AUSTRALASIAN COLLEGE OF
SPORT AND EXERCISE PHYSICIANS

Private Health Insurance Reforms – Second Wave: Consultation

Australasian College of Sport and Exercise Physicians Submission (February 2021)

Introduction

The Australasian College of Sport and Exercise Physicians (ACSEP) welcomes the opportunity to make this submission to the Department of Health's "Private Health Insurance Reforms – Second Wave" Consultation.

The following comments are made through the perspective of Sport and Exercise Physicians' scope of practice. Sport and Exercise Physicians are recognised specialists managing acute and chronic musculoskeletal conditions, medical conditions associated with exercise and the use of exercise and physical activity in the primary, secondary, and tertiary prevention of many chronic diseases such as mental illness, diabetes, cancer, cardiovascular disease and dementia. In particular, the musculoskeletal conditions of osteoarthritis, chronic back pain and anterior crucial ligaments (ACL) injuries of the knee are referenced in this feedback response.

This consultation specifies rehabilitation services focusing on post-surgical management of both medical conditions and surgical conditions. We propose that this approach to rehabilitation should occur earlier on in the disease pathway, specifically after injury in the case of ACL injury and after diagnosis of osteoarthritis. Many patients pursue surgical management for non-evidenced based reasons including ease of navigation, social expectation, medical hierarchy, lack of knowledge, lack of application of biopsychosocial models of care and/or status quo. Early care-plan development by a multi-modal practitioner, such as a Sport and Exercise Physician, would minimise unnecessary surgery resulting in more cost-effective treatment and improved patient outcomes.

ACL Injuries

In Australia, the number of ACL reconstructions is increasing dramatically. Work is being done in the realm of prevention, but little attention is directed to alternative treatment pathways to surgical reconstruction. This is despite the fact that the ACL can anatomically heal, that patients can return to pivoting sports without surgery and that many patients who have surgery do not return to their previous level of activity.

Global research (predominantly from registries in countries using different models of care, in particular non activity-based payment models) has demonstrated similar outcomes beyond two years in patients treated non-operatively versus operatively after ACL injury. [1]

It is important to note that there is typically an out-of-pocket expense for surgical procedures which may seem acceptable to patients given the social regard for surgery and the one-off nature of the payment, however there are also large out-of-pocket expenses required to complete adequate rehabilitation programmes. Typically, rehabilitation for non-operative care extends for three to six

[1] A Randomized Trial of Treatment for Acute Anterior Cruciate Ligament Tears
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months, whereas rehabilitation for operative care often extends from six to twelve months. This results in an additional expense for patients and extended recovery time, which may contribute to patients not returning to their previous level of activities after injury and surgery.

Osteoarthritis

Patients experiencing ACL injury, regardless of how they are treated, are more likely to develop early osteoarthritis in the injured knee. We believe this is a group that would benefit from regular monitoring, exercise prescription and offering lifestyle advice for the secondary prevention of osteoarthritis. A similar model of care may be developed to ensure these patients are optimally managed between injury and the development of osteoarthritis symptoms to reduce the likelihood that they will incur disability and potentially the need for a total knee replacement.

We note that non-operative treatment programmes for osteoarthritis that focus on education, exercise treatment and weight loss incur high out-of-pocket expenses for patients. Hospital-based rehabilitation services are accessed for these models of care (eg NSW OACCP) as they utilise PHI funding for day admissions. These services often require half to full day admission which may be an inconvenient time commitment for patients and result in large costs, of which the patient may not be aware. These treatment avenues could be made available to patients within community settings in a more cost effective and time convenient method.

Physical rehabilitation requires behaviour change and patient self-motivation. This can be facilitated using asynchronous and synchronous blended models of care including SMS messaging, telephone, and video consultations in addition to face to face visits in the home or in community clinic settings. The creation of bundled models of care rather than activity-based payment models can facilitate this additional supportive care without creating a time burden on health care providers. This could also be utilised towards a health coach for behavioural change (particularly with respect to chronic pain and weight loss) as a valuable component of the health care provider team.

Regarding bundled payments, a regulated framework for monitoring outcomes should be considered to gather data that will better inform the provision of value-based care. This may include functional measures, patient reported outcome measures, patient satisfaction, cost and episodes and duration of care.

Development of care and rehabilitation plans

Within the current workflow stream for a patient undergoing a surgical procedure, it appears the most convenient place for the care-plan to be created as standard pro-forma linked to an existing network of providers, issued as part of the surgeon's process, managed by the practice assistant/administrator and signed off to access payment for the appropriate MBS related item number. We do not see that this significantly differs from the status quo as there are no restraints within that clinical decision-making process, for example the care plan could simply include "physiotherapy as often as required".

An improved alternative would include a practitioner specialised in multimodal care, including pain education, medication prescription, counselling, physical activity advice and goal and expectation setting around physiotherapy/exercise rehabilitation, such as Sport and Exercise Medicine Physician.

However, current funding proposal of the scheme seems to be linked to surgical fees. This presents a barrier to a clinician with more expertise being engaged in the care-plan creation, which should ideally occur before surgery so that realistic expectations can be set, and the care team can be established with the patient bale to fully consider their options.

It is also unlikely surgeons, while well placed to sign off on rehabilitation plans, will wish to engage significantly in this process. Offering pre-operative plan assessment (such as with pre-operative anaesthetic assessment) can remove the burden on the surgeon, allowing them to focus on the procedure and perioperative care. This will also create expectations about rehabilitation prior to intervention when the patient is not impacted by unfamiliar environments and pain etc. ensuring a seamless transition to rehabilitative care provision after surgery.

We propose that the care plan could have its own MBS Item number or alternatively it could be linked to rehabilitation service provision. Should surgeons be the only practitioners creating these care plans, we do not believe outcomes will be improved, transparency will be increased, or patients will be given greater choice. There is also the risk that incentives between private hospitals and the surgeons operating within them will collude to create seamless pathways of hospital delivered or hospital-controlled care, thereby obfuscating any financial benefit proposed by the reform and any personalisation for the patient.

The option to be involved in prehabilitation with the creation of the care plan at an earlier stage could be funded within existing MBS models (e.g., standard time tiered consultation as recommended by the MBS task force review (SCPCCC) or an additional and specific item number to allow the care plan to be distinct from the surgical procedure).

We believe this will facilitate a smoother transition to future models of care plan and community-based care for non-operative management of these conditions, noting that many people having surgery do not require it and many people having surgery are not satisfied with the outcomes of that choice (up to 30% of TKR). There are many reasons for these sub-optimal outcomes including inappropriate indication, inadequate rehabilitation, and confounding factors (for example comorbidities and depression).

Responses to questions regarding rehabilitation services

1. **Which procedures and/or MBS item numbers should have a rehabilitation plan?**

   1. Knee – TKR (49517/49518), UKR, ACL (49542, 49539)
   2. Hip – THR (49318).
   3. Back surgery – laminectomy, discectomy, fusion.
   4. Non-Operative rehabilitation for osteoarthritis and back pain. (noting this is currently not included in the proposal)

   We believe that rehabilitation for various medical conditions should not be triggered by a surgical event, but by diagnosis or an injury event. This would enable conditions to be managed in a way that may prevent the need for surgery. Many people undergo unnecessary surgery and indeed are unhappy with their postoperative results, these people would benefit from a coordinated and monitored management plan.

We refer to the excellent overview in *Providing physical activity interventions for people with musculoskeletal conditions* (Ellis, Garratt & Marshall, 2017) that outlines evidenced based programmes for people diagnosed with osteoarthritis and chronic back pain.[2] A stratified approach to care pathways can be developed to determine who has access to programmes outside surgical settings. We support the notion of a qualified medical practitioner overseeing any such care plans to avoid unimodal approaches. For example, some patients will require care for their mental health or weight in order to participate in exercise programmes or may be more suited to behavioural change coaching than group-run structured programmes based on exercise alone. The use of screening tools can help medical practitioners define when these additional or alternative treatments may be indicated, ensuring resources are used appropriately.

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

   The plan should include details regarding the condition, including goals, expectations around timeframe/prognosis for recovery, number of appointments required, monitoring framework, identification of psychosocial barriers to progress, identification of possible avenues to mitigate psychosocial barriers, identification of comorbidities and a plan to address those impacting prognoses. There should be capped expectations (unless recognised complications arise) around the number of appointments to allied health/other services with a focus on self-management. Note equivalent outcomes after shoulder surgery – decompression, sham surgery with a single physiotherapy visit and 15 physiotherapy visits.[3]

   There could also be a set parameter of evidence-based treatment provision as many treatment modalities continue to be offered by physiotherapists for a number of reasons, including patient expectation. For this reason, exercise physiologists hold an advantage as they do not provide these hands-on modalities but work entirely in the scope of exercise and education.[4]

   This coordinated care process can be utilised to gather important data, such as outcome measures, case adjustment variables, and there should be a focus on linking these data with the existing National Joint Replacement Registry. It is important that data is not duplicated across stakeholders, but shared.

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

   A monitoring framework similar to that developed for MBS related chronic care plans could include sign off by all relevant parties at specific time intervals and submission to all parties and the insurer. Sporadic audit by PHI can also monitor compliance.

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[2] Ellis, B., Garratt, A., & Marshall, T. (2017). *Providing physical activity interventions for people with musculoskeletal conditions.* Arthritis Research UK. https://www.versusarthritis.org/media/2177/physical-activity-msk-health-report.pdf

[3] Paavola, M., Malmivaara, A., Taimela, S., Kanto, K., Inkinen, J., Kalske, J., Sinisaari, I., Savolainen, V., Ranstam, J., Jarvinen, T. L. N. (2018). Subacromial decompression versus diagnostic arthroscopy for shoulder impingement: randomised, placebo surgery controlled clinical trial. *BMJ* 2018; 362 :k2860.

[4] Jamtvedt, G., Dahm, K.T., Holm, I., Flottorp, S. (2008). Measuring physiotherapy performance in patients with osteoarthritis of the knee: A prospective study. *BMC Health Serv Res 8, 145.* https://doi.org/10.1186/1472-6963-8-145

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 available to once created?**

   All care providers involved throughout the course of the condition including surgeon, allied health, health coaches, GP and the patient. There is potential for a case manager (eg insurer) to also be supplied with the care plan as they may be able to identify services applicable to the patient that may not be known to the care plan creator.

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

   PHI recognised health care providers for certain conditions, ideally with outcomes monitoring data; directories available through Primary Health networks and local health networks; and marketplaces of providers that are transparent with respect to cost, procedure outcomes (PROMS, return to work, use of analgesics etc.) and PREMs could exist so that patients could choose not just the care pathway their surgeon or hospital prefers, but that which is their preference based on geographical location, ease of access, patient reviews, care pathways that suit their needs (e.g. blended\virtual\face to face care,) types of service providers included (e.g. health coach, medical management of pain, exercise physiologist, exercise trainer physiotherapist etc.). These marketplaces could be provided to patients by their PHI after notification of upcoming procedures and be made available on information pages of PHI websites.

   This is a challenging area as in private community practice there is no restriction on offering services which are often directed at patients themselves. Medical practices creating rehabilitation plans are very likely to use their familiar networks at the expense of services that provide better quality and outcomes. One way to mitigate this is transparency around patient satisfaction and outcomes of individual services.

   It is also likely that surgeons will develop their own in-house teams to capitalise on rehabilitation funding (some device companies are already managing post-operative care as an incentive for surgeons) and private hospitals will try to capture this work. These service providers should also be accountable and transparent with respect to service provision outcomes and patient reviews.

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

   We believe that private hospitals' income will be negatively impacted by community-based provision of healthcare and these organisations may react to this by trying to capture this patient population as they transition out of the hospital into these rehabilitation processes.

   Hospital-based rehabilitation services are not necessarily best placed to deliver in the community, in addition many patients have existing health care providers that they would prefer to use post-operatively who can be supported to deliver patient-centred, goal-oriented rehabilitation programmes in a team environment. For example, most patients having elective orthopaedic surgery do not have an existing relationship with hospital-based providers and do not need to continue to see them following discharge from hospital.

Transition arrangements will need to consider the impact on private hospitals, which are already being impacted by the awareness that many elective orthopaedic procedures are not evidence based resulting in decreased utilisation. This will continue as models of care arise to support non-operative care of osteoarthritis and back pain. There are systemic problems with activity-based funding and delivery of high cost/low value surgical care as the path of least resistance within the current health care system. The private hospital network depends on these elective procedures for income.

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

This proposal offers the opportunity to create a compliance framework based upon outcome measurements, including patient satisfaction, patient reported outcome measures, functional measures, cost, and delivery of care episodes. The addition of case-mix adjustment variables would contribute to a benchmarking opportunity to further inform patient care and improve transparency around the outcomes of various service providers, which will help inform patient choice and also allow services to compare their performance**.**

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

The regulatory burden will naturally include whatever paperwork is required. We understand that ideally digital communications with standardised forms will be the most useful for both data collection and communication, however all PH insurers could collaborate on providing the same reporting platforms\forms so that healthcare providers are not navigating numerous and unfamiliar methods of communication. The Work Injury schemes provide standard forms across jurisdictions, for example.

Funding for completion of this paperwork and the time taken to complete case conferences will ameliorate the regulatory burden.

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

As Sport and Exercise Physicians, we currently provide non-operative management of a multimodal nature based on exercise therapy and lifestyle change to patients with osteoarthritis and back pain (among other conditions).

Sport and Exercise Physicians can provide both treatment and rehabilitation plans for patients with these conditions that consider pain management, education, management of comorbidities, identification of opportunities for lifestyle change based on patient preference and access to care. We currently utilise the assistance of allied health professionals including physiotherapists and exercise physiologists, direct patient exercise prescription and modification, advice regarding orthotic requirements e.g., braces, virtual platforms for exercise prescription and referral to additional specialist services as required. There is a focus on self-management which is an important requirement for successful home-based rehabilitation.

Sport and Exercise Physicians are also able to provide this service for patients not considering or requiring surgical intervention such as in ACL injury, back pain, and early diagnosis of osteoarthritis. We feel that these patient groups do not have access to the opportunity for a cohesive management plan that is monitored over time. This results in inappropriate treatment, over-treatment, under-treatment, and the unnecessary and ongoing burden of disability.