AOA SUBMISSION

Consultation paper: private health insurance reforms – second wave

8 February 2021

AUSTRALIAN ORTHOPAEDIC ASSOCIATION

Introduction

The Australian Orthopaedic Association welcomes the opportunity to submit a response regarding the Consultation paper: private health insurance reforms – second wave: Consultation 2: Expanding home and community based rehabilitation care.

The Australian Orthopaedic Association (AOA) is the peak professional body for orthopaedic surgeons in Australia. AOA provides high quality specialist education, training and continuing professional development. AOA is committed to ensuring the highest possible standard of orthopaedic care and is the leading authority in the provision of orthopaedic information to the community. AOA members have long provided a significant contribution to the Australian government regulatory processes that relate to hip, knee, shoulder and other arthroplasty devices.

AOA's National Joint Replacement Registry (AOANJRR) provides excellent post market surveillance on joint replacement procedures carried out across Australia to ensure ongoing safety and efficacy of the medical devices implanted. AOANJRR also collect Patient Reported Outcomes Data (PROMs) nationally therefore AOA is in a unique position to work with government in the introduction of a new models of care for arthroplasty patient rehabilitation.

Patient Focussed Care

AOA believes that patient care is paramount, and the overall goal must be to produce the best outcomes for patients undergoing arthroplasty procedures and follow up rehabilitation in the type of facility most suited to their particular circumstances.

In order to achieve this the concept of primacy in the doctor patient relationship must be recognised, accepted and enshrined in any model of care going forward.

Patient safety, patient and surgeon choice of location of surgery must be considered, with the ultimate decision resting with the surgeon as to the appropriate facility for surgery, and post-surgery rehabilitation if required. Currently between 60% and 70% of total hip and knee replacement surgery is done on a short stay basis with stays as short as 24-48 hours.

To support the implementation of the short stay arthroplasty model of care and to guide other health care professionals, the Australian Knee Society and the Arthroplasty Society of Australia are creating a consensus statement around post arthroplasty rehabilitation based on available evidence. This should be available within the next few weeks.

The requirement for postoperative length of stay and rehabilitation options are decisions which must remain in the purview of the treating orthopaedic surgeon. AOA is heartened to see this has been recognised within the consultation document which proposes that the orthopaedic surgeon has responsibility for completing the form regarding postoperative rehabilitation.

It should be recognised that early discharge often means more work for orthopaedic surgeons and their practices, taking over many of the roles traditionally covered by rehabilitation physicians: supporting patients by timely and frequent access in the early post-operative phase, attending to wound care, analgesic prescription, responding to physiotherapists and at home care attenders. This is actually quite onerous. It is reasonable that this additional work be recognised and it is the reason why many surgeons embracing short stay arthroplasty are currently seeing better remunerated contracts than are on offer at present.

AOA believes any move towards a change of model of care for arthroplasty patients must include all stakeholders and therefore AOA fundamentally opposes, on behalf of its members, “managed care” or third-party contracts outside of the direct doctor patient relationship. The doctor patient relationship is direct and most interested in patient outcome, the cost savings and benefits generally follow.

It needs to be acknowledged that a target of 100% of arthroplasty cases being treated as short stay patients with out of hospital rehabilitation will be unachievable in the short or longer term. Patient related factors to be considered regarding the length of stay or type of rehabilitation will include:

- Current health status including comorbidities;
- Social factors including support available in the home;
- Psychosocial factors including mental health comorbidities
- Rural, regional and remoteness of their home

Considerations for change

AOA has considered the proposed changes to Private Health Insurance (PHI Reforms second wave) and in the main agrees with the proposals therein.

AOA takes this opportunity however, to advance the following observations:

The current global trend in this area is that major joint replacement surgery is being increasingly undertaken as day surgery (23-hour) with patients being discharged directly to home. AOA believes it is timely to review the legislation as it pertains to day hospitals and the role of specialist day hospitals for day stay arthroplasty procedures.

Both North America and the United Kingdom, as well as parts of Europe have moved towards arthroplasty on a day surgery basis. The Australian health sector is beginning to move in this direction, but this trend is occurring in a patchwork fashion and in an uncoordinated manner.

A changed model of care must also be based on the best clinical evidence available and must be fit for purpose in the Australian setting. As always patient safety is of primary importance. As always patient safety is of primary importance and any change requires systems to implemented that ensure that this is carefully monitored. The AOANJRR is uniquely and ideally placed to the to monitor these outcomes and report back to Government.

In Australia, there are currently a number of organisations (including Private Health Insurers) developing models of care that combine short stay arthroplasty with an in-home post-operative rehabilitation programme. These programmes are being offered in vertically integrated models that have the potential to constrain patient and surgeon choice in regard to hospital and implant.

AOA believes these new developments require careful scrutiny, as already there are reports of incentives – particularly financial incentives - being offered as inducements to participation. This practice does not always result in improved patient outcomes.

Independent research is required to optimise short stay arthroplasty and optimum rehabilitation as the evidence base in this area is currently lacking. As a result, pre-operative predictive clinical guidelines as to which patient will require inpatient rehabilitation are currently often inaccurate. This will require funding. It is also worth noting that day stay arthroplasty models that have a punitive component if the clinical care pathway requires changing during the episode of care will adversely impact on the most frail and elderly patients

How to change

The provision of what was traditionally an in-hospital episode of care in an out of hospital setting (ie: hospital in the home / home-based rehabilitation arrangements) has been occurring for a number of years.

More recently this care model has been considered for a number of procedures normally considered as more major surgery, such as hip and knee joint replacements.

There have been a number of isolated trials of home rehabilitation of post-operative hip and knee joint replacement patients, but none have been undertaken utilising a coordinated whole of industry approach.

AOA believes the coordination required to make evidence-based changes to models of care or to introduce new models across the health sector should be undertaken by way of establishing a consultative partnership with the relevant stakeholders.

Consultation of this nature will provide an opportunity for a coordinated pilot project to be undertaken and evaluated to ensure there is a consistent approach to implementation of the agreed care model. It will also ensure that collaborative groups develop appropriate resources, protocols and safety nets to facilitate the arthroplasty day surgery models of care.

Patient and wider community education about choices of arthroplasty care available and different models of care must occur to enable any change to be implemented. Patients also need to be aware that new models of care may not be suitable for their particular circumstances.

As a result, dedicated patient education programs will be required as the community perception around inpatient rehabilitation being both desirable and superior to other models of care is creating barriers to potential changes to this practice.

Sustainability in healthcare

AOA members strongly believe, and are committed to, ensuring the sustainability of both the public and private elements of Australia's well regarded national system of healthcare delivery.

There are obviously significant market forces driven by potential “cost savings” for those purchasing the services. Undertaking arthroplasty as day surgery potentially reduces hospital costs associated with this type of surgery but only if patients are carefully selected and that their expectations are met or exceeded thorough the whole episode of care.

Some data have demonstrated that savings of approximately 30% in savings have been achieved by moving some arthroplasty cases (whose health and risk profile is appropriate) to day surgery hospitals.

Some further observations are:

- firstly, that current private health insurance arrangements drive patients into inpatient rehabilitation as it is fully reimbursed while less expensive outpatient rehabilitation is not, despite both having similar outcomes for many patients:
- and secondly that it should be recognised that short stay arthroplasty models place a greater burden of care on family and the local community.

In conclusion, AOA believes this initiative is very exciting and has merit. AOA believes the type of change desired requires careful stewardship through a stakeholder group to ensure a smooth transition to implementation.

The most significant perverse disincentive to changing the model of care for arthroplasty patients would be to allow an uncoordinated, piecemeal implementation of changes to the current model of care, which is clearly not to the benefit of any of the groups involved.

In conclusion

AOA is highly interested in being involved as a leader in this change process as AOA members are best placed to provide the accurate and contemporary clinical advice that will underpin the success of the trial project.

Thank you.

Michael Gillespie

AOA President