health professionals and health practitioners, and their associated scope of practice, are not suited to meet the needs of the Australian health system. This is contributing to unsafe and inefficient care delivery. There have been substantial changes in population health needs and the technologies, structures and processes of the health care system, yet there has been little change in the health workforce to adapt to the system requirements. Many of the difficulties in adapting the workforce are created by existing legislation and regulation,

the funding models for health professional services, and entrenched professional cultures.'[22, page 2] Flexibility of roles and responsibilities, delegation of tasks, and cultural adjustments by healthcare professionals have been recognised as particularly important in remote and rural areas.[23]

Reflecting the particular challenges associated with the provision of healthcare in non-urban settings, the Australian Government has stated that it will work with rural health and consumer groups, private health insurers and other key stakeholders to develop a private health insurance product designed specifically for Australians living in rural and remote areas. The Government will form an advisory committee on private health insurance, to be tasked with advising on this and other reforms that will give consumers better access to standard levels of coverage, easier to understand policies and fine print, standardised medical procedure definitions and single medical bills. The Government has also stated that it will protect the current community rating system to ensure rural and remote Australians aren't disadvantaged.

The following areas lend themselves to being examined in more detail:

1. **Funding models that are activity-based and outcome-focused rather than centred around health professions**

   The OECD has prepared a useful summary discussing contemporary healthcare payment innovations and how funding mechanisms can be used to more closely align health policy objectives with provider incentives.[24] These issues have recently been further explored in the Australian context.[25] A closely related issue is the effective utilisation of the health workforce and how restrictions on the scope of practice among healthcare practitioners constrain the development of alternative models of care and sub-optimally utilise the available skill base.

   'Australia is unusual among developed countries in our use of medical professionals to perform many routine tasks that evidence shows can be provided by nurses and other health care workers with appropriate training and support.'[26]

   National Boards are responsible for regulating health professions, including setting the standards, codes and guidelines by which they practise, and the scope of practice of self-regulated professions are codified by various membership associations. However, the current health professional registration and credentialing processes generally assume that scope of practice cannot be shared among health professionals, limiting the implementation of scope of practice changes among health professionals.[27]

   Further, funding models for health services (e.g. Medicare Benefits Schedule, Community Pharmacy Agreement) are siloed and restrict the funding of service delivery to specific professions or sites of practice, unrelated to other professions' scopes of practice and their competence in providing certain services.

   Alternative funding models, e.g. that are activity-based and outcome-focused, would increase competition by allowing professions to work to their full scope of practice and encourage practices to adopt more innovative and efficient models of practice for specified procedures. This is one

[22] Leggat S. Changing health professionals' scope of practice: how do we continue to make progress? Deeble Institute Issues Brief. Canberra: Australian Healthcare and Hospitals Association; 2014.

[23] Rygh E, Hjortdahl P. Continuous and integrated healthcare services in rural areas. A literature study. Rural and Remote Health 2007;7(3):766.

[24] Organisation for Economic Co-operation and Development (OECD). Better ways to pay for health care. OECD; 2016.

[25] Dawda P. Bundled payments: their role in Australian primary health care. Pathways to Reform. Canberra: Australian Healthcare and Hospitals Association; 2015.

[26] Leeder S, Russell L, Doggett J and Scott I, op cit.

[27] Leggat S, op cit, p 9.

example where increasing competition would improve health care services in rural and remote communities particularly.

'Much has been written about the difficulties in the development and implementation of health policy that is perceived as redistributive. It is clear that health policies can have "a direct and significant effect on the incomes of healthcare providers" suggesting that it will always be difficult to coalesce the interested parties in health policy that may improve effectiveness and efficiency of the system but which may put dominant groups or individual in positions where they are less well off. This suggests that there may be advantages in focusing discussions away from health professions onto essential work roles.'[28, page 16]

The findings of a literature review examining continuous and integrated healthcare services in rural areas indicate that this may be achieved by decentralisation of services, delegation and substitution of tasks, interdisciplinary and team-based working, flexibility of roles, and cultural adjustments. In addition, it was found that programs such as integrated and managed care pathways, outreach programs and shared care were relevant measures.[29,30] Telemedicine may also be a useful tool to achieve access to services in remote areas. Most of the literature in this area comes from industrialised countries in Europe, USA, Canada and Australia, with much of it identifing a lack of evidence and indicates the need for future research. There is also a need for further studies on the relevance and validity of these findings in other regions, including Australia.

Case example: insertion of long-acting reversible contraceptives by practice nurses and nurse practitioners

Unplanned pregnancy is a key health issue for women in Australia. There has been increasing recognition, nationally and internationally, that a key way to reduce unintended pregnancy is to use more effective and less user-dependent methods of contraception such as long-acting reversible contraceptive (LARC) methods. Despite evidence for the effectiveness of, and satisfaction with, LARC methods, as well as support for their use by peak bodies and key opinion leaders in Australia and internationally, use of LARC methods in Australia continues to remain low.

A recent paper[31] explored policy, regulatory, workforce and funding factors that enable or hinder healthcare providers to provide safe, effective and efficient contraceptive care. A key finding was that while registered nurses and nurse practitioners can be trained to insert LARC methods, funding of these services through the MBS is restricted to general practitioners.

A funding model that supported provision of contraceptive care by registered nurses and nurse practitioners would facilitate these health professionals working to the full scope of their practice, increasing the application of competition in the provision of contraceptive services. This would increase the productivity of the health workforce and expand sector capacity.

2. Referral pathways utilising the allied health workforce

[28] Leggat S, op cit p 9.

[29] Rygh E, Hjortdahl P. Continuous and integrated healthcare services in rural areas. A literature study. Rural and Remote Health 2007;7(3):766.

[30] Weinhold, I and Gurtner, S. Understanding shortages of sufficient health care in rural areas. Health Policy, 2014; 118(2); 201-214.

[31] A health system that supports contraceptive choice. Canberra: Australian Healthcare and Hospitals Association; 2016. At: http://ahha.asn.au/sites/default/files/docs/page/final_report_ahha_-_a_health_system_that_supports_contraceptive_choice_-_results_and_.pdf.

While patients do not need a general practitioner (GP) referral to see a specialist, if the patient requires Medicare to pay them a rebate to assist covering the cost when visiting a specialist, a GP referral needs to have been obtained first.

There is evidence that supports reformulating this policy to allow referrals to be provided by allied health professionals, safely and effectively within their scope of practice, without disadvantaging patients by preventing eligibility for Medicare rebates. Such redistributive models could facilitate these health professionals working to the full scope of their practice, reduce duplication and unnecessary services, and increase the application of competition. Such an approach also ensures more effective use of health system capacity by allowing more highly trained health practitioners to attend to more complex cases. Models have been developed that demonstrate net annual savings to Medicare and patients.[32]

Case example: physiotherapist referral to specialist medical practitioners

Currently in Australia, if a physiotherapist refers a patient to a specialist medical practitioner, the patient is not eligible to receive a Medicare rebate and must pay in full for the treatment service. As a result, almost all physiotherapists choose to refer their patients to a GP, so the GP will write the specialist referral and the patient can receive a Medicare rebate. A cost to the health system (both from Government and possibly as an out-of-pocket cost) is incurred when visiting a GP to obtain a referral to a specialist medical practitioner.

A change in current policy to allow patients to receive a Medicare rebate in instances of direct referral by physiotherapists to specialist medical practitioners would have many benefits. Direct referral to relevant specialists would save treatment costs for the patient and the Australian health system and avoid the double-handling of having to engage a GP in the treatment process simply to write a referral. This would also save time for patients by not waiting for a referral to be processed by a GP. Access to direct specialist treatment may well provide for early recovery and better treatment outcomes overall. The diversity, skills and knowledge of physiotherapists are not being fully utilised and recognised by current policy, which is costing governments, Medicare and patients more than needed. Individual physiotherapy practitioners recognise their professional limitations and know when and who a patient should be referred to, but patients should not be financially penalised when referred by physiotherapists who have expertise in a relevant field and are operating within their scope of practice.

While there is a risk of some inappropriate referrals, a recent paper identified and examined the likely overall impact on referrals to specialist medical practitioners, the MBS and patient costs. Findings indicated that the introduction of Medicare rebates payable to patients referred to medical specialists from physiotherapists is likely to save Medicare more than $13.6 million per year and patients more than $2.1 million per year in out-of-pocket costs.[33]

3. Systems exist to support informed choice

Patients do not always make the choice of provider, often relying on the opinion of or referral from a medical practitioner. This delegation of decisions has implications for how competition impacts on patient and health professional choices, and it is important that:

[32] Comans T, Byrnes J, Boxall A-M and Partel K. Physiotherapist referral to specialist medical practitioners. Report by the Centre for Applied Health Economics, Griffith University and the Deeble Institute for Health Policy Research for the Australian Physiotherapy Association; 2013.

[33] ibid.

a. Patients have, and are aware of, their right to choice.

   For example, referrals for pathology are provided to patients on pathology request forms that specify a specific company and locations of their pathology collection sites. While pathology services can accept pathology request forms written on any company form, patients are not being provided with information about their choice of pathology services. Consideration should be given to 'generic' pathology request forms. Locations of different services could be provided separately.

b. Similarly, specialist referrals are provided to patients directing them to a named specialist. While medical practitioners should support patients in making an informed choice about which specialist to attend, consideration should be given to patients being provided with referrals directing them to a type of specialist, to ensure it is clear they are aware of their right to choice, and that there is sufficient information to support informed patient choice.

   Data transparency can be considered in terms of its potential to drive improvements in accountability, choice, productivity, quality and outcomes, social innovation, and economic growth. There is strong evidence of the benefits of data transparency across a wide range of industries, and emerging evidence of similar benefits in healthcare.

   While state and territory governments have policies on their commitment to openness and transparency of data, the data is rarely presented in a level of detail that supports patient choice (either as an individual, or with the assistance of their medical practitioner) at the time decisions are being made, nor in a manner that facilitates understanding and therefore true informed consumer choice.

   Data held by Government and private health insurers could be better used to support user choice. There have been calls in Australia to publish fees charged by specialists, to 'name and shame' those who charge exorbitant fees that are many times the Medicare rebate. Suggestions have included an online database of doctors' charging histories and median fees, as well as publishing the AMA's recommended fees.[34] A further step would be to also make available intervention rates and treatment outcomes so that consumers can assess the relative quality of care as it relates to their own healthcare needs.

   Data transparency is not without risks. However it has transformed many industries, and consideration should be given to the approaches taken internationally where gains to health system performance have been made without the risks being realised.

   Case examples: data transparency internationally

   United States: As part of the Obama administration's work to make the US health care system more affordable and accountable, data began being released that summarises the utilisation and payments for procedures, services, and prescription drugs provided to Medicare beneficiaries by specific inpatient and outpatient hospitals, physicians, and other suppliers.

   These data include information for the 100 most common inpatient services, 30 common outpatient services, all physician and other supplier procedures and services, and all Part D prescriptions. Providers determine what they will charge for items, services, and procedures provided to patients and these charges are the amount the providers bill for an item, service or procedure.[35]

[34] Murphy F. Name and shame overpriced specialists: college. Medical Observer. 24 March 2015.

[35] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html

United Kingdom: British heart surgeons began voluntarily publishing outcome data in 2005. By 2010, their risk-adjusted mortality rates for CABG and aortic valve replacement had fallen by more than one-fifth and one-third, respectively.[36]

United States: In 2015, two new, unrelated search tools opened to the public, promising to make elective surgery planning easier and more transparent. The sites (SurgeonsRatings.org and Surgeon Scorecard (https://projects.propublica.org/surgeons/)) organise Medicare fee-for-service data into searchable databases based on criteria including death rates, adjustment for pre-existing patient conditions and evaluations by other doctors.[37]

Worldwide: Archimedicx (www.archimedicx.com) is a company that claims to have devised a system for rating hospitals based on dozens of variables comprising millions of data points in over 300 common medical procedures and treatments, providing a hospital search engine for the benefit of patients seeking access to better treatment worldwide. To do this it has acquired up-to-date data from independent sources in order to calculate an objective, evidence-based hospital quality score for the given procedures and treatments.

c. Coordinated and integrated care is not compromised

Vast amounts of clinical data are also now kept in the electronic health records of general practices, and used for a variety of purposes beyond patient care, including audit and improvement activities, research, patient risk stratification, integrated care programs, and to populate shared health records such as the national *My Health Record*.

There is a widely held perception that because data are held electronically, they can be easily used for these secondary purposes. However, there is a multitude of products in existence, and each has been developed independently with inconsistent structures, data elements, clinical terminologies and classification systems.

To preserve efforts in achieving coordinated and integrated care, the introduction of competition to health services cannot currently be dependent on effective transfer of health records via electronic health records. The lack of standards across electronic health records will make linking individual health data for integration of care across different sectors of the health care system difficult until a national cohesive approach is pursued in this area.[38]

[36] Henke N, Kelsey T, Whately H. Transparency – the most powerful driver of health care improvement? London: McKinsey & Co.; 2011.

[37] http://edition.cnn.com/2015/07/14/health/confidential-data-doctor-shopping/index.html

[38] Gordon J, Miller G, Britt H, op cit, p 3.

5. Other Requests for Information

5.1 Characteristics of certain human services

5.2 Characteristics of the nature of certain service transactions

5.3 Costs and regulations for specific human services

5.4 Costs and regulations for specific human services

The Commission is seeking information on which human services have these characteristics:

- Service recipients are willing and able to make decisions on their own behalf and, if not, another party could do so in the best interest of the recipient
- User-oriented, timely and accurate information to compare services and providers can be made available to users so they are able to exercise informed choice or, if not, this could be cost-effectively addressed
- Service recipients (or their decision makers) have sufficient expertise to compare alternative services and providers or, if not, this barrier could be overcome
- Outcomes experienced by a service recipient and their family and friends in past transactions can inform which service and provider they choose in the future.

For specific human services, the Commission is seeking information on the nature of service transactions based on these characteristics:

- The nature of the relationship between the service user and the provider
- Whether the service is used on a one-off, emergency or ongoing basis
- Whether the service can be provided remotely
- The extent to which services to an individual can be unbundled
- Whether there is a strong case for the provider to supply multiple services to an individual with complex needs.

The Commission is seeking information on the supply characteristics of specific human services including:

- Economies of scale and scope — in terms of costs and service quality — that may be lost by having a larger number of competing providers
- The potential for service provision to be made more contestable because there is capability beyond an existing provider that could pose a credible threat to underperformance
- Whether there are barriers to providers responding to change, or new suppliers entering the market, that limit the scope for increased competition, contestability and user choice or, if they do, what could be done to address this
- Technological change that is making competition and user choice more viable
- Factors affecting the nature and location of demand, such as geographic dispersion of users, the distribution of demand among different types of users, particularly disadvantaged and vulnerable users, and anticipated future changes in demand.

For specific human services, the Commission is seeking information on:

- The costs that consumers would incur by becoming more active in selecting the services they receive, adapting to changes in how providers supply services, and switching services when a decision is made to do so
- The regulatory arrangements and other initiatives that governments would have to modify or establish as part of their stewardship role, including to inform users about alternative services and providers, maintain service quality, protect consumers (especially disadvantaged or vulnerable users) from being exploited, and to fine-tune policies in response to any problems that emerge
- How the compliance costs faced by service providers will be affected by changes in government stewardship, and the adjustment costs that providers will bear in order to shift to a more user-focused model of service provision
- The extent to which such costs are one-off or an ongoing impost.

The Commission welcomes information from participants on the costs faced by different types of providers, with different motivations and governance structures, when shifting to a more user-focused model of service provision.

Given the variation across such a broad range of health services, and the unique complexities that would need to be examined for each service, AHHA will provide feedback on specific services and the proposed scope of competition changes once they are identified for review in the next phase of the Productivity Commission inquiry into *Human Services: Identification of Sectors for Reform*.

However, as part of their further deliberations the Productivity Commission is referred to Section 1 of this submission in which a set of general principles are outlined as necessary pre-conditions when examining the scope for increased competition in human services within the health sector.

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