Australian
Private Hospitals
Association

Submission to the Consultation on Private Health Insurance Reforms – Second Wave Rehabilitation

Monday 8 February 2021

Australian Private Hospitals Association ABN 82 008 623 809

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Introduction

Summary

The Australian Private Hospitals Association (APHA) supports the view that consumers should have choice and access to appropriate and cost-effective care. For some consumers, in some circumstances, rehabilitation care in the home is the most appropriate and cost-effective option.

However, APHA is concerned that the Consultation Paper released by the Department of Health (the Department) presents an inadequate, and in parts inaccurate exploration, of the issue. Consequently, the proposed reform as outlined in the Consultation Paper will not meet the Australian Government's stated objectives for private health insurance.

If the Government is to provide quality and choice to consumers, while at the same time ensuring affordability and sustainability of private health insurance, then private health insurance must be carefully targeted. Hospital cover products provide benefits for specialist multi-disciplinary rehabilitation while general/ancillary products provide cover for allied health and hospital-substitute care[1].

APHA contends the reform that is needed is the provision of a default benefit for hospital managed specialist multi-disciplinary rehabilitation in the home so consumers requiring this level of care will have greater access to care options of this type.

Criteria used for many years to define the type of service appropriately funded through hospital cover private health insurance are summarised in the Guidelines for Recognition of Private Hospital-Based Rehabilitation Services (Rehabilitation Guidelines).[2] APHA maintains the Rehabilitation Guidelines remain a relevant basis for distinguishing specialist multi-disciplinary rehabilitation, including specialist multi-disciplinary rehabilitation delivered in the home, from other services which may be useful to post-surgical patients. APHA is of the view that all rehabilitation services for which hospital cover benefits are provided, and all rehabilitation services funded by private health insurers as hospital substitute services[3], should be delivered in a manner consistent with these Rehabilitation Guidelines.

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[1] Private Health Insurance Act 2007, clause 69-10 Meaning of hospital-substitute **treatment** https://www.legislation.gov.au/Details/C2020C00026 **Accessed 8 February 2021**

[2] Guidelines for Recognition of Private Hospital-Based Rehabilitation Services – August 2016 http://www.apha.org.au/resource/guidelines-for-recognition-of-private-hospital-based-rehabilitation-services-march-2015/. Accessed 31 January 2021.

[3] Private Health Insurance Act 2007, clause **69-10** Meaning of hospital-substitute treatment **https://www.legislation.gov.au/Details/C2020C00026** Accessed 8 February 2021**.**

Discussion

The Department indicated in the virtual consultation with stakeholders (Thursday 28 January 2021) it was their intention reform be focused on rehabilitation for patients undergoing orthopaedic joint replacement surgery. Consequently, for brevity, this response will be confined to the appropriateness and relevance of the proposed reform to patients undergoing hip and knee joint-replacement therapy.

The Consultation Paper proposes, "The appropriate medical practitioner, whether it be the orthopaedic surgeon, rehabilitation physician or GP, would be responsible for developing a rehabilitation plan, which if appropriate for the patient, would include out of hospital care as part of their treatment". This proposal appears to be different from current practice in which the individualised rehabilitation plan is signed off by the clinician responsible for delivering the rehabilitation care, i.e. a specialist rehabilitation physician (or equivalent), not the clinician referring a patient for specialist rehabilitation assessment. A specialist rehabilitation physician has significant training and experience in rehabilitation medicine and is able to conduct expert evaluation and management of patients with impairments and disabilities, including the development of rehabilitation plans[4].

This response will include:

- An appraisal of whether the proposal meets the Government's objectives for private health insurance, i.e. 'to promote affordability, quality, sustainability and greater choice for consumers'
- Critique of some of the statements and assumptions made in the Consultation Paper
- Responses to the specific questions asked by the Department.

[4] Rehabilitation Medicine Society of Australia and New Zealand Position Statement: The Role of the Rehabilitation Physician in the provision of Rehabilitation Medicine Services. (2017). https://rmsanz.net/wp-content/uploads/2019/12/Position-Statement-on-role-of-rehab-physician-Sept-2017-1.pdf. Accessed 5 February 2021.

The Consultation Proposal and the Australian Government's objectives for private health insurance

In responding to this consultation, APHA believes the Department's Consultation Paper has not sufficiently defined the intent of this reform proposal nor has it shown that this proposal will necessarily meet the Federal Government's objectives for private health insurance.

Affordability and sustainability

This proposal assumes greater availability and utilisation of rehabilitation-in-the-home services, as an alternative to hospital-based rehabilitation, will improve the affordability and sustainability of private health insurance.

However, the proposal provides no evidence or modelling to show this would be the case. For this objective to be achieved:

- Patients receiving hospital-based rehabilitation would need to need to receive equally effective intervention at a lower cost
- The savings achieved would need to offset increases in utilisation and cost of healthcare overall.

While this proposal might lead to some patients who currently receive specialist rehabilitation on a day-program basis receiving a home-based rehabilitation program, it is unlikely to dramatically improve the cost-effectiveness of rehabilitation care overall. On the contrary, in some instances their care might be more expensive. Without careful implementation, the expansion of home-based rehabilitation could result in adverse outcomes with consumers receiving cheaper care, but less effective outcomes and incurring more expensive care requirements down the track.

This reform proposal could also open the way for people who currently do not receive specialist rehabilitation funded through private health insurance hospital cover, making a claim for rehabilitation-in-the-home, increasing the overall benefits paid by private health insurers and forcing upwards pressure on premiums.

Although a number of studies have shown effective results from home-based interventions, these studies have not shown true comparisons with hospital-based interventions:

- The patient cohorts in these studies have not been the same as found in hospital-based programs
- The interventions have been less intensive (one factor in reducing their cost) than hospital-based programs.

Quality

The quality of private health insurance depends on its ability to support consumers to meet the costs of accessing private health care and protect consumers from sudden and unaffordable health expenses.

Quality private health insurance also needs to provide cover for an acceptable range of health services necessary for consumers to have their health needs met to the level expected by the Australian community. Current regulation already recognises that home-based rehabilitation falls within the range of services covered by private health insurance. As such the proposal does nothing to increase the services covered by private health insurance.

This proposal appears to imply that a medical clinician who is not a specialist in rehabilitation might appropriately sign off on a rehabilitation plan for services to be delivered in the home but does not address how the quality of this service would be assured.

This proposal must also be reviewed in light of emerging business practices. One major health insurer has introduced contracts which incentivise orthopaedic surgeons to refer a set percentage of patients to a rehabilitation service specified by the insurer. Another major insurer owns a substantial stake in general practice provision raising the question as to whether this might give rise to potential incentives being offered to general practitioners.

In this respect the proposal does not improve, and may risk diminishing the value of private health insurance cover. It may result in patients receiving services of a lesser quality. It may also reduce the minimum level of cover provided in hospital policies below the Gold level (where cover for rehabilitation can be restricted).

The provision of quality and appropriate rehabilitation services is crucial to avoiding future health costs, including risk of surgical revision, unnecessary emergency department presentations and chronic conditions.

Choice

The proposal might indirectly facilitate choice for consumers to the extent it formalises conversations between consumers and their treating clinician, however, this process by itself will not address the other necessary conditions for effective choice to be available to consumers including:

- Access to clear, accurate and impartial information about the services available, their appropriateness and their cost
- Availability of rehabilitation-in-the-home services
- Continued availability of insurance cover for other rehabilitation options including multi-disciplinary day programs and overnight admitted rehabilitation care
- A sustainable market for the provision of quality rehabilitation-in-the-home services including specialist multi-disciplinary rehabilitation in the home.

In light of the points outlined above, it is questionable whether the partial benefits of this reform justify the administrative burden involved and the attendant risk of unintended consequences such as an increased and unsustainable level of claims for private health insurance.

APHA's alternative approach to reform

If the intent of the reform is to promote provision of cost-effective care for privately insured patients, then it is important to first define what cost-effectiveness means, how it is measured and how it is attained at the level of the individual consumer and across the private health sector as a whole. There are three related questions that need to be addressed:

- What is the most cost-effective way to deliver rehabilitation care?
- What is the most sustainable and cost-effective way to use private health insurance support access to rehabilitation care?
- How do you ensure sustainable delivery of relevant and appropriate services?

Defining cost-effective treatment

For post-surgical patients, care in the home can range from:

- Self-managed care involving no clinical intervention other than the aftercare provided by the surgeon or a general practitioner
- Home-based treatment by a single allied health practitioner
- Home-based treatment by a multi-disciplinary rehabilitation team lead by a clinician specialised in rehabilitation medicine.

It is important to recognise the cost of delivering each of these broad types of care can be quite different depending upon the range of interventions required and the intensity and duration of treatment.

Evaluation of cost-effectiveness needs to take account of both the cost (to the consumer, government and insurer) and the outcomes achieved. Although a number of studies have shown that effective rehabilitation can be provided in the home for some patients, it has not been conclusively shown that effective rehabilitation, for patients who require speciality multi-disciplinary rehabilitation of the intensity provided in a private hospital, could be provided with the same level of intervention at a lower cost, if the service were provided in the home.

It is important to note that a significant proportion of the rehabilitation care provided by APHA member private hospitals is provided on the basis of day programs where the consumer lives at home and attends the hospital at least a couple of times a week. These programs are a highly efficient means of delivering intensive rehabilitation care.

What is the most sustainable and cost-effective way to use private health insurance to support access to rehabilitation care?

In addition to overnight in-patient specialist rehabilitation services, private health insurance can assist in meeting the post-operative needs of consumers through access to:

- Single allied health practitioners through general/ancillary private health insurance

- Day programs provided by a private hospital through private health insurance hospital cover
- Rehabilitation-in-the-home service managed by a private hospital through private health insurance hospital cover
- Hospital-substitute rehabilitation including rehabilitation in the home through a non-hospital provider covered by general/ancillary private health insurance[5].

A complete analysis of the role of private health insurance in meeting the post-operative needs of patients receiving lower limb joint replacement would consider the clinical role and economics of each of these options.

Each of these avenues through which private health insurance provides benefit to consumers needs to be aligned with actuarially robust product design and, in the Australian context, an appropriate framework of risk equalisation. APHA notes that risk equalisation is the focus of a separate research project to be commissioned by the Department this year. It is important that any proposed reform be informed by that research.

How do you ensure sustainable delivery of high quality and appropriate services?

Private sector health services evolve and grow when financial incentives align with effective models of clinical care. Unless appropriate and relevant services are available, consumers cannot access them.

There are a number of recent and fast growing entrants delivering health services in the home. The Government needs to ensure services that emerge provide high quality and appropriate levels of service.

APHA contends there are two challenges facing providers seeking to provide quality specialist multi-disciplinary rehabilitation in the home:

- Achieving critical mass without commitment across multiple insurers
- Competition from the emergence of vertically integrated business models where insurers are also health service providers who preferentially support their own services, and refuse to fund other service providers.

APHA argues if privately insured Australians are to access the range of choices they expect, and the range of choices available through the public health sector, the time is right for introduction of a default benefit for the provision of hospital-managed specialist multi-disciplinary rehabilitation-in-the-home.

[5] Private Health Insurance Act 2007, clause 69-10 Meaning of hospital-substitute **treatment** https://www.legislation.gov.au/Details/C2020C00026 **Accessed 8 February 2021**

Since 1998, Australia's public patients have been able to readily access hospital treatment in the convenience of their homes and communities, through the Australian Health Care Agreements.

By contrast, it was not until 2000 that private patients were able to access private health insurance cover for hospital treatment delivered in the convenience of their homes. At that time, default benefits were payable to accredited private hospital outreach services.

In 2007, funding was restricted to only those instances where a private health insurer agreed to pay for the service. Since then private health insurers have been persistent in their reluctance to support home-based services.

The lack of a default benefit for hospital-managed specialist rehabilitation-in-the-home services means insurers that do not specifically contract with a hospital to cover services delivered in the home, do not provide their members with any cover for that service:

- Consumers, even those with Gold level policies, find that their cover has in effect a restriction on the coverage provided for rehabilitation. They may find there is no service in their location covered by their policy, or that such services are full. They may find the services covered by their insurer are limited and inappropriate for their specific needs, as recommended by their treating clinician.
- Consumers may find that care options are available to some consumers but not others, purely on the basis of the insurer they are with. While consumers have the right to switch to another insurer, this process can be cumbersome and stressful at a time when they need to be able to focus on their recovery. Switching to another insurer can be costly both financially and in terms of features lost from the old policy.

Hospitals have invested in developing rehabilitation-in-the-home services with the support of one payer but not others, inevitably struggle to establish such programs on a sustainable basis. Without scale such programs lack long-term viability and never reach the point where they deliver measurable change in the service profile.

A default benefit does not guarantee consumers protection from out-of-pocket costs and it is not at a level sufficient to dampen the interest of providers in contracting with insurers at a competitive price.

A default benefit would not impose additional benefit outlays on private health insurers. This is because it would provide patients currently admitted for hospital-based specialist rehabilitation, on either a day or overnight basis, with the opportunity to receive some, or all, of this service at home where this was clinically appropriate.

As such, a default benefit targeted at the provision of specialist multi-disciplinary rehabilitation in the home would:

- Increase the affordability of contemporary patient-centred care options in specialist multi-disciplinary rehabilitation
- Increase the value proposition of private health insurance

- Maintain the sustainability of private health insurance by enabling the emergence of new services without forcing all private health insurers to meet the full cost of such services.

The case for reform – a critique of assumptions

The Department makes a number of statements in the Consultation Paper which APHA contends are open to question. These are discussed below.

1. **Rehabilitation following an orthopaedic procedure 'often occurs in hospital when some or all of the care could, in appropriate circumstances, occur out of hospital'.**

   In point of fact, the overwhelming majority of post-joint replacement patients rehabilitate out of hospital. Data published by the Australasian Rehabilitation Outcomes Centre (AROC) and the Australian Orthopaedic Joint Replacement Registry (AOJRR) shows that nationally about 35 percent of patients who receive private hospital knee and/or hip joint replacement surgery in the private sector plan go to in-patient, overnight admissions for rehabilitation[6,7,8]. This means that the remaining 65 percent either:

   - Go home, with no further clinical intervention other than the aftercare provided by their surgeon or general practitioner
   - Go home and access treatment in the community from a single allied health practitioner
   - Go home and attend a day program provided by a private hospital or a non-hospital provider
   - Go home and receive care in the home which may be provided by a private hospital or by a non-hospital provider.

   Furthermore, the number of inpatient rehabilitation episodes (public and private) for hip and knee replacements decreased 1.5 percent between 2017-18 and 2018-19, despite an increase in number of hip and knee replacement procedures (public and private) by 0.9 percent[9,10].

[6] Statistics have been calculated based on number of hip and knee replacement procedures in AOANJRR reports and rehabilitation episodes from AROC data. Some data has been updated since the publication of the AOANJRR report publication, however, not all data, therefore for simplicity the data used comes from the released report.
[7] Australian Orthopaedic Association National Joint Replacement Registry (AOANJRR). Analysis of State and Territory Health Data All Arthroplasty 1993/1994 – 2018/2019. Sydney; AOANJRR: 2020. https://aoanjrr.sahmri.com/documents/10180/689628/2020+Analysis+of+State+and+Territory+Health+Data+All+Arthroplasty Accessed 29 January 2021.
[8] AROC Annual Reports: The state of rehabilitation 2015-2019. Wollongong; the University of Wollongong. https://www.uow.edu.au/ahsri/aroc/dataset/reports-benchmarks/ Accessed 26 January 2021.
[9] AOANJRR Report 1993/1994 – 2018/2019.
[10] AROC Annual Reports: The state of rehabilitation 2015-2019.

Table 1: Hip and Knee Replacements (public and private)

Year (FY)	Hip and Knee Replacements procedures	Annual change (%)	Rehabilitation inpatient episodes (all Orthopaedic replacements)	Annual change (%)
2016-2017	110,078	-	30,426	-
2017-2018	113,239	2.9%	30,328	-0.3%
2018-2019	114,314	0.9%	29,859	-1.5%

Source: Procedure numbers are from: AOANJRR 2020 Annual Report Analysis of State and Territory Health Data All Arthroplasty 1993/1994 – 2018/2019.
https://aoanjrr.sahmri.com/documents/10180/689628/2020+Analysis+of+State+and+Territory+Health+Data+All+Arthroplasty.
Rehabilitation episodes are from: Anywhere Hospital AROC Impairment Specific Report on Orthopaedic Replacements (Inpatient - pathway 3), July 2018 – June 2019. Australasian Rehabilitation Outcomes Centre 2019.
https://documents.uow.edu.au/content/groups/public/@web/@chsd/@aroc/documents/doc/uow260776.pdf

How effective is overnight, inpatient specialist multi-disciplinary rehabilitation?

Published data by AROC demonstrates the effectiveness and efficiency of inpatient specialists multi-disciplinary rehabilitation for orthopaedic replacements. Although published data combines results for both public and private sectors, the private sector accounts for 86.2% of rehabilitation for orthopaedic replacements.

The effectiveness of overnight, inpatient specialist rehabilitation is measured by a FIM Efficiency Score – the amount of improvement in functional independence relative to the length of stay. Over time, the efficiency and effectiveness of overnight, inpatient specialist multi-disciplinary rehabilitation following joint replacement surgery has improved:

- The length of stay of rehabilitation inpatients for all orthopaedic replacements has decreased 13.7 percent, so that patients are staying and average of 1.8 days less in 2019 than they were in 2005.
- Functional independence scores (FIMS) on admission, whereby a lower FIM score represents less functional independence, have decreased 2.4 percent since 2005, indicating that patients are who were admitted in 2019 had poorer function than those admitted in 2005.
- The change in FIM score from admission to discharge, in 2019, was 25.8 percent better than it was in 2005, indicating improved outcomes.

- The FIM Efficiency Score has improved by 41.7 percent over the same time-period, indicating improved outcomes over a shorter time period[11].

Table 2: Rehabilitation all Orthopaedic Replacements (Public and Private)

Year (CY)	Admission FIM	LOS (days)	FIM change	FIM Efficiency (FIM change/LOS)
2005	98.4	13.1	15.1	1.2
2016	98.9	11.6	16.5	1.4
2017	98.3	11.4	17.1	1.5
2018	97.3	11.3	18	1.6
2019	96	11.3	19	1.7
Change between 2019 and 2005 (%)	-2.4%	-13.7% (1.8 days)	25.8%	41.7%

Source: AROC Annual Reports: State of Rehabilitation- Inpatient Reports, various years.
https://www.uow.edu.au/ahsri/aroc/dataset/reports-benchmarks/

In conclusion, overnight inpatient rehabilitation for post joint replacement surgery has become more efficient and more effective while treating a cohort of patients who on admission had a lower starting point in terms of functional independence than 14 years ago.

Are the patients receiving in-patient rehabilitation comparable to studies in trials of rehabilitation in the home?

Examination of the characteristics of patients in often cited studies claiming comparable outcomes through rehabilitation-in-the-home programs shows they are usually quite different cohorts from those found in overnight in-patient rehabilitation[12].

Are the rehabilitation-in-the-home programs cited in research actually comparable to hospital-based rehabilitation?

As summarised in the following table, the Rehabilitation Guidelines[13] specify requirements for hospital based specialist multi-disciplinary rehabilitation which are significantly more intensive than low-cost rehabilitation in the home-based programs.

11 AROC Annual Reports: State of Rehabilitation- Inpatient Reports, various years.
https://www.uow.edu.au/ahsri/aroc/dataset/reports-benchmarks/

12 Faux et al, Evaluating the role of rehabilitation for lower limb joint replacement, deconditioning and cancer, 2018.

13 Guidelines for Recognition of Private Hospital-Based Rehabilitation Services – August 2016. http://www.apha.org.au/resource/guidelines-for-recognition-of-private-hospital-based-rehabilitation-services-march-2015/ Accessed 31 January 2021.

This table shows how a hospital-managed specialist multi-disciplinary rehabilitation program, designed to meet the needs of a patient requiring specialist rehabilitation, would be more intense than home-based programs intended for other cohorts. A full description of a program of this type is provided at Appendix A.

Overnight in-patient rehabilitation (24 hour care)	**Hospital-based day program**	**Hospital-managed home program**	**Hybrid home program (Buhagiar, et al 2017 [14])**	**Rehabilitation in the home (Sattler et al[15])**
Multi-disciplinary team under the direction of a Consultant in Rehabilitation Medicine	Multi-disciplinary team under the direction of a Consultant in Rehabilitation Medicine			
Daily coordinated program of care. Multi-disciplinary care available 7 days per week.	More than 5 sessions per day or 3-5 sessions per half day, typically one or more times per week	Four weeks, multi-disciplinary, commencing immediately after discharge. Daily interactions	Approximately 2 weeks after surgery, 1 group-based outpatient exercise session; general aerobic components as well as general functional and muscle-specific exercises at home (un-supervised). Participants were encouraged to attend 1 to 2 classes from the third to 10th week after surgery	Early mobilisation pre-discharge from acute setting plus self-directed, low-cost, three-exercise bike pedalling–based protocol

[14] Buhagiar MA, Naylor JM, Harris IA, Xuan W, Kohler F, Wright R, Fortunato R. Effect of Inpatient Rehabilitation vs a Monitored Home-Based Program on Mobility in Patients With Total Knee Arthroplasty: The HIHO Randomized Clinical Trial. JAMA. 2017 Mar 14;317(10):1037-1046.

[15] Sattler L, Hing W, Vertullo C. Changes to rehabilitation after total knee replacement. Australian Journal of General Practice, 01 Sep 2020, 49(9):587-591

2. **The Department states "While there is debate about the precise numbers, it appears private patients in private hospitals receive significantly more rehabilitation in hospital than public patients in public hospitals."**

   It is extremely difficult to compare rehabilitation in the public and private sector due to fundamental differences between the types of procedures performed in a private hospital compared to a public hospital, the casemix of the patients, discharge events and therefore the requirements for rehabilitation.

   Furthermore, as explained in Appendix B, published data sets are both incomplete and inconsistent.

   It is important to consider the possibility of an alternative interpretation to that given in the Consultation Paper, i.e. that public patients lack sufficient access to in-patient rehabilitation.

   A proper evaluation of the availability and utilisation of serviced post-hip and knee replacement surgery would need to take account of all care pathways including those delivered in specialist rooms, in-patient and out-patient services.

Responses to the questions posed by the Department

The Consultation Paper proposes, "The appropriate medical practitioner, whether it be the orthopaedic surgeon, rehabilitation physician or GP, would be responsible for developing a rehabilitation plan, which if appropriate for the patient, would include out of hospital care as part of their treatment". This proposal appears to be different from current practice in which the individualised rehabilitation plan is signed off by the clinician responsible for delivering the rehabilitation care, i.e. a specialist rehabilitation physician (or equivalent), not the clinician referring a patient for specialist rehabilitation assessment. A specialist rehabilitation physician has significant training and experience in rehabilitation medicine and is able to conduct expert evaluation and management of patients with impairments and disabilities, including the development of rehabilitation plans[16].

For the sake of clarity throughout APHA's response to the question below, the process referred to in the Consultation Paper proposal will be referred to as the "plan" in quotation marks.

1. Which procedures and/or Medicare Benefit Schedule (MBS) item numbers should have a rehabilitation plan?

Before defining the scope of this reform, the Government must first be clear about the need for reform, its intent, desired outcomes and means by which these desired outcomes can be measured. The Department indicated in the virtual consultation with stakeholders (Thursday 28 January 2021) it was their intention that reform be focused on rehabilitation for patients undergoing orthopaedic joint replacement surgery. APHA recommends before more wide-spread application is considered, any reform proposals should first be further developed and tested with reference to a narrow range of orthopaedic joint replacement procedures.

2. How prescriptive should the plan be, regarding the type of care services to be included? What exemptions if any should be available?

The question of how prescriptive "the plan" should be cannot be resolved until the purpose of "the plan" is clarified. It is essential any prescribed " or process should not on impinge clinical autonomy in determining the appropriate care

[16] Rehabilitation Medicine Society of Australia and New Zealand Position Statement: The Role of the Rehabilitation Physician in the provision of Rehabilitation Medicine Services. (2017). https://rmsanz.net/wp-content/uploads/2019/12/Position-Statement-on-role-of-rehab-physician-Sept-2017-1.pdf. Accessed 5 February 2021.

pathway for the patient.

The Rehabilitation Guidelines describe the circumstances in which private health insurance might cover specialist rehabilitation care but these guidelines are not intended as a tool for referrers[17].

There are a range of screening tools that can be used to measure functional independence but these tools require specific training and expertise and do not replace clinical assessment[18]. The Department's consultation document uses the term "rehabilitation plan" (referred to in APHA response as the "plan") in a novel way to describe a process that could be signed off by a general practitioner or surgeon i.e. a medical practitioner who under current arrangements might refer a patient for:

- Specialist rehabilitation (which could include admission to a private hospital for services covered by private health insurance hospital cover)
- Treatment delivered by a non-hospital service provider which might be covered by a private health insurer as a hospital-substitute service under general or ancillary cover[19]
- Treatment by an allied health professional (which might include services covered by private health insurance under general or ancillary cover).

The requirements for specialist rehabilitation services provided in a private hospital and covered by private health insurance are spelt out Guidelines for Recognition of Private Hospital-Based Rehabilitation Services – August 2016[20]. These require a rehabilitation plan is written and signed off by the clinician/multi-disciplinary team responsible for delivering the care. All care and interventions are outlined in the rehabilitation plan after a comprehensive assessment by the multi-disciplinary team. The rehabilitation plan is developed in collaboration with the patient (and their carer(s) where appropriate) and forms part of the medical record maintained by the clinical/health service provider. The

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[17] Guidelines for Recognition of Private Hospital-Based Rehabilitation Services – August 2016 http://www.apha.org.au/resource/guidelines-for-recognition-of-private-hospital-based-rehabilitation-services-march-2015/ Accessed 31 January 2021.

[18] Green, J.; Eagar, K.; Owen, A.; Gordon, R.; and Quinsey, K., "Towards a measure of function for home and community care services in Australia: Part 2 - Evaluation of the screening tool and assessment instruments" (2006). Centre for Health Service Development - CHSD. 22.

[18] Green, J.; Eagar, K.; Owen, A.; Gordon, R.; and Quinsey, K., "Towards a measure of function for home and community care services in Australia: Part 2 - Evaluation of the screening tool and assessment instruments" (2006). Centre for Health Service Development - CHSD. 22.

https://ro.uow.edu.au/chsd/22[19] Private Health Insurance Act 2007, clause 69-10 Meaning of hospital-substitute **treatment** https://www.legislation.gov.au/Details/C2020C00026 **Accessed 8 February 2021**

[19] Private Health Insurance Act 2007, clause 69-10 Meaning of hospital-substitute **treatment** https://www.legislation.gov.au/Details/C2020C00026 **Accessed 8 February 2021**

[20] http://www.apha.org.au/wp-content/uploads/2016/08/Guidelines-for-Recognition-of-Private-Hospital_Based-Rehabilitation-Services-AUGUST-2016-FINAL.pdf

rehabilitation plan is personalised and specifies goals to be achieved over a specified period of time. It is a confidential document between the clinicians/health service and the patient[21].

APHA is of the view that these Rehabilitation Guidelines with, minor amendments, are equally applicable for specialist rehabilitation delivered in the home. APHA contends that all rehabilitation services covered by hospital cover benefits and all rehabilitation funded as a hospital substitute service[22] should be delivered in a manner consistent with the Rehabilitation Guidelines.

If the intention of this proposal is that a surgeon or general practitioner might lead and coordinate a multi-disciplinary team in devising and delivering a 'non-specialist' rehabilitation "plan", such a proposal would raise a whole range of specific issues that would need to be worked through. Consultation with the relevant Colleges and professional bodies and with the Medical Services Advisory Committee to determine the appropriate funding, training, skills and clinical governance implications must be undertaken. Any proposed reforms must also take account of work undertaken by the MBS Review including specifically the Report from the Specialist and Consultant Physician Consultation Clinical Committee and the Report from the Report on Primary Care[23] [24].

In considering how prescriptive the "plan" should be, the Department needs first to consider, why the "plan" is necessary in the first place:

- Is it to ensure that referring clinicians conduct a structured conversation with consumers regarding options for pre- and post-operative care?
- Is it to ensure that clinicians follow agreed clinical guidelines? If so, it would first be necessary to establish whether such clinical guidelines exist and if not, establish the case for their creation. This is a matter for consultation with the relevant craft groups.
- Is it to ensure that clinicians are aware of the care options that may be covered by the consumer's private health insurance? If this is the case, a "plan" would seem to have little relevance. Rather the solution would be for consumers and clinicians to have accurate and accessible information about:

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[21] Guidelines for Recognition of Private Hospital-Based Rehabilitation Services – August 2016 http://www.apha.org.au/resource/guidelines-for-recognition-of-private-hospital-based-rehabilitation-services-march-2015/ Accessed 31 January 2021.

[22] Private Health Insurance Act 2007, clause 69-10 Meaning of hospital-substitute **treatment** https://www.legislation.gov.au/Details/C2020C00026 **Accessed 8 February 2021**

[23] This comment should not be taken to imply any comment or critique of the Report from the Specialist and Consultant Physician Consultation Clinical Committee. https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbs-review-2018-taskforce-reports-cp/$File/SCPCCC%20Report.pdf or the work of the MBS Review in relation to General Practice and Primary care https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbs-review-2018-taskforce-reports-cp/$File/SCPCCC%20Report.pdf, accessed 8 February 2021

[24] This comment should not be taken to imply any comment or critique of the Report on Primary https://www.health.gov.au/resources/publications/report-on-primary-care , accessed 8 February 2021

- The cover provided by a consumer's policy
- The providers accessible to the consumer who provide relevant care and are eligible for private health insurance benefits (both those contracted by their insurer and those that are not)
- The consumer's rights in relation to use of their private health insurance including the right to switch to another insurer or upgrade their cover.

What is meant by exemptions? This question cannot be answered without first clarifying the intent of this reform and the purpose of the "plan".

Under current arrangements all patients receiving specialist rehabilitation care through a private hospital are treated in accordance with a personal rehabilitation plan signed off by the treating specialist rehabilitation physician (or equivalent) as the clinician responsible for leading the multi-disciplinary team delivering the care[25]. APHA would expect that a personal rehabilitation plan would be in place consistent with the Guidelines for Recognition of Private Hospital-Based Rehabilitation Services, irrespective of the setting in which specialist multi-disciplinary rehabilitation care was delivered.

3. What mechanisms should be in place to ensure compliance with developing and reviewing a rehabilitation plan?

The question regarding compliance cannot be addressed until the purpose of "the plan" has been adequately defined.

In any case, the issue of compliance must not constrain clinical autonomy. It should be noted that clinicians currently providing services that are paid for under hospital cover are already required to:

- Operate within the scope of practice for which they are credentialed at that particular facility
- Comply with MBS items and associated rules
- Comply with the by-laws of the hospital to which they are credentialed
- Comply with the Medical Board of Australia's Code of Practice
- Comply with the requirements of their respective College.

Specifically "the plan" should not prevent a surgeon or general practitioner from referring a patient to a service when it is their professional opinion that such a referral is in the best interests of the patient.

4. It is expected that the plan would be developed in consultation with the patient and potential rehabilitation providers. Which parties should the rehabilitation plan be made available to once created?

[25] Guidelines for Recognition of Private Hospital-Based Rehabilitation Services – August 2016 http://www.apha.org.au/resource/guidelines-for-recognition-of-private-hospital-based-rehabilitation-services-march-2015/ Accessed 31 January 2021.

Currently rehabilitation plans developed for the purpose of providing specialist rehabilitation care within a private hospital (including a service delivered in the home) are delivered in consultation with the consumer and members of their care team. They form part of the patient's confidential medical record. There is no reason for it to be disclosed to anyone else.

Private hospitals, when submitting claims to private health insurers, provide coded data relevant to the episode of care and a rehabilitation certificate signed by the clinician responsible for leading the multi-disciplinary care team. A copy of the standard certificate agreed by the Consultative Committee on Private Rehabilitation (CCPR) is attached at Appendix C. This certificate has no standing in regulation but is an industry agreed form developed to encourage private hospitals and insurers to adopt a common and consistent approach to the management and administration of claims processes.

5. What arrangements, if any, should be in place to assist medical practitioners to identify appropriate home or community-based rehabilitation services and oblige insurers to fund these services?

Information provision

The provision of information to surgeons and consumers should be independent of commercially vested interests. Existing independent sources should be harnessed and combined through an interface that can be integrated with practice software and systems:

- HealthDirect should list all accredited providers
- Privatehealth.gov.au should provide details of all providers contracted to provide services by each health insurer.

Insurers and the providers of practice software products should not be permitted to push or promote one service over another. Insurers should not be permitted to incentivise or reward doctors for choosing one service over another.

APHA notes that one major health insurer has introduced contracts which incentivise orthopaedic surgeons to refer a set percentage of patients to a rehabilitation service specified by the insurer. Another major insurer owns a substantial stake in general practice provision raising the question as to whether this might give rise to potential incentives being offered to general practitioners. The ownership of significant service provision arms by health insurers including providers for in-home care is also a major development that must be taken into account in the context of this proposal.

Insurers and service providers should be required to disclose any financial relationship or financial interest that could be perceived, either directly or indirectly, as a conflict of interest.

Obligations on insurers to fund these services

Insurers should be obliged to provide a default benefit to all accredited providers delivering specialist multi-disciplinary rehabilitation services delivered in the home in a manner that is consistent with the Rehabilitation Guidelines.

6. What transition arrangements and timeframe would be appropriate to implement this reform?

Further consultation is required in order to make the case and clarify the focus of reform. This needs to be done before any transition arrangements and timeframe can be considered.

7. What are appropriate metrics for measuring the impact of this proposal?

Any metrics would need to be specific to the scope and purpose of reform and adjusted for the acuity of the patient cohort.

If clinical outcomes indicators were to be mandated they would need to be specific to the purpose for which rehabilitation was provided – in the first instance post-operative rehabilitation for hip and knee replacement.

Any metrics for measuring the impact of reform should be determined with the input of relevant clinicians and agreed to by the Australian Government and industry for industry-wide implementation. It should not be permitted for insurers to require additional metrics or variations of the agreed metrics.

Although the Australasian Rehabilitation Outcomes Centre has developed a dataset for out-patient rehabilitation, APHA does not consider this dataset to be appropriate as a mandatory data-set for measuring the impact of reform in relation to the provision of rehabilitation-in-the-home.

8. What is the regulatory burden associated with this proposal?

The regulatory burden of this proposal cannot be assessed until it is further developed and focused.

For private hospitals, regulatory burdens could include:

- Costs of renegotiation of contracts
- Specific data collection/monitoring
- Provision of information and administrative support to clinicians responsible for producing the “plan”
- The unintended consequence of having to develop, and have funded, plans for the less complex patients who don’t have them/require them.

If a service, including specialist multi-disciplinary rehabilitation services delivered in the home, meet the requirements of the Rehabilitation Guidelines, this reform should not result in insurers being able impose an additional requirement for a “plan” or reject payment of benefits on the basis that a “plan” has not been completed.

APHA is of the view that all rehabilitation services funded by private health insurance, including hospital-substitute services[26], should be delivered in accordance with the Guidelines. Only thus could consumers be assured that the quality and safety of the service provided in the home is consistent with the quality and safety of service for which they would otherwise have required admission to a hospital.

9. Service providers: what services would you deliver under this proposal?

Private hospitals would be pleased to have the opportunity to provide high quality, appropriate and guaranteed funded home-based rehabilitation to suitable patients including services enabled through 'virtual health'.

[26] Private Health Insurance Act 2007, clause 69-10 Meaning of hospital-substitute **treatment** https://www.legislation.gov.au/Details/C2020C00026 **Accessed 8 February 2021**

Appendix A: Rehabilitation in the Home Proposal

This appendix outlines an example of a rehabilitation in the home program as provided in the private hospital sector.

Purpose

A multi-disciplinary team working towards achieving functional outcomes, within the most appropriate environment, that translates to increased participation in life roles and independence for the patient. The treatment provided will facilitate increased functional independence that can help improve the quality of life of the patient, with the ultimate goal of increasing their capacity to participate in self-managed programs for pursuing and maintaining meaningful goals.

An integrated multi-disciplinary team under the direction of the rehabilitation consultant will perform a comprehensive assessment and an individualised rehabilitation plan developed. In a consultative process with the patient and their family, short and long-term goals will be established, providing an alternative to inpatient rehabilitation where clinically indicated.

Multi-disciplinary teams offer specialist therapies to patients recovering from surgery, trauma and medical complications. This multi-disciplinary approach to patient care can be replicated in the home environment through a highly coordinated service focussed on goal setting, outcome measures and patient-centred care.

Reason for Referral

The home-based rehabilitation program is targeted at patients requiring rehabilitation care provided by a specialist multi-disciplinary rehabilitation team. The patients' care needs at the time of referral and home environment are conducive to home-based therapy. This model of care will:

- Be provided by a multi-disciplinary team under the clinical management of a Rehabilitation Medicine Consultant
- Target patients with a reasonable expectation of functional gain
- Focus on improving the functional status of patients in their home environment.

Admission and exclusion criteria

Patients will be admitted or excluded from the home-based program depending on factors that would influence their ability to participate in therapy and/or discharge home.

Admission criteria:

- Patient is medically stable

- Patient and, where appropriate, (in the case of cognitive decline) the family and/or carer are willing to take part in an active rehabilitation program that is not centre-based and is within the home or community environment
- The patient and where appropriate (in the case of cognitive decline) the family and/or carer have goals to be achieved by the implementation of a multi-disciplinary therapy program
- The patient is committed to participate within a rehabilitation program.

Exclusion criteria:

- Patient is not medically stable
- There are no goals to be achieved after the conclusion of the multi-disciplinary assessment
- The environmental hazard review is deemed unsafe for clinical practice
- Rehabilitation for drug or alcohol dependencies.

Referral sources

As with an inpatient rehabilitation program, patients identified as requiring home-based rehabilitation services can be referred via various pathways:

- Directly referred from the community (e.g. treating GP) without having had an acute or rehabilitation admission
- Patients referred by an acute hospital, avoiding an inpatient rehabilitation admission
- Patients transitioning from an inpatient rehabilitation program, to a home-based program with the aim of reducing inpatient length of stay and maximising functional gains in the home environment.

Treatment team

A patient receiving home-based therapy will have access to a similar cohort of specialist rehabilitation clinicians to a patient receiving inpatient treatment.

Each patient will receive input from a core group of clinicians. Core members of the treating team include:

- Consultant in rehabilitation medicine
- Physiotherapist
- Occupational therapist
- Care coordinator

As clinically indicated under the guidance of the rehabilitation consultant, patients will receive input from other members of the treating team, including, but not limited to:

- Nurse
- Social worker
- Dietitian
- Speech pathologist
- Exercise physiologist

- Psychologist

Substitution for an inpatient rehabilitation admission

This program will act as a substitution for an inpatient rehabilitation admission, with patients receiving input from members of the specialist rehabilitation team.

Consultant directed care:

- Involvement of rehabilitation consultant and/or equivalent
- Consultant-led case meetings, reviewing patients admitted in the program.

Individualised treatment program and multi-disciplinary specialist care:

- Frequency of therapy and disciplines engaged in the program dependent on patient and family needs – determined during initial assessment
- Goal focussed therapy delivered by various rehabilitation clinicians.

Coordination of care:

- Care Coordinator assigned to each patient, responsible for coordinating therapies and reporting feedback from the patient and case meetings
- Care Coordinator will make regular contact with patient and family to ensure care needs are met by treating team.

Program outline

Referral
Patient is referred to a specialist rehabilitation service having been identified with rehabilitation goals. Referrals can be received via the community, acute hospitals and rehabilitation facilities.

Patient assessment
Patient is assessed by a member of the treating team and appropriate mode of delivery of rehabilitation services is determined (inpatient, home-based or outpatient). A fund-check is undertaken to ensure the patient has the necessary health fund eligibility.

Beginning of program
Following consultation with the patient and family/carer, the patient is provided with a program, articulating frequency and timing of rehabilitation care. This will include appointments with a rehabilitation consultant.

During the program
Intervention will be provided to patients following consultation regarding the reasonable achievement of functional goals. Treatment will be provided with the aim to target various aspects of a patient's rehabilitation:

- Increase strength and endurance
- Increase ability to perform activities of daily living

- Family and/or carer training in support of the entitled member both physically and/or cognitively
- Social support
- Community reintegration as appropriate
- Assessment of the home environment and arranging home modifications/equipment as appropriate
- Liaising with relevant community services to enable patient support and as part of a discharge plan to the community
- Patient-related outcome measures will be assessed on admission and discharge from the program and during as indicated.

Patient goals and discharge date will be reviewed throughout admission in the program and formally during the case review meetings. A discharge date will be made in consultation with the patient and communicated to the team by the care coordinator.

Discharge from the program

Upon discharge from the program, the patient will be reviewed by a rehabilitation consultant and physiotherapist, whereby final outcome measures will be assessed and discharge instructions provided to the patient and family/carers. Referrals will also be made to relevant community services and ongoing outpatient rehabilitation as required to ensure the patient is supported upon discharge from the program. A summary of the patient's admission into the home-based rehabilitation program will be forwarded to the patient's GP and referring physician/surgeon as required.

Appendix B: Published Data Sets

Australian Institute of Health and Welfare (AIHW) Admitted Patient Care

There are significant issues with rehabilitation data collection in Australia. For example, some of the caveats with one of the major data sources, the AIHW, are:

- Data published by the AIHW is based on data provided by states/territories. Jurisdictions differ in the way in which they classify and count same-day separations for rehabilitation care, resulting in large variation between states as shown in the table below.
- Some jurisdiction's admission policies (Victoria and Western Australia) do not recognise same-day rehabilitation services delivered by private hospitals within the scope of data reported for admitted patient services. Consequently these services are not reported in the data[27].
- A significant quantum of rehabilitation care delivered in the public sector in some states is reported to the AIHW as 'non-admitted' care. This data is not included in the data below.

Table 3: Separations for rehabilitation care, all hospitals (public and private), states and territories, 2018–19[28]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Separations	275,308	44,153	94,542	12,110	30,352	2,003	10,121	2,000	470,589
Separations per 1,000 population	28	5.8	16.2	4.1	12.9	2.6	23.7	10.7	15.7
Proportion of all hospital separations (%)	8.5	1.5	3.5	1.1	3.8	0.9	7.3	1.0	4.1

Source: AIHW Admitted patient care, 2018-19.

The following table shows detailed breakdown on the nursing and allied health services delivered as non-admitted care by the public sector that might be broadly relate to rehabilitation. It is not possible to determine definitively how many of these interventions were delivered as rehabilitation care. Some may have been delivered as mental health, palliative care or gerontology. Nevertheless, this table indicates that the scale of rehabilitation services delivered by the public health sector extends well beyond the scope of data reported for admitted care.

[27] AIHW. PHI use in Australian hospitals, 2006-07 to 2015-16, pp 130-131.
[28] AIHW Admitted patient care, 2018-19.

Table 4: Rehabilitation related services delivered as non-admitted care by the public sector

Tier 2 outpatient clinic type	NSW	Vic	Qld	WA[a]	SA	Tas	ACT	NT	Total
40.09 Physiotherapy	342,152	234,041	354,027	140,260	80,038	79,095	35,128	8,769	1,273,510
40.12 Rehabilitation	243,944	641,568	44,718	71,825	30,720	2,761	11,549	1,462	1,048,547
40.06 Occupational therapy	132,504	103,880	129,409	75,850	19,353	11,229	13,485	6,555	492,265
40.23 Nutrition/dietetics	93,420	73,048	103,491	28,073	16,186	10,316	8,192	3,742	336,468
40.18 Speech pathology	160,847	51,843	57,889	18,426	12,024	8,500	2,856	1,098	313,483
40.11 Social work	95,091	31,391	62,090	32,351	13,320	9,531	17,737	11,281	272,792
40.21 Cardiac rehabilitation	125,528	4,682	64,133	31,028	9,618	10,930	6,944	301	253,164
40.25 Podiatry	89,097	31,199	42,907	21,155	18,920	14,036	10,314	3,112	230,740
40.44 Orthopaedics	113,722	591	37,078	30,816	2,326	15	687	2,473	187,708
40.05 Hydrotherapy	100,050	21,600	9,338	17,488	10,851	427	1,182	0	160,936
40.40 Respiratory	53,125	4,848	32,220	14,527	28,348	1,386	6,920	1,426	142,800
40.17 Audiology	42,521	32,236	37,777	9,512	6,525	5,707	3,394	3,004	140,676
40.36 Geriatric evaluation and management (GEM)	31,084	25,814	29,589	36,383	5,101	47	1,561	0	129,579
40.16 Orthoptics	40,072	25,177	26,455	8,641	6,065	2,083	459	0	108,952
40.32 Continence	24,868	50,522	7,760	17,418	3,546	305	705	348	105,472
40.60 Pulmonary rehabilitation	54,691	278	16,010	20,525	0	2,400	1,077	374	95,355
40.03 Aids and appliances	10,023	15,497	45,217	5,817	2,823	681	761	1,574	82,393
40.04 Clinical pharmacy	931	1,462	60,501	385	3,315	279	52	2,168	76,240
40.42 Circulatory	14,615	138	28,940	6,320	7,499	3,371	1,431	1,407	69,093
40.33 General counselling	25,124	0	18,786	285	2,792	18	4,982	0	59,387
40.39 Neurology	7,004	8,751	7,534	21,511	1,453	292	48	11	48,129
40.56 Falls prevention	22,034	10,722	2,627	5,168	3,697	0	956	0	46,604
40.57 Cognition and memory	24,104	14,762	1,151	1,547	410	0	17	0	45,204
40.15 Optometry	1,559	0	27,127	5,735	2,030	2,779	61	1,912	41,991

Source: AIHW Table S3.13: Non-admitted patient service events (aggregate data) for Tier 2 allied health and/or clinical nurse specialist intervention clinic categories, states and territories, 2017–18

Appendix C: Rehabilitation certificate

REHABILITATION PROGRAM CERTIFICATE HOSPITAL:	Affix patient identification label here UR no
Certificate No:	Family name:
□ Inpatient	Given names:
□ Day Patient	Address
□ Outpatient/Sessional	DOB: Sex □ M □ F

Health Fund:	Fund M'Ship No

Sections 1-3 to be submitted with first and interim claims, with first claim no later than 21 days.

Section 4 to be submitted at time of discharge or alteration to program or setting.

Section 1: PRE-ADMISSION ASSESSMENT

Pre-admission assessment performed?:Yes/No If no, why?

Patient Source:	□Community	□Acute Care Prog - This Hospital	□Acute Care Prog - Another Hospital
If another hospital ticked, please give name:			
	□Consulting Rooms	□Hostel	□Nursing Home
Patient assessed suitable for:	□Inpatient	□Day Patient	□Outpatient/ Sessional

Patient willingness and capacity to comply with program?: Yes/No

Section 2: ADMISSION DETAILS

Rehabilitation Diagnosis, Comorbidities and Complications:

Program:	**Orthopaedic:**	□Upper Limb	□LowerLimb	□Joint Replace	□Spinal Surgery	□Mixed
	Neurological:	□Parkinsons	□Peripheral	□Diffuse CNS	□Spinal	
		□Traumatic Brain Injury		□Non Traumatic Brain Injury (Stroke)		
	Other:	□Amputee	□Pain	□Reconditioning		
		□Cardiac (Phase 2)		□Major multiple trauma		

Section 3: INPATIENT AND DAY PROGRAM REHABILITATION PLAN Date:

Expected Length of Stay:	Total Inpatient Days:	Total Same Days(Ambulatory): over a total of weeks

The Plan will significantly improve the following:	□Cognitive Skills	□Strength/Fitness
	□Communication/Swallowing	□Functional Independence - ADLS
	□Gait Mobility/Balance	□Pain Management
	□Joint Mobility/Flexibility	

I the Treating Specialist certify that I have discussed the Rehabilitation Program with the Patient/Representative who agrees to actively participate in the Program.

Name:	Signature:	Date:
Phone Number:	Fax Number:	

Section 4: DISCHARGE STATUS

Actual Length of Stay (days):	Discharge Date:

Discharge Destination: □Home □Hostel □Nursing Home □Other