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RACP submission to Discussion Paper on a Proposed Productivity Commission inquiry into the private health sector

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About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of 15,570 physicians and 7,000 trainee physicians, across Australia and New Zealand. The College represents a broad range of medical specialties including addiction medicine, general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, and geriatric medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to comment on Labor's Discussion Paper on a proposed Productivity Commission inquiry into the private health sector. This submission comments on current practicalities associated with financial transparency of out-of-pocket (OOP) medical expenses and the challenges associated with delivering greater transparency and informed financial disclosure in the specialist physician space. It also suggests better solutions for the following questions:

- What are the legislative and other barriers to improving transparency of out-of-pocket costs and how could these be addressed?

- Should informed financial consent arrangements be formalised? How could current arrangements be improved? Could bills for in-hospital treatment be simplified?

We understand that the Discussion Paper and the associated consultation process will inform the terms of reference and structure of the proposed Productivity Commission inquiry into the private health sector. Accordingly, this submission concludes by directly addressing the required terms of reference for the inquiry.

Financial transparency and its implications for competition and equity in healthcare

We are guided in this submission by our motto of 'hominum servire saluti' ('to serve the health of our people'). We believe that patients should be able to access the healthcare they need when they need it. At the same time, we recognise that private sector involvement is a feature of our healthcare system through funding and provision of healthcare services, both directly through direct patient OOP expenses and indirectly via patient contributions to private health insurance premiums.

Both systems must work together efficiently to minimise service gaps and improve the health of the population. This means that we are guided by the idea that there should be appropriate policies and systems in place to ensure that patient contributions do not create inequities in access to care and lead to vulnerable people being further disadvantaged and deprived of services that should be available to all Australians based on their need and not on their ability to pay.

We believe that improving the transparency of out-of-pocket costs and medical practitioner fees is an important though by no means only way to mitigate the inequities of access that may be introduced by out-of-pocket expenses. Such measures are likely inevitable given that they were the focus of consideration of the recent Ministerial Advisory Committee on OOP Costs. Measures to improve transparency constitute a 'low hanging fruit' solution to the equity problems generated by high out-of-pocket expenses, as it is intrinsically desirable that patients have better access to information on the costs they are likely to face when seeking medical treatment. Better access by patients to information on costs of alternative treatment pathways can also facilitate better shared decision making.[1]

Given the above considerations we offer the following observations on the complexities, practicalities and challenges associated with improving financial transparency of the costs associated with both in-hospital medical services and medical services provided in the community by private practitioners:

- Significant OOP medical expenses have been typically depicted as problematic in terms of a 'bill shock' where a patient who has undergone a significant medical procedure may receive a significant upfront bill after their hospitalisation. However, OOP costs can be equally detrimental to access where there are cumulative costs which add up to significant amounts of financial expense over a patient's lifetime from the receipt of non-acute and community-based care – a typical example is a patient who suffers from chronic co-morbidities and has to have frequent appointments with a variety of different providers. In these cases, there is a relationship between existing fee levels for specialist-provided services, the need to see multiple specialists and in some cases undergo repeated testing and consultation (largely due to healthcare that is not sufficiently well integrated) and possible detrimental

[1] Henrikson N, Shankaran V. Improving Price Transparency in Cancer Care. Journal of Oncology Practice 2016 12:1, 44-47

health outcomes due, for instance, to exacerbation of chronic conditions if a consultation has been missed.[2] [3]

- Appropriate financial disclosure in the context of healthcare markets specifies not only the cost of a procedure but, crucially, whether there are alternatives that offer similar benefits at less cost to the patient.[4] This can be difficult for patients to determine. Further, a patient's general practitioner or whoever else plays the role of the patient's general health care advocate may not have the knowledge, information or time to investigate and advise on alternatives. Design of an appropriate information source or disclosure mechanism may therefore require consideration of the reporting of some relevant non-fee related (e.g. outcomes-based) measures to assist patient decision making. Although it may be an unattainable ideal at least in the short to medium term, a benchmark which has recently been proposed for a financial disclosure standard in medicine is one that accounts for the costs of a full pathway of treatment and all the alternatives open to the patient.[5]

- In the case of in-hospital treatment, fees may be invoiced from multiple sources (emergency department, inpatient physician/surgeon/anaesthetist, pharmacy, allied health, consumables). Standardised arrangements that allow patients to liaise with one body (e.g. the private hospital) to manage one 'headline' fee would assist patients in navigating the post-treatment financial maze, compared to the current scenario where they may receive multiple bills from various providers in the weeks or even months after their hospitalisation.

- There are already several websites run by private operators[6] or private health insurers[7] which attempt to provide a medical fee disclosure service. However, whether rightly or wrongly, these services may be perceived as subject to a conflict of interest precisely because they are operated by private sector profit-making interests. As a result, many providers may be reluctant or even be actively opposed to having their information disclosed on such sites,[8] which then reduces their utility to consumers. There may also, rightly or wrongly be insufficient consumer trust in the accuracy of the information provided on such sites because of perceived conflict of interest. It is likely that an independently operated registry or fee disclosure website established by a government health agency may promote greater provider and consumer trust and induce greater participation and coverage.

- We understand that the Ministerial Advisory Committee on Out of Pocket costs has made recommendations to the Health Minister for a centralised fee registry website and we await with interest the full details on this proposal. There are several design issues associated with such a centralised registry that need to be addressed:

    - **If participation in the website is voluntary, will there be sufficient incentives for providers to participate?** On the one hand, being listed on a registry would mean that fee-setting behaviour would be more constrained, since the practitioner would have to commit to whatever fee schedules they made public on the website. This may be a disincentive to getting listed. On the other hand, the reputational and promotional incentive to join may exceed any disincentives insofar as listed practitioners may be more likely to be looked up and visited by patients, with those who decline listing looked on unfavourably by potential patients.

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2 Carpenter A, Islam MM, et al. Affordability of out-of-pocket health care expenses among older Australians. Health Policy. 2015 Jul;119(7):907-14. doi: 10.1016/j.healthpol.2015.03.010.

3 Callender EJ, Corscadden L, Levesque JF. Out-of-pocket healthcare expenditure and chronic disease - do Australians forgo care because of the cost. Aust J Prim Health. 2017 Apr;23(1):15-22. doi: 10.1071/PY16005.

4 Currow D, Aranda S. Financial toxicity in clinical care today: a "menu without prices'. Med J Aust 2016; 204 (11): 397. doi: 10.5694/mja16.00182

5 Currow D, Aranda S. Financial toxicity in clinical care today: a "menu without prices'. Med J Aust 2016; 204 (11): 397. doi: 10.5694/mja16.00182

6 For example, Seekmedi.com (https://www.seekmedi.com) is run by a GP.

7 For example Whitecoat which was established by NIB (https://www.whitecoat.com.au/)

8 One example of this is the following comment that was left on the Facebook site of Whitecoat:
I requested they remove my details from their site.... which they took without asking.... they refused because I am listed with APHRA, even though the address they have is incorrect. I am aware that they have taken some peoples personal addresses and refuse to remove them. I am lucky the address they have is an old office which I haven't been at for five years, but it's still inappropriate and completely unethical refuse to remove someone's details. Definitely will not use their site

- **To what extent may the 'pro-competitive' impacts of listing practitioner fees be offset by the incentive for 'below-average' fee setters to revise their fee schedules upwards once they become aware of the fees set by more expensive competitors?** It is well known from research into other industries that one of the facilitating factors behind collusive practices or industry-wide 'price fixing' is competitors' knowledge of each other's prices which is why regulators tend to be suspicious of information sharing arrangements around price[9]. However, there is some overseas evidence that the introduction of well-designed fee disclosure mechanisms in healthcare can facilitate greater competition overall.[10] [11] Hence it is possible that while there may be some effects in facilitating upward fee setting by the below-average fee setters, this is netted out by the pro-competitive effects of displayed fees and therefore facilitates the ability of patients to 'shop around'.

- **What kinds of services should have their prices reported and what additional information needs to be available in this context?** For instance, would the disclosure mechanism only cover MBS-listed services? It would be undesirable to only provide transparency for a small number of services, allowing others to effectively remain outside public scrutiny. On the other hand, it needs to be carefully considered how detailed would a fee disclosure registry need to be to ensure its effectiveness and user-friendliness to patients. A well though-out set of inclusion criteria for reported services and appropriate specifications for the optimum amount of information on these need to be developed as part of the design work for a fee registry website.[12]

- **What will be suitable accountability provisions for the website?** It is essential that such a registry have an appropriate complaint and recourse seeking mechanism to address patient and provider concerns over the accuracy of presented information. There also needs to be accountability in the form of penalties for non-compliance if the site is to have any lasting credibility as a trusted information source.

- **Is there a need for additional design features to improve inherent issues with the transparency approach to OOP fees?** For some of the reasons discussed previously, even with a well-designed fee registry website there will remain an element of 'stickiness' in patient choice due to difficulties in interpreting information and the fact that choosing one provider may imply choosing a 'package' of other providers who are part of the initial provider's referral networks. Patients may also not interpret information accurately. For instance, although the evidence for this is mixed and mostly comes from US studies, a significant percentage of consumers may associate higher fees with higher quality.[13] A range of design and education features might be needed to address these and related problems.

Proposed terms of reference

As stated in the discussion paper, the inquiry should start from the principle that every Australian must be provided with the highest quality of health care regardless of where they live and their capacity to pay. The purpose of the inquiry should therefore be to look at the broader interaction of the private and public sectors.

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[9] See for instance the concerns raised by Australian Competition and Consumer Commission legal action against Informed Sources (Australia) Pty Ltd and four petrol retailers in relation to the petrol price information exchange service operated by Informed Sources (https://www.accc.gov.au/media-release/petrol-price-information-sharing-proceedings-resolved). Ultimately in this case, the matter was resolved because the price exchange had similar aims of making the information accessible to consumers for their benefit, but it does reflect the fact that there is a balancing act involved in provision of such information insofar as it can also be exploited by competing providers.

10 Whaley C, Schneider Chafen J et al. Association between availability of health care prices and payments for these services. JAMA. 2014;312(16):1670-1676. doi:10.1001/jama.2014.13373

11 Wu S, Sylwestrzak G et al. Price Transparency for MRIs increased use of less costly providers and triggered provider competition. Health Affairs 33, NO. 8 (2014): 1391–1398 doi: 10.1377/hlthaff.2014.0168

12 Hibbard J, Greene J et al. An experiment shows that a well-designed report on costs and quality can help consumers choose high-value health care. Health Affairs 31, NO. 3 (2012): 560–568 doi: 10.1377/hlthaff.2011.1168

[13] Estimates range from 21 per cent (Phillips KA, Schleifer D, Hagelskamp C. Most Americans Do Not Believe That There Is An Association Between Health Care Prices And Quality Of Care. Health Aff (Millwood). 2016;35(4):647-53.) to 48 per cent (Finding Quality Doctors: How Americans Evaluate Provider Quality in the United States: Research Highlights - http://www.apnorc.org/projects/Pages/HTML%20Reports/finding-quality-doctors.aspx)

The inquiry should take a wide-ranging perspective starting from the principle that any private patient contributions, whether direct (through OOP expenses) or indirect (through paying PHI premiums), must not create inequities in access to care and lead to further disadvantage for vulnerable people.

Currently the questions asked in the discussion paper presuppose that the system of incentives for private health insurance should essentially remain in place, subject to tinkering. However, though one of the traditional rationales for existing PHI incentives is that this stimulates the private health sector and therefore takes capacity and cost pressures off the public system, the evidence for this is weak.[14] The coexistence of a private and public hospital system, which the RACP supports, may therefore not require that the existing system of PHI incentives and rebates continue in their current form. For instance, there may be alternatives which should be considered as part of this process, such as the introduction of a Commonwealth Hospital Benefit which would integrate current activity-based funding of public hospitals with comparable subsidisation of services in private hospitals. Under this approach, funding would 'follow the patient' across private and public hospitals. This option was raised in a 2015 discussion paper on federalism.[15]

As part of the broader reconsideration of the current private health insurance settings, the inquiry should review the comparative benefits of different private health insurance systems across the world. The Commonwealth Fund regularly reports on the comparative effectiveness of national health systems; a similar benchmarking exercise should be undertaken as part of the proposed inquiry.

- **We recommend broadening the terms of reference of the proposed Productivity Commission inquiry to include a more general question on the most efficient and equitable and way of supporting the historical private/public mix to ensure it continues to provide high quality universal healthcare for future generations.**

As noted above, there is a nexus between significant out-of-pocket expenses and healthcare that is insufficiently linked across the primary, secondary and tertiary health sectors. This nexus can arise in two ways. Firstly, both high out-of-pocket expenses and insufficiently linked healthcare contribute to poor management, particularly of patients with chronic comorbid conditions. In the case of out-of-pocket expenses this is because high levels of expenses lead to patients skimping on their care[16], leading to preventable exacerbation of their conditions. Secondly, insufficiently linked or integrated care can be a cause of high out-of-pocket costs because it leads to repeated or duplicated testing, unnecessary visits and the logistical difficulties faced by patients in coordinating their own care. Thirdly, better integrated care would itself be a solution to the problem of insufficient financial transparency on out of pocket costs insofar as it would facilitate more consolidated billing and better information on treatment pathways. Fourthly, high out of pocket costs lead to economically and socially disadvantaged patients relying on the under-resourced public system where they may face longer waiting times. This must be considered in the light of the taxpayer support for the private system which is financially inaccessible to such patients

- **We recommend that one of the terms of reference of the inquiry refer to options for better coordinated or integrated healthcare as a means of addressing out-of-pocket expenses and improving the quality and accessibility of healthcare.**

[14] Eldridge DS, Onur I, Velamuri M. 2017. The impact of private hospital insurance on the utilization of hospital care in Australia. Applied Economics, 49(1): 78-95; Cheng, Terence Chai, 2014. "Measuring the effects of reducing subsidies for private insurance on public expenditure for health care," Journal of Health Economics, Elsevier, vol. 33(C), pages 159-179.

[15] Reform of Federation Discussion Paper 2015.

[16] Callender EJ, Corscadden L, Levesque JF. Out-of-pocket healthcare expenditure and chronic disease - do Australians forgo care because of the cost. Aust J Prim Health. 2017 Apr;23(1):15-22. doi: 10.1071/PY16005