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Policy context

Increasingly, consumers expect their governments, health services and health practitioners to assist them to be:

- More informed and involved generally;
- Managing their health where possible; and
- Providing prompt, appropriate and individualised help when required.

As such, listening, shaping and responding to consumer expectations of healthcare could now be seen as a critical strategic area within healthcare policy for re-orienting health systems, services and practitioners.

Historically, issues of technical quality of care and patient adherence were seen having precedence over consumer expectations (specifically) and consumer empowerment (generally)—both were effectively seen as optional extras. In contemporary health policy, this view has changed considerably; policy makers realise technical quality and adherence cannot be achieved simply by telling people what to do. Furthermore, socio-political change and higher educational attainment within the population have meant that community expectations have risen in regard to being communicated and involved with their care. To some extent, the internet and social media has facilitated this.

There are also sound economic arguments for understanding consumer expectations and incorporating them into health policy, given that high reliance on health services without a resilient community is not financially sustainable.

Unfortunately—and counterproductively—our efforts to achieve this ideal (and more responsive) health system are hampered by current environment and general continuation of the “optional extra” approach to consumer expectations and empowerment. Within health policy, “increased consumer expectations” has become a common refrain in relation to rising health care costs, alongside population ageing, increasing burden of chronic illness, and higher-cost medical technologies.¹ While the latter factors have been well quantified, “consumer expectations” of healthcare systems, services and practitioners remains a nebulous construction of both evidence and stereotypes.

For example, there is the common belief that older people have lower expectations of healthcare and accept “what they are given.” Evidence from the UK suggests that older people actually have *higher* expectations of healthcare compared to others within the community, but they are more likely than others to feel that those expectations were met and thus be satisfied with the healthcare received.²

This paper will discuss how consumer expectations of healthcare can be conceptualised based on current evidence and policy environment, and how these expectations may impact on health systems, services and practitioners generally.

Conceptualising consumer expectations of healthcare

While there is considerable debate about how consumer expectations can be conceptualised, one definition that reflects general consensus on consumer expectations of healthcare is:

Patients' expectations have been defined as the anticipation that given events are likely to occur during, or as an outcome of, healthcare.²

These expectations can be sub-categorised; for example:³

- *Predicted (or practical) and ideal expectations*: predicted expectations relate to what people **think or believe will actually happen** during or as a result of a health service, whereas ideal expectations relate to what people **want to happen**.
- *Normative expectations*: what individuals **think or believe should happen**, which may substantially impact on patient satisfaction (discussed below).
- *Unformed expectations*: expectations that individuals are not able to adequately express, typically due to lack of experience with a given situation.

In addition, expectations may also be categorised in relation to *process expectations* (e.g. what is expected from health practitioners, contents of health information, healthcare environments) and *outcome expectations* (e.g. alleviation of illness, restoration of health).⁴

In general, consumer expectations of healthcare will be compared by consumers with their experience with what actually happened during their healthcare intervention, service or treatment. This then influences their perception and satisfaction with that experience.³ For example, where healthcare exceeds expectations, increased satisfaction may be reported by consumers (and vice-versa).²

As mentioned above, consumer expectations of healthcare have undoubtedly increased in part due to the ready availability of health information on the Internet. Many consumers are apprising themselves of information about diseases and treatments at a level not seen before, and then interacting with a health system that has been slow to respond to this phenomenon when compared to other industries.⁵

For example, in an Australian study of “Dr Google” and his/her influence on consultations with psychiatrists found that approximately one-third of patients discussed information that they found on the Internet with their psychiatrist, and one-third reported that this information influenced their decision-making.⁶

The generalizability of this Australian study is limited; the proportion of people responding to the survey with a tertiary qualification was over 70%, almost double that of the proportion in the general Australian population. However, this does illustrate the potential asymmetry in consumer expectations of healthcare across the population based on differences in education (or health literacy). For this reason, this paper will discuss health literacy as a key aspect of consumer expectations of healthcare.

Intersection between consumer expectations and health quality frameworks

“Rising consumer expectations” in public policy debates are popularly (and pejoratively) considered to only relate to issues of **quantity**: in health, this means *more services, more GPs, more high-cost pharmaceuticals, more hospital beds*. Perhaps more usefully, consumer expectations of healthcare could be reframed around the notion of **quality**.

It seems self-evident to say that healthcare quality would be one of the most fundamental consumer expectations of the health system, of health services and health practitioners. An international survey of consumers in health systems broadly comparable to Australia (e.g. UK, Switzerland, France, Belgium and Canada) show that health systems' "focus on prevention" (as an indicator of quality) was a substantial consumer expectation that was generally considered unmet by the health system in question.⁷

As such, policy makers could re-characterise consumer expectations according to the general dimensions of healthcare quality in Australia: safety, effectiveness, appropriateness, acceptability, access and efficiency (Table 1).

Table 1: Consumer expectations of healthcare relative to dimensions of quality

Quality dimension	General definition in relation to healthcare quality	Examples of application to consumer expectations of healthcare
Safety	Minimisation of harm arising from healthcare (delivery, interventions, environments, professionals etc)	<ul style="list-style-type: none"> • Use of healthcare interventions with low risk of harm; harm may be broader than “adverse events” and include side effects of treatment, intervention or service • Provision of information about risks/potential harms in making decisions about health care (e.g. through decision aids)
Effectiveness	Treatment, intervention or service will produce measurable benefit and attain desired outcomes	<ul style="list-style-type: none"> • Evidence-informed choice combined with shared decision making
Appropriateness	Interventions, treatments and services are evidence-based, and will produce desired outcomes that substantially outweigh negative consequences	<ul style="list-style-type: none"> • Under/over-utilised interventions or treatments
Acceptability	<p>Acceptability of care: Opportunities must be provided for health consumers to participate collaboratively with health organisations and service providers in health service planning, delivery, monitoring and evaluation at all levels in a dynamic and responsive way. Consumer and community participation should enhance the level of acceptability of services, which is the degree to which a service meets or exceeds the expectations of informed consumers.</p> <p>Opportunities for consumers to have input into healthcare delivery and take into account consumer perspectives</p>	<ul style="list-style-type: none"> • Patient-centred services or practitioners • Consumer involvement in decision-making processes at all levels

Quality dimension	General definition in relation to healthcare quality	Examples of application to consumer expectations of healthcare
Access	Equitable access to health services irrespective of factors such as geography, socioeconomic or demographic group, age or sex	<ul style="list-style-type: none"> • Waiting times • Open hours • Health literacy-promoting organisation • Information on services and treatments
Efficiency	Resources used in manner that achieves greatest value-for-money and benefit, reducing costs and waste wherever possible	<ul style="list-style-type: none"> • Performance systems incorporate measures around consumer expectations and experiences; • Navigation

Definitions for dimensions of quality adapted from *Better Quality, Better Health Care*.⁸

Consumer expectations of healthcare in Australia: a case study on quantity vs quality

Perhaps one of the most prominent examples of consumer expectations in Australian healthcare plays out with increasing regularity in national and social media: inclusion of new pharmaceuticals on the Pharmaceutical Benefits Scheme (PBS).

Much of the public’s attention is often in relation to high-cost cancer treatments, with the prototypical case being trastuzumab (Herceptin®).⁹ However, it is not necessarily confined to cancer treatments; a number of petitions are currently listed on www.change.org for PBS subsidies for other types of drugs; for example, extended indications for esomeprazole and aripiprazole.

A current petition concerning nafarelin (Synarel®) for treatment of endometriosis, and its public “reasons for signing” by petitioners, is illustrative of the general tenor of public debate and consumer expectations in this area. As examples of the various reasons for signing given by consumers on the website expressing their expectations about its inclusion on the PBS, consider the following quotes from petitioners on the change.org nafarelin [petition](#):

As a sufferer of this horrible illness at the age of only 20 years old, I understand how painful and debilitating it can be for people. The fact that the drugs are not already available on the PBS [i]s an outrage!

Having been a sufferer of this condition in the past and it starting at quite a young age I find it astounding that a medication that can help sufferers is not made affordable for all.

A dear friend of ours suffers from endometriosis and the pain disrupts her entire life. This drug needs to be on the PBS.

[B]ecause if there was a condition where men's testicles hurt so badly [they] couldn't work then [I] guarantee the drug would be on the PBS already.

As often commented on, there is concern about whether public debate in this area is a legitimate expression of consumer expectations, or whether it is partly the product of sophisticated (and legal) marketing techniques by pharmaceutical companies: so-called “corporate colonization” of health activism (and thus consumer expectations).¹⁰ This reveals a substantial tension within our healthcare system—the prohibition on advertising of prescription-only pharmaceuticals under the regulatory system established by the *Therapeutic Goods Act 1989*, and Medicines Australia’s self-regulatory *Code of Conduct* (particularly section 13.7, “disease education activities in any media”).

This tension, and how it might influence consumer expectations, is currently being played out in Australia in relation to Lyrica® (pregabalin). Originally listed on the PBS in November 2012 for treatment of chronic nerve pain, with a projected \$447 million cost over the first five years,¹¹ total PBS expenditure for the first calendar year of listing (2013) was only \$36 million.¹² In 2014, Lyrica’s sponsor, Pzifer, have launched a national media campaign around promoting awareness of nerve pain (Lyrica’s PBS-approved treatment indication) through their “morethanmedication.com.au” program.

Such disease awareness campaigns are, quite naturally, targeted at consumers with the intention of changing their expectations about the pharmaceuticals they are prescribed. Where those newly moulded expectations increase demand for a high-cost pharmaceutical (or other treatment, intervention or test), they become a considerable challenge for our health system, health services and health practitioners. This is an example of consumer expectations and quantity.

This illustrates how consumer expectations of healthcare are often framed in terms of **quantity**: in this case, more pharmaceuticals, and how our “penny pinching” government will not subsidise them. The commercial imperatives of pharmaceutical companies aside, the Australian healthcare system has, on occasion, successfully reframed consumer expectations in this area in line with **quality**. Perhaps the foremost example of this—on the national scale required to effect necessary change—is the National Prescribing Service’s [Antibiotic Resistance Fighter](#) campaign. This campaign was designed to change consumer expectations around being prescribed antibiotics for the common cold—a long recognised exercise in clinical futility, yet simultaneously a common practice due to the consumer expectation to go to the GP and “get a script”.

Such quality use of medicine approaches could be further developed as a means to change consumer expectations around medicines, particularly high-cost medicines.

Consumer expectations and healthcare financing

Perhaps the most vexed issue in understanding consumer expectations of healthcare is that of expectations around healthcare financing. This has played out in graphic detail most recently in relation to the debate around the proposed \$7 co-payment for GP consultations under Medicare. From this debate, it is clear that Australian consumers have very specific expectations around healthcare financing, particularly about what services should be funded. It goes without saying that this expected “core” of services includes GP consultations.

Other types of health (or health-related) services provoke vigorous debate in the opposite direction. For example, public financing of homeopathy in Australia would likely create substantial debate similar to that occurring in the United Kingdom, where such services are currently subsidised under the National Health

Services Directory (NHSD). Such services are examples of those outside the core expectations for public financing.

Between the two extreme examples of GP services and homeopathy lies a continuum of services where consumer expectation and policy are constantly shifting. Perhaps the foremost example of the shifting dynamics of consumer expectation and financing is that of Medicare subsidy for psychology (and like) services under Medicare. The introduction of these services (almost a decade ago) was in response to increasing consumer expectation for more readily accessible mental health services. This response to consumer expectations has then created greater consumer expectations around access to allied health services under Medicare; the ultimate extension of this being the Denticare proposal.

In terms of healthcare financing and consumer expectations, this response-creation-response cycle is an effective form of positive feedback loop: spending creates expectation of further spending. In essence, financing new health initiatives is often in response to consumer expectations, but doing so then creates further consumer expectations, that are then the subject of further policy response (or not).

Service location is another potential area where this consumer expectation "response—creation cycle" may occur. For example, establishment of super-clinics and the notion of co-location of allied health professionals with GPs; while a worthy aim, this response—creation of "co-location expectation" is difficult to achieve and maintain in a system essentially constructed from small, separated practitioners/practices. Greater integration of information technology architecture and inter-professional practice could potentially meet the larger consumer expectation of an improved health system in a more equitable fashion, rather than meeting in a piecemeal manner through super-clinics in selected locations.

In common with other aspects of consumer expectations, harnessing consumer expectations should be central to policy design. Responding to consumer expectations at earlier stages, such as primary healthcare, is critical: where expectations for healthcare financing can be met at earlier preventive/ambulatory stages, it may assist in building expectations at the "right" end of the health system. In doing so, there is the potential to reduce disease burden and healthcare expenditure.

Consumer expectations of healthcare in Australia: major strategic quality initiatives

Clearly, consumer expectations should be tied to quality. If so, what are the major initiatives in Australia associated with improving the quality of healthcare which may influence consumer expectations in the future?

Table 1 (above) identified several initiatives: patient or consumer health information systems; evidence-informed choice and shared decision making; patient-centred care; health literacy-promoting organisations; system navigation; and performance systems which incorporate measures around consumer expectations and experiences. This paper will discuss these and the issues associated with responding to and shaping consumer expectations, drawing from Australian and international research and policy trends.

Patient or consumer health information systems

A number of countries have invested heavily in presenting health information in line with consumer expectations, with the aim of providing evidence-based and authoritative information. Good examples are Britain's 'Patient.co.uk' (<http://www.patient.co.uk/>) and the US National Institutes of Health 'Health Information' site (<http://health.nih.gov/>).

These sites provide a level of consistent content and layered detail, interaction and personal application which is largely missing in Australian sites, notwithstanding the recent investment in 'Healthdirect Australia' (<http://www.healthdirect.gov.au/>), and (at a state level) sites such as Better Health Channel.

It remains a critical issue for clinicians and consumers that sites such as these stay abreast of improving health information provision and technology challenges and continue to provide information to consumers which they want. Consumers source much of their health information from the web,¹³ and the rise of alternative providers of information mean that authoritative sites are competing on many fronts.

Submissions to the Australian Commission for Safety and Quality in Health Care during its 2013 consultation on health literacy provide support for high level and centralised resources for patient health information, with systems and resources for health services to make it easier to keep people informed.¹⁴

This sentiment was strongly endorsed at seven consultation workshops around the state of Victoria between February–April 2014 in the development of a health literacy statement for Victoria.¹⁵ Participants at the workshops—who included health practitioners, consumers and carers—agreed that the current approach to developing and providing health information at the health service level is not streamlined, produces masses of information (much of which is not accessible) or does not meet people's needs. The criticisms of the current situation were further informed by audits undertaken by several health services. The challenge of responding to diversity in individual abilities was underscored by the lack of health information materials in different/more suitable formats (e.g. easy-to-read, pictorial, braille, translated, audio, multimedia). Particular gaps are information which takes into account age, disability and language; resources encouraging questioning and shared decision making; and information that is more active in orientation (i.e. what will happen next, what to do next, what to do if problems emerge).

Repeatedly, the following question (and expectation) was raised: if health information topics are broadly the same at each health service or for groups of health practitioners, why is it not produced or provided centrally by people with the expertise? In this context, a need was for agreed or standardised resources or templates, ideally held by a central site, which services could then tailor in certain ways (e.g. adding their service logo and local contact information).

However, without an overarching policy framework, consumer information continues to be a patchwork of small-scale initiatives and (sometimes poorly) duplicated resources, with serious gaps in quality and content and which do not meet overall consumer expectations. Initiatives such as the UK Health Information Standard may provide means to address this.¹⁶ The forthcoming health literacy report by the Australian Commission for Safety and Quality in Health Care may provide a context for reform in this area.

Health services and health professionals need to be able to have reliable, validated, evidence-based, authoritative information sources to recommend to patients and families who want more detail. In

conclusion, without a substantial infrastructure for patient health information, clinicians do not have the supports for evidence-informed choice and shared decision making.

Evidence-informed choices and shared decision making

In line with general consumer expectations, Australia has strengthened the capacity of people to make evidence-informed choices through, amongst other means, subscription to [The Cochrane Library](#); however, shared decision making remains an elusive goal.¹⁷

Shared decision making, informed by evidence, is not just a lofty expectation; it can lead to improvements in key health consumer outcomes. For example, interventions such as decision aids, improve people's knowledge regarding options, and may reduce use of elective surgery.¹⁸ Patient experience surveys indicate that involvement in decisions about health is expected by most consumers, albeit to varying degrees,¹⁹ so supporting health practitioners and consumers to achieve this remains a key health systems goal (especially given the variation in common procedures observed across Australia).²⁰ Most activity in this area consists of awareness-raising and workshops,²¹ so the challenge is how to reduce the barriers to use these tools in the Australian context through enabling policy.

One of the barriers is that they are seen as a separate product (and, indeed, expectation) to written health information. Decision aids are gold class, whereas much health information is not at this standard. How could it be made easier for health services and practitioners (and governments) to provide information that is closer to a decision aid than is currently the case?

One way forward might be to examine existing health information resources for consumers for all common surgical procedures where there is wide variation in utilisation across Australia (based on data from the Commission's recent report) – and audit the extent to which they conform with quality criteria for decision aids. The strategic policy aim would be to examine how to bring a larger number of existing resources up to meet standards and expectations, a more prudent and efficient approach than developing a gold class resource for a small number of conditions that will be largely unfamiliar to most health services and practitioners. It could also help to build the case for more consistency across health information – given that there is such variation in content for many conditions and procedures.

A second major barrier to using tools such as decision aids is the lack of familiarity in health practitioners with using and applying concepts such as shared decision making. This raises the associated issues of communication skills training for health practitioners.

Patient-centred health practitioners

Central to contemporary consumer expectations, health policy and effective health systems is the exchange of meaningful information through interpersonal communication and information provision. Overall, on several indicators, consumers' expectations of health practitioners are met, although seemingly less satisfactory from the perspective of younger people, or from people who live in the most disadvantaged areas.²²

Many health practitioners are already aware of these challenges. For health professionals consulted in the Victorian health literacy workshops (mentioned above), the importance of supporting career-long learning opportunities for health practitioners to gain communication skills was repeatedly endorsed. Key

communication skills spoken of in these workshops included being able to communicate respectfully and effectively with consumers and carers, and also communicating effectively in teams and with other health practitioners.

Communication skills training for health practitioners was seen as a major gap, not only at university level, but also throughout professional careers. In part, this is related to new professional challenges arising in response to changing social expectations and socio-demographics, and the consequential changes in consumer expectations that this creates. Health practitioners new to the workforce *want* to learn more and interact with consumers more effectively or sensitively, but feel under-prepared because there was insufficient attention to communication issues during their training. Training therefore needs to be continuous, and be accredited. It also needs to be available for ancillary staff involved with consumer contact within the health system (e.g. health service receptionists). Health practitioners should be able to get advice on how to communicate with people with disabilities, with people from different cultural backgrounds and other groups.

The topic of improving communication skills of clinicians should be put on the curriculum agenda of tertiary institutions. Related initiatives should be examining the issue of core competencies for health professional communication with relevant national agencies and professional colleges.

Health literacy promoting organisations: navigation

The concept of a "health literate organisation" has been promoted by the USA's Institute of Medicine,²³ and is supported by Australia's healthcare standards.¹⁴ Consumer navigation of the health system continues to be a vexed issue, particularly from the perspective of consumer expectations of the system and the sorts of assistance that should be available to them. The most recent findings from the ABS *Patient Experiences Survey* (2012-2013) indicate that whilst health professionals helped people with service coordination, there is room for improvement.²²

Both health practitioners and consumers find navigation of the health system a problem. In Victoria, community members and health professionals stated repeatedly (at the recent health literacy workshops)¹⁵ that the health system is becoming so complex to navigate that without people occupying specialised roles as "navigators" or experts on service availability (on an informal or formal basis), the complexity and specialisation of the system was major barrier to timely access by consumers or carers to services. As a concept, 'navigation' referred to both physical assistance in getting around a health service complex and also an information provision role, and is an increasingly central (and unmet) consumer expectation.

The role of service navigation emerged as a critical function which could be occupied by health practitioners, as well as community members with suitable training. Some argued this should become a designated role for health practitioners so that others in the service knew who to contact. A range of core information databases exist to support service navigation, but awareness of these resources is still patchy. These could be better promoted to health services, including:

- National Health Services Directory: <http://www.nhsd.com.au/about-us>
- Health Translation sites such as: <http://www.healthtranslations.vic.gov.au/>
- the NH&MRC register of clinical guidelines: www.clinicalguidelines.gov.au

The key message on health system navigation is that health practitioners and consumers face similar problems, and better partnerships to address this would be more in line with consumer expectations. There should be increased recognition of the role of navigator. A national summit should be held to explore the implications for health professionals and community members in terms of role, responsibilities, and training needs.

Health service performance

Improving the performance of health systems is not only a process informed with the views and expectations of health practitioners and consumers: it should also be based on evidence. What evidence is available to inform this process?²⁴

At the bedrock of care is evidence for healthcare interventions. In Australia, consumers may look on *The Cochrane Library* to see if there is any evidence of a treatment proposed by their health practitioner, and expect to be able to discuss this with them. This is the basis of evidence-based medicine and evidence-based practice.²⁵ Increasingly, though, there is a growing body of evidence summarising the effects of different types of interventions, not only clinical treatments but also interventions which aid the effective and efficient *implementation* of clinical care and healthcare experiences.²⁶

To illustrate where such evidence can be used, consider the following example. In 2005, the USA's Commonwealth Fund released a six-country comparative survey with adults suffering from a variety of illnesses. Responding to questions about hospital and discharge experiences, at least one-third of respondents in each country (Australia, Canada, Germany, New Zealand, UK and USA) "did not receive instructions about symptoms to watch for, did not know whom to contact with questions, or left without arrangements for follow-up care."²⁷ Once again, this can be interpreted as an unmet consumer expectation with significant quality ramifications: inadequate preparation for discharge is a cause of adverse events and readmission.²⁸ Evidence-based interventions designed to improve this situation will contribute substantially to the health system's ability to meet consumer expectations.

Evidence to improve healthcare experiences would include interventions implemented at several levels; for example, government policy, service delivery or organisational program. Evidence for systems improvement may feed into different policy purposes such as the development of a new policy or guideline, conducting a review or audit, as well as analysis of research gaps and priorities or disseminating evidence in knowledge transfer networks.

In the last two decades, there has been a substantial growth in the number of published systematic reviews of such interventions, fuelled by the Cochrane Collaboration, as well as in response to need.²⁹ Improving people's interactions with the health system can lead to improved communication and health outcomes. What does it tell us which helps to frame the task of meeting and harnessing consumer expectations?

Taking the framework for the second half of this paper to organise the evidence from selected systematic reviews, we can see that outcomes across the spectrum can be improved through purposeful interventions.³⁰

- *Patient or consumer health information systems:* Kinnersley and colleagues found that interventions to help people address their information needs in consultations increase question-asking during consultations, patient participation and improve patient satisfaction.³¹
- *Evidence-informed choice and shared decision making:* Interventions to improve informed consent consistently improve knowledge and satisfaction with decision making.³²
- *Patient-centred health practitioners:* Dwamena and colleagues found that interventions to promote patient-centred care within clinical consultations were effective across studies in transferring patient-centred skills to providers.³³
- *Health literacy promoting organisations and navigation:* Improving the quality of communication between health practitioners and between health practitioners and consumers may improve health outcomes.³⁴
- *Health service performance:* Involving consumers in developing patient information materials can improve the clarity and relevance of materials, and can improve people’s knowledge without increasing their anxiety about medical procedures.³⁵

What this tells us is that there are choices: for health systems and individuals. We can improve health outcomes across the spectrum, from knowledge to clinical outcomes, by adopting strategies which harness consumers and health practitioners in partnership and with active involvement. To do so would place primacy on consumer expectations about the quality of their interactions with the health system.

Potential policy directions

Much of contemporary Australian health policy is focused on how to make the system more affordable and sustainable in the long-term. The current policy approach is, in areas like inclusion of high-cost pharmaceuticals on the PBS or charging for previously bulk-billed consultations under Medicare, often quite contentious, as it conflicts with consumer expectations (rising or otherwise). As indicated above, where this becomes contentious, the tenor of debate typically degenerates into a consumer position of disdain for heartless “penny-pinching” by governments over health, and the opposite position by governments that responsible, controlled spending is necessary in order to guard against cost blow-outs and ensure health system sustainability.

The key policy question is this: while some (such as pharmaceutical companies) may be **creating** consumer expectations, and others try to **manage** consumer expectations (e.g. governments through the PBS), is it instead possible to **harness** consumer expectations in a manner that satisfies all parties? We offer two potential policy directions that may harness consumer expectations in such a manner.

In the case of consumer expectations for information and empowerment in healthcare decision-making processes, this is eminently possible using evidence-based, readily available means. For example, in many common healthcare situations, decision aids exist that enable health services and practitioners to empower shared decision making by consumers. As already noted, decision aids have many long-term cost saving advantages, reducing the use of surgical treatment for selected conditions.³⁶

The challenge of decision aids in this country is that they have not been supported for introduction outside of a research environment. It would be a relatively simple matter to compare health information for common (and highly variable) surgical procedures, and to work to improve this.

Consumer expectations about healthcare financing and availability must also receive critical policy attention, particularly in the current climate with the ongoing debate about GP out-of-pocket costs. Harnessing consumer expectations in the primary healthcare system is all-important; as mentioned above, this is where policy should concentrate on focusing consumers' expectations. One potential policy direction that would harness consumer expectations may be to more fully realise the role of nurse practitioners in providing front-line services for minor conditions. While currently a much-underutilised feature of Medicare, a nurse practitioner consultation could be promoted in a manner that satisfies consumer expectations for quality primary healthcare:

- *Accessible*: potentially less waiting for a nurse practitioner than a GP;
- *Affordable*: less cost than seeing the GP;
- *Appropriate*: as a means by which consumers can address minor conditions (or routine visits for more complex conditions), nurse practitioners offer a perfectly appropriate alternative;
- *Safe and effective*: due to their level of training, and supervision/direction by GPs—a safe and effective means by which consumers can receive care for minor conditions, routine follow-up for some chronic conditions, and referral where the nurse practitioner feels GP intervention is necessary.
- *Efficient*: in relation to the use of resources, particularly cost and time (for the consumer, as well as for government)
- *Acceptable*: with consumer and carer participation in the planning, delivery, monitoring and evaluation.

It should also be considered empowering, as nurse practitioners may operate as navigators for consumers.

Naturally, current policy and workforce issues may inhibit such a policy direction. In the long term, modifications to our current Medicare payment model for nurse practitioner (and GP) consultations would be necessary. In particular, consumer expectations would be that such a move costs them **less**. As such, the potential issue that a nurse practitioner is unable to deal with their presenting condition, thus necessitating a GP referral (a cost on top of their nurse practitioner appointment), must be dealt with. One way to do this is for Medicare to effectively indemnify the consumer against this—where a referral to a GP is necessary, a consumer is not charged for the nurse practitioner consultation (and effectively pays what they would now by going straight to a GP). While this incurs system cost, it is more than likely that it would be offset by system savings through better use of resources for the many occasions where a nurse practitioner consultation is an appropriate service.

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