07/02/2021

Hon Greg Hunt MP

Minister for health

Commonwealth of Australia

Re: PHI Reform Comments feedback

Dear Minister,

I am writing to comment on the PHI reform being undertaken at present.

I am a Rehabilitation Medicine Consultant Physician in QLD.

Care provided in private hospitals is an important part of the health delivery for Australians, it fulfils the following:

1) Decrease public hospital burden.
2) Improve efficiency for elective procedures.
3) Allow selection of preferred hospital and practitioner for the care of the privately insured.
4) Allows for training of future specialists through STP funding.

If we do not have a strong private Health service, the likelihood is that our public hospitals will become overwhelmed by higher demand for beds both for elective and non-elective patient admissions. It is already evident that public services are still struggling to provide patients with elective procedures by using the Surgery Connect services or equivalent.

Private health insurance policies have been increasing over the years which makes them less affordable to ordinary Australians. The main causes for it are in my opinion:

1) Increased costs of health provision in general due to economic issues at a national level including indexation and costs of materials, importation of most equipment and medicines and maintenance costs which are all increasing over time, as well as salaries for health personnel attached to the private health system.
2) The increased usage of private health funding by public hospitals, billing private health funds for the services provided publicly to privately insured patients.
3) The fact that health funds have become for profit organizations which require to provide dividends to shareholders.
4) Economic uncertainty which is multifactorial.
5) Our Ageing population requiring more hospital services.

In my personal view the current situation is unsustainable in the long term. The public health system has become a competitor to private hospitals to attract privately insured patients causing a higher demand on the health funds in turn needing to fund more admissions which in the end increases the premiums. Public hospitals may game the system towards privately insured patients to attract more funding causing a false economy, for example by using Surgery Connect to offload public lists in private hospitals to decrease the burden of waiting lists in the public system.

The only way to deal with this situation is to streamline the system to their respective services and make the public patients lists more available to public patients and encourage the privately insured patients to seek the service of private services in private settings. The only reason to charge a private health fund for a public admission is if that service cannot be provided privately.

Regarding Rehabilitation, some health funds are advertising rehabilitation in the home, however this is just physiotherapy in the home which is not rehabilitation. Rehabilitation has a multidisciplinary approach whereby there is intervention of a team of health professionals aiming to achieve the best outcome for the patient's problems in the most efficient, holistic and safe way possible. It includes the planning of the admission and discharge from hospital as well as future care in the environment which offers the best outcomes for the specific issues of the patients.

Rehabilitation can be provided in many environments, Rehabilitation Medicine Physicians are specifically trained to determine based on the patients' medical/surgical and psychosocial factors which is the best setting for that person to undertake their rehabilitation, and which allied health or nursing interventions will be required to maximize their care and make it more cost-effective and efficient for that patient.

Due to the diversity of Australia each state and territory have their own idiosyncrasies and even within each state or territory in Australia there are diverse factors which may influence how the care will be provided and why, for example distances may make the provision of some home services impossible. It is the role of the Rehabilitation Physician to ensure the best care is provided in the best environment due to the complexities of peoples care.

There may be a perception that privately insured patients spend more time in inpatient rehabilitation, the likelihood is that they have earlier access to these services as they are more efficient than public hospitals. Public Rehabilitation services have historically been overwhelmed with long waiting lists, patients waiting for inpatient rehabilitation beds having therapy in non-specialized settings may be beyond the inpatient stage and other type of services may be needed. Public services have dedicated home based services and most private services do not have that advantage due to how the systems have been set up and due to the lack of remuneration of those services.

There is also a sense of entitlement from some privately insured patients, as they have been paying their premiums every year for many years, they feel they have the right to decide where they are to have their rehabilitation opting for an inpatient stay. Also, when they communicate with their health fund, they are told they are entitled to it.

The decision to keep a patient in hospital is not taken lightly by most doctors. There are medical and psychosocial factors that need to be considered before sending someone home following a major surgical procedure or a life threating injury or medical illness. It cannot be all scripted and put in a common protocol as every patient has a different idiosyncrasy and the idea is to provide the best care possible to obtain the best outcome possible for them. There are factors that the lay person may not understand and the decision if the patient stays in hospital or goes home and undertakes outpatient services must rest on the doctor with the most knowledge and understanding of the patient's rehabilitation and medical problems.

Rehabilitation at home has a specific role for some people, however it is not always the most cost-effective way to provide rehabilitation due to factors including sparsity of population, accessibility and transport for personnel and set up times, lack of specific equipment, costs of liability insurances etc. As an example, if a patient requires more than one type of allied health and/or nursing therapy, the therapists have to travel to that person's home in a company car or their own, transit time has to be added to their journey, then arrival and set up, treatment and documentation and then finalize and repeat with another patient, therapy time may be sacrificed due to time slot allocation per patient, and trying to reach more patients and having time wasters like parking and setting up. In a centre based program the therapists are in one place, already set up, with adequate equipment and training, and all is provided to maximize the therapy and by default the outcomes of the patients, with minimal time wasted. Also, it allows the patients access to the community and limits their isolation at home.

Rehabilitation in the home is a good tool for people who rarely leave their environment or if they have a disability that precludes access to the community or for the very old who generally do not leave their home or cannot, also if there are specific goals to be achieved in the home. A Rehabilitation Medicine Physician is the best placed specialist to determine in conjunction with allied health and nursing as well as the patient where and what type of therapy is the best for their specific issues. The importance of the logistic factors is paramount in the funding of services which may on paper look good but at the time of execution fail to deliver the expected results due to time, access issues and equipment constrains. Rehabilitation in the home may be more effective in densely populated areas but in more regional areas due to the distance between people it may not be the best means to reach larger numbers of patients.

Centre based rehabilitation can be provided as inpatient, day therapy or specific outpatient therapy by allied health. It may be more efficient to bring the patients to the facilities with transport either privately or publicly funded to achieve the ideal amount of therapy and not be shortchanged by time constrains. Group and individual therapy can be provided at the same time and more than one patient can be seen decreasing the costs of personnel and maximizing the amount of therapy to be provided to the clients.

The motivation to participate in therapy is also another issue. In my personal experience with centre based day programs patients develop a bond with therapists and other patients creating a healthy competitive and motivational environment which benefits them to continue their progression to normality. This also applies to inpatient services.

In relation to aftercare, Orthopaedic Surgeons are best placed to provide post-surgical after care but not rehabilitation as they are not trained for it. They do not have enough knowledge of general medicine and pain management to provide that type of care to patients. General practitioners do not have the training either and they have the least amount of time to deal with a rehabilitation plan and ongoing review due to time constrains relating to their own jobs, most of them are extremely busy with their practices and usual patients to put the burden on them, which may increase the risk of adverse events.

There are surgical, medical, and psychosocial issues which impact the health and wellbeing of patients needing rehabilitation and Rehabilitation Medicine Physicians are specifically trained to approach and treat or triage these issues, minimizing adverse outcomes. In a figure of speech, you have to "use the right tool for the job" you are undertaking to get the best result.

Rehabilitation Medicine Physicians can effectively manage and interact with allied health practitioners in a common language to maximize communication and goal setting to achieve the best outcomes for their patients.

Relating the costs of private health practitioners in rehabilitation, most practitioners prefer a no gaps approach to avoid patients being out of pocket.

The decisions and responsibilities over a patient rest with the admitting doctor and not with the funding body, hence it is the doctor who must be able to canalize the best care and decisions relating how someone should be medically treated. They have the set of parameters to make that decision and the understanding of the complexity of factors which may affect a particular person following specific health problems, these factors are not linear, and some may not be related to the reason for admission but developed or became known after or during that admission.

The rehabilitation services provision needs to be flexible, as the ever-changing needs of patients need to be evaluated frequently and there may be moments where home therapy may be better, or centre based therapy may be better or both, and they must be interchangeable.

One of the issues with home-based rehabilitation for privately insured patients is the ability to follow them up from a medical viewpoint whilst they are receiving therapy and the responsibility for their care at home, which in most cases is at specialist level. At present there is no private health funding for these services.

The planning of how private services work must be reviewed by private practitioners who understand the intricacies for the provision of these services and their funding in consultation with the funding bodies and private hospitals.

The introduction of specific items for rehabilitation services is a good idea but it will need to be done in consultation with private practitioners and the RMSANZ and AFRM to help determine the best way to design those items, based on the specialty requirements. Rehabilitation Medicine is a multifaceted specialty with broad margins that interlink with other specialties and care should be taken to ensure the items represent the right remuneration for service provided.

Regarding rehabilitation plans:

1) They are paramount to address the complex needs of most patients in rehabilitation.
2) They are designed to maximize therapy and cost effectiveness.
3) They can be used to plot the trajectory of the patient through the service with regular checks and frequent patient evaluation and case conferencing with the rehabilitation team, to assist in clinical decisions.
4) They must be flexible.

The rehabilitation plan should encompass the needs and issues of the patients as well as the solutions to those through a plan of action encompassing the medical, physical, and psychosocial needs and aspects of the patients treated. This is for all modalities of service provision.

With the advent of more teleconferencing item numbers, it is possible to enhance the service provision relating to medical care for specific patients that fulfill a specific criterion (safety, medical, psychosocial and demographic) and who can benefit from home-based rehabilitation but the funding for this service needs to be adequate to reflect the effort required and the risk of providing that type of service privately. One caveat is our ageing population and their ability to interact with new technology.

We must not forget the focus of any healthcare are the patients we look after. In the case of privately funded services, patients pay for a service which they expect to receive, in this case they have a voice on what they believe as the best care for themselves following options provided by practitioners with their best interest at hand.

In Conclusion:

1) Premiums of private health funds are increasing due to the higher utilization of those services by public hospitals and due to our ageing population requiring more hospital admissions.
2) The availability of rehabilitation settings may differ depending on demographics which may make impractical more home-based services.
3) We must not confuse Rehabilitation services with single allied health therapy.
4) Rehabilitation plans are an excellent tool to systematically establish a treatment plan and the monitoring of that treatment and its outcomes regularly.
5) Psychosocial factors are often neglected after major surgery and medical illnesses and these patients may require in hospital treatment to overcome those issues.
6) The medical/rehabilitation issues allowed to be treated through private health funds may need to be reviewed and expanded to include potentially more preventative measures for specific populations like the elderly to enhance their health and minimize future health care needs.

Finally, the health system as a whole should be looked at in an organic way, as issues in any parts of it will have repercussions in others if the whole is not taken into account. Both the private and public systems are intertwined and the issues that affect one will affect the other. Health remains the costliest expense to the Australian taxpayers and the importance of efficiency must be highlighted at all levels as it will ultimately translate into cost-effectiveness and service delivery improvement, however not always the lowest cost approach is the cheapest in the long term, and a careful approach to cost savings should

be taken to avoid future health care deficiencies or inadequacies which will impact on the health of the Australian public. More open communication between Private Health funds, Private Hospitals and medical practitioners may improve the service delivery and costs in the private setting.

Please contact me should any of the above need clarification. I am at your disposal should you require further discussion.

Yours Faithfully

Dr David Eckerman
MBBS FAFRM (RACP)