Members Health
FUND ALLIANCE

11 February 2021

Private Health Insurance Branch
Department of Health
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Re: Supplementary Submission: Consultation on Private Health Insurance Reforms Second Wave

Further to our submission to the Department of Health *Consultation on Private Health Insurance Reforms Second Wave*, Members Health submits the following supplementary concerns raised by two health insurance funds. These two funds were unable to meet the tight time lines set by the Department of Health on *Consultation Two: Expanding Home and Community Based Rehabilitation Care*, and we make this submission on their behalf.

In recent years there has been strong growth in the provision and utilisation of home/community based rehabilitation services largely driven by health funds' strategic investment and support for these services. Health funds have been actively promoting the additional availability of these services. This growth should be evident in the Hospital Substitute Treatment, part 2 and 4 sections of APRA reporting for all funds.

There is a concern, however, that given the recent increase in demand for home-based rehabilitation, hospitals are seeking ways (through red tape and existing doctor/hospital relationships) to control the provision of these services, shutting out already well-established home-based rehabilitation providers.

Therefore, overarching the concern is the desire for existing arrangements between health funds and out-of-hospital and community-based rehabilitation providers not to be inadvertently impacted or disadvantaged by the proposed reforms.

1. **Hospitals may gain influence with the proposed changes.**

   Hospitals already have close relationships with doctors, particularly where rehabilitation is involved.

   Although we believe the intent of the reform proposal is to facilitate greater access and choice for patient's to independent care options, there are concerns that it will in fact give the hospitals greater influence and control of the care pathway and funding.

   This could be an unintended consequence of requiring doctors to apply greater formality to their rehabilitation plans.

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2. Accreditation and benchmarking may mount unwarranted red tape on established home-care providers.

The existing accreditation process for home-care service providers is varied, and health funds have worked hard to establish trusted relationships with existing independent rehabilitation providers.

Health funds also conduct their own due diligence to ensure service providers meet and exceed the required clinical and legislated standards (e.g. ACHS).

Private Health Insurers support independent rehabilitation providers who achieve the same accreditation standards as hospitals (e.g. ACHS equip 6), which includes established clinical indicator programs.

Additional reporting for out-of-hospital and community-based rehabilitation service providers should also remain cognisant of the service type and scale of practice, rather than be applied homogenously through a single oversight body across all providers for out-of-hospital care.

For the already established home-care service providers, any additional reporting and benchmarking requirements may pose an unnecessary – and in some cases, unattainable – cost, thereby favouring hospitals and increasing health fund costs. For example, reporting where it is subject to clinical coding.

3. Health fund contracting with independent rehabilitation providers is key.

We acknowledge that there is no mention of forcing health funds to contract directly with hospital providers for out-of-hospital and community-based rehabilitation in the reform proposal.

However, given the concerns above relating to doctor-hospital relationships and red tape, it should be reiterated that health funds retain the ability to contract directly with out-of-hospital and community-based rehabilitation service providers rather than having preferred provider obligations embedded into existing hospital arrangements, e.g. default benefits.

In summary, two health insurance funds have expressed concern that this reform will not result in an increase in options for out-of-hospital rehabilitation, will not increase patient choice and will not result in cost savings. Instead, it may in fact have the opposite effect, giving hospitals added influence in out-of-hospital care and adding unnecessary red tape for well-established providers.

Rehabilitation plans agreed between the treating doctor and the care provider already form the basis and criteria for out of hospital rehabilitation care. The current proposal may increase regulatory costs to both private health insurers and to Medicare.

Given the rushed consultation process, which took place over the Christmas holiday period and during a global pandemic, Members Health encourages the Department of Health to consult further with all relevant stakeholders before coming to a final position on these reforms, so that all relevant perspectives and views are given fair consideration and unintended consequences are avoided.

Sincerely

MATTHEW KOCE
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