Australian Society of Orthopaedic Surgeons

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CONSULTATION PAPER – PRIVATE HEALTH INSURERS REFORMS SECOND WAVE

The Australian Society of Orthopaedic Surgeons (ASOS) has reviewed the consultation paper and makes the following comments:

CONSULTATION 2: EXPANDING HOME AND CUMMUNITY BASED REHABILITATION CARE

1. Australian orthopaedic surgeons have a long and distinguished history of treating patients who require rehabilitation and are well versed in the clinical indicators for hospital or home rehabilitation. Over time, hospital stay and rehabilitation needs have been reduced through the combined effects of improved techniques, implants and pain management. These innovations have evolved organically and have been medically led, with the beneficiaries being patients and their insurers/3rd party payers.

2. The Australian Orthopaedic Association is responsible for setting the standards of orthopaedic practice in Australia including guidance associated with rehabilitation for patients who have undertaken orthopaedic procedures.

3. ASOS has the following concerns with the proposals as outlined in the consultation paper including unreferenced and unquantified statements such as:

    I. *"Some or all of the care could, in appropriate circumstances occur out of the hospital"* – pg.14
    II. *"Providing appropriate care in cost effective settings can improve the affordability of PHI"* – pg.14
    III. *"Carefully designed rehabilitation services provided in the home or community can be significantly more cost effective than similar services provided in the hospital"* – pg.15
    IV. *"Many patients prefer treatment outside hospital and these services could have better patient outcomes"* – pg.15

4. The proposal's 'preferred approach' is to introduce a mandatory rehabilitation plan. Without this plan, no benefits will be paid.

    The details of this plan are sketchy, leaving important questions unanswered, such as:

    - Who is responsible for writing the plan? *"The appropriate medical practitioner, whether it be orthopaedic surgeon, rehabilitation physician or GP would be responsible for developing the rehabilitation plan which, if appropriate for the patient would include out of hospital care as part of their treatment."* – pg.15
    - Who is legally liable for the plan?
    - Can there be more than one plan and, if so, what happens if the plans conflict with each other?
    - If there is one plan and one benefit for the plan, how are patients rebated for the services of other medical practitioners involved in the plan.
    - Who is responsible for setting the guidelines of the plan and what input do third party payers have into these guidelines?

- What is the mechanism for changing the guidelines? Will they be subject to ministerial approval or authorization for change?
- Will the plan be placed into legislation/regulation?
- Will private medical practitioners be able to set their own fees for the development of the plan or is it envisaged that the plan will be subject to price control or compulsory contract with the patient's health fund i.e. is it intended to set up a situation where no medical practitioner can write a rehabilitation plan unless they have contracted with the health fund covering the reimbursement costs of the plan?
- Can a template plan be used by medical practitioners with some slight variation for patient circumstances?

5. ASOS also has concerns about those home rehabilitation companies owned by health funds or health fund allies who have contracted with health funds on the promise of greater business opportunities.

   This raises several questions:

   I. Will a patient be forced to use a home rehabilitation service that is under contracted or owned by their health fund or will the patient have options to choose their own rehabilitation service from a number of competing providers i.e. will there be an open market for rehabilitation providers?
   II. Can a health fund force a doctor to refer to a specific rehabilitation company/provider in which it has a proprietary interest for home rehabilitation or is the doctor able to recommend a number of options to the patient to provide this service?

6. Increased workload on medical practitioners.

   The proposal states, *"some medical practitioners may have an increased work load in determining rehabilitation arrangements as this proposal would involve the consideration of a wider range of rehabilitation options and documenting the type of rehabilitation that is appropriate for each patient."*

   ASOS is disappointed that the Department, with its resources, has not quantified what it believes the increased administration burden placed on medical practitioners. The Department may have overlooked the fact that any activity a treating doctor undertakes for a patient has potential legal ramifications due to the doctor's duty of care. This means that requirement for a mandated plan in a required format with information designed to meet the needs of third-party funders will require additional staff time, which must be paid for ultimately by the patient, unless their insurance adequately covers this cost.

   It could be expected that the outcome of this proposal would be the need to recruit specialist rehabilitation plan managers to medical practices to manage the paper flow, adding considerable cost to the patient's treatment.

   Furthermore, ASOS is concerned that its members may be unfairly blamed for health fund denial of care with health fund members being told that their treating doctor has provided 'insufficient information' to justify their rehabilitation program. Disputes of this nature simply add to the patient's unfavourable perception of the value of private health insurance. In addition, what starts out as a simple approval process, can develop into a complex system of onerous administrative requirements.

   ASOS notes that there is no commitment on behalf of the Department of Health to any funding of what will be an imposed increase in the cost of practice.

CONSULTATION 4: APPLYING GREATER RIGOUR TO CERTIFICATION OF HOSPITAL ADMISSION

1. ASOS maintains that the quality of healthcare and medical treatment is determined by the speed and effectiveness of the response to a person's adverse health events. A critical part of meeting acceptable standards of patient safety and treatment is the ability of a medical practitioner to admit patients after appropriate clinical diagnoses, to hospitals for treatment as determined by accepted clinical indicators.

2. Hospital admission arrangements for certain procedures have been facilitated by the categorization of hospital admissions into type A [hospital admission overnight stay/higher accommodation benefits], B [hospital admission (no overnight stay)/lower accommodation benefits (in reality, no accommodation benefits)], and C [no hospital admission hence no accommodation benefits].

3. In its consultation paper, the Department of Health seeks to alter these arrangements claiming "*the Department has been made aware of issues relating to the inappropriate certification of type B and type C procedures by a small number of providers".*

4. It is of concern to ASOS that the Department is recommending interventions that it is not prepared to quantify or identify and hence interventions are based on unsubstantiated claims by unknown parties that a problem exists but the extent of the problem is admitted to be small.

5. Based on the failure to outline the case for change, ASOS cannot support the recommendations in the proposal until such times as the Department is prepared to offer clear evidence as to why the problem cannot be resolved in its current "small" state.

6. By failing to offer any substantial evidence, the Department runs the risk of being seen to support restricting hospital admission simply to meet the demands of third-party payers who are committed to reducing costs of hospital treatment.

7. The proposal could also be seen to be passing the blame for refusal of treatment onto doctors and away from third party funders.

8. ASOS does not have confidence in the ability of a new bureaucracy/tribunal/industry panel to manage disputes and will remain sceptical of the proposal until such times as the Department releases relevant data and details of what the composition of such a body would entail.

CONCLUSION

The proposal, 'Expanding Home and Community-based Rehabilitation Care' (Consultation 2) and 'Applying Greater Rigour to Certification for Hospital Admission' (Consultation 4) demonstrates the Federal Department of Health's intention to directly intervene in the delivery of healthcare services for all Australians in the area of rehabilitation and hospital admission.

ASOS recommends that the Department provide detailed information to back the assertions in the proposals if it wishes to gain the support of the wider medical profession and convince sceptical doctors that it is working in the interests of all Australians and the universality of Australian healthcare.

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