RMSANZ
Rehabilitation Medicine Society of Australia and New Zealand

8 February 2021

PHI Consultation Mailbox
phiconsultation@health.gov.au

Dear Sir or Madam,

Re: Consultation paper: private health insurance reforms – second wave December 2020

Thank you for the opportunity to respond to the consultation paper which we read with interest. We will restrict our responses to issues affecting people living with disabilities and rehabilitation. A line from lees letter and ref to our webpage

Members of the RMSANZ have promoted ambulatory rehabilitation (or out of hospital rehabilitation), for over a decade and conducted numerous research trials to support and explore models of ambulatory rehabilitation. In an era where medical advice is more keenly attended to by government, we are grateful to be given the opportunity and enthusiastic to contribute to the consultation paper.

The Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ) represents the profession of consultant physicians who practice in the discipline rehabilitation medicine (Consultant Physicians in Rehabilitation Medicine[1]). Our members are also members of the Australasian Faculty of Rehabilitation Medicine (AFRM) of the Royal Australasian College of Physicians (RACP), our academic partners who also conduct the Government approved training program for consultant physicians in rehabilitation medicine, at the RACP[2].

Consultant Physicians in Rehabilitation Medicine coordinate teams of therapists, doctors and nurses, work across all care settings including ambulatory and since 2002 have been collecting data on patient outcomes and costs at the Australasian Rehabilitation Outcomes Centre (AROC - Wollongong University)[3] of which the Australian Department of Health, the Department of Veterans Affairs and the state governments of NSW and Victoria were founding members. (See Appendix for further details).

The RMSANZ represents the practice of rehabilitation medicine on a state, national and international level. Our members have participated in the Private Health Ministerial Advisory Committee rehabilitation subgroup meetings in 2018[4], the NSW COVID Clinical Council and the MBS Review Taskforce. We will also be hosting the world congress in

Rehabilitation Medicine of the International Society of Physical and Rehabilitation Medicine (ISPRM) In Sydney in 2024.

Our qualifications are recognised by the National Specialist Qualification Advisory Committee and we receive AHPRA medical registration as consultant physicians in rehabilitation medicine. Our 4 years post graduate training program prepares consultant physicians in rehabilitation medicine for practice in rehabilitation across all settings in hospital, ambulatory (hospital substitution), in reach and community settings.

The centrepiece of our training program is the development of the rehabilitation plan. Qualification is based on summative and formative assessment of the physician's capacity to write and execute rehabilitation plans and to lead multidisciplinary rehabilitation teams to deliver value based care.

No other specialist physician or surgeon is trained in or practices exclusively in rehabilitation.

Our members principally treat people with temporary or permanent disability following surgery illness or injury. We care for people of all ages who suffer disability from trauma, arthritis and stroke to amputees, or those with spinal cord injury and brain injury. As we are responsible for the patient both clinically and legally while they receive rehabilitation services under our direction, we prioritise patient safety and clinical outcomes. Our extensive peer review networks, regulatory commitments to continuing professional education and our involvement in training and mentoring mean that we are often called upon to advocate for patients. The central position of safety and efficiently achieving patient outcomes remains at the core of our clinical practice and is thereby insulated from the imperatives of shareholder's interests.

Since 2016 the federal government has mandated via regulation that rehabilitation plans be completed by rehabilitation physicians for rehabilitation in private hospitals, in accordance with recommendations made by The Consultative Committee on Private Rehabilitation. This national industry committee comprising representatives of the Australasian Faculty of Rehabilitation Medicine, Private Healthcare Australia, the Australian Private Hospitals Association, the Department of Veterans' Affairs and the Private Health Insurance Ombudsman outlined guidelines for the recognition of Hospital-Based Rehabilitation Services and are used by the majority of private health insurers to fund in-hospital rehabilitation[5].

The guidelines indicated in two of its four criteria for recognition of private rehabilitation services as follows "Rehabilitation care provided by a multidisciplinary team which is under

the clinical management of a Consultant Physician in Rehabilitation medicine or equivalent." And "Rehabilitation care provided by a specialist rehabilitation team on an admitted or non-admitted basis in a specialist rehabilitation unit (a separate physical space)".

These criteria support the option of developing out of hospital rehabilitation programs and also emphasise the leadership role of the rehabilitation physician. In our experience neither general practitioners nor orthopaedic surgeons have equivalent levels of training or experience in rehabilitation medicine to take a leadership role in the delivery of rehabilitation services or the writing of rehabilitation plans.

Consultants in rehabilitation medicine possess the clinical authority to make decisions regarding the rehabilitation of people recovering from illness or injury.

As a discipline Consultant Physicians in Rehabilitation Medicine have actively led guideline development, debate and research into "out of hospital" service delivery in rehabilitation. Research Institutes in all states of Australia have undertaken world class innovation and scientific trials into ambulatory care. In NSW the Centre for Rehabilitation Innovations has developed an algorithm powered by artificial intelligence that identifies patients who are more likely to benefit from "out of hospital" rehabilitation while in South Australia Prof Maria Crotty has led Australia's largest trial in telerehabilitation for home based stroke rehabilitation. In other states innovations in home based care and rehab in the home have been pursued for more than a decade and currently, there are ongoing studies led by our members being funded by the private health insurers.

RMSANZ has developed a working group with one of the PHI to develop ambulatory models of care and has developed a guideline document in patient selection for inpatient rehabilitation following knee replacement[6]. The AFRM (RACP) has developed a position statement in strong support of rehabilitation in the home[7] and the Rehabilitation network in NSW has developed a document on standards in rehabilitation models of care including rehabilitation in the home[8]. Members of the RMSANZ are considered both nationally and internationally as experts in the research and development of rehabilitation in the home models of care, telerehabilitation and ambulatory rehabilitation.

We have skills and capacity to work with the Private Health Insurers and the government to identify opportunities in the patient journey that can be used to prepare rehabilitation plans and to revise them, as our members work with consumers and acute physicians and surgeons during all stages of in hospital and out of hospital multidisciplinary rehabilitation.

Finally, with respect to a number of details in the report we have noted our responses separately in an appendix to this submission so that we do not distract from our support of

the government in developing ambulatory models of care funded by private health insurers. Further, due to our members close collaboration with acute care physicians and surgeons and our deep understanding of the experiences of people receiving rehabilitation from the coal face to the board level, we offer our contributions to the further development of health insurance reforms as they relate to out of hospital models of care in rehabilitation.

We seek an urgent meeting with the Minister of Health in order to expand on the issues raised in this submission and familiarise him with the ongoing work in rehabilitation taking place for Australians living with a disability.

Thank you for taking the time to read this submission and we look forward to further contact with the project leaders.

Yours Sincerely

Dr Michael Chou (President of the RMSANZ)

Appendix 1

1. RMSANZ support access to affordable and sustainable private health insurance products for young people with disability and support their maintenance on the family private health insurance policy. We do ask one question that relates to a time when people living with disability may wish to become independent from their families or may wish to start a family of their own. In the event that the person living with a disability wants to have a personal private health insurance cover or start one with a family of their own would there be any issues with covering preexisting illnesses or any waiting periods to receive cover? In our opinions that would not be desirable and needs to be addressed by regulators
2. The RMSANZ support the use of the NDIS definition of disability and people living with disabilities.
3. It was indicated that there are no MBS item numbers that are specific to rehabilitation physicians. We believe that item 880[9] refers only to consultant physicians in rehabilitation medicine or geriatricians and is not available to orthopedic surgeons, general practitioners or other medical practitioners. It should be noted in the Private Health insurance (Complying Product) rules 2015 there is no mention of any Medicare items numbers attached to rehabilitation medicine and this may require review by legislators and regulators.
4. RMSANZ has noted that for a hospital substitution service such as ambulatory rehabilitation or out of hospital rehabilitation to be recognized by the private health funds they may need to be reconciled with the hospital service being substituted (in this case inpatient rehabilitation). However, if the patient is at home or in the community they will not be registered as an inpatient of the hospital from which they came and as such will offer up complex administrative adjustments for both payers and hospitals. It is noted that the design of the insurance product will need to be undertaken on a fund by fund basis. Further the administration of such programs may incur costs for funders providers and government. The RMSANZ is concerned that the design process not be undertaken without representation from the RMSANZ to ensure that patient safety and achievable high quality outcomes remains a paramount priority of the insurers.
5. We were buoyed by the reference to evidence based care and the development of guidelines. The RMSANZ is committed to evidence based care and are in the process of writing best practice guidelines in ambulatory care. We also note a reference to the easy adaptation of other guidelines. In our opinion the adaptation of other guidelines and indeed all guideline needs to be developed in Australia using NHMRC guideline development principles[10] which involves a consortium of academics in rehabilitation medicine,. Many of our members have extensive experience in guideline development including guideline in acute pain management and the management of traumatic brain injuries. Guidelines prepared outside such principles may not adhere to evidence based practice and may be vulnerable to misuse. The regulator needs to play a role to ensure that guideline development follows evidence based medicine and formal scientific guideline development protocols.

6. In terms of the questions asked at the end of the section in rehabilitation, we would be happy to canvass our members and distill their responses, into a more formal report. However the timing of the consultation prevented us from being able to hold formal meetings and workshops with our members until late January.
7. Consultant Physicians in Rehabilitation Medicine lead and coordinate multidisciplinary teams of doctors, nurses and therapists to deliver treatments to people living with disabilities (both permanent and temporary). These involve drug treatments, surgical procedures, exercise based therapy, the introduction of electronic assistive devices, home modifications, voice and communication training, psychological interventions, training in return to work skills and the introduction of government and private services funded through aged care and the national Disability Insurance Scheme

Consultant Physicians in Rehabilitation Medicine and their teams work across all care settings, including:

i) In-reach consultation and early rehabilitation in the acute hospital setting (eg acute management of people with orthopaedic conditions related to trauma, Spinal Cord Injury and Traumatic Brain Injury)
ii) Inpatient Rehabilitation Units in public and private subacute and acute hospitals.
iii) Day Only Rehabilitation Units, which often integrate with inpatient units so that hospital length of stay is minimised, people with disabilities are able to live in their homes and services are efficiently delivered.
iv) Outpatient services and interventions both hospital based and community based from Community Health centres in order to support General practitioners to manage their patients in the community
v) In-home rehabilitation provided for free from some public hospitals or by the payment of “out of pocket” expenses by people living with a disability as currently there is insufficient funding for these services available from the Private Health insurers

[1] https://www.racp.edu.au/docs/default-source/advocacy-library/role-of-the-rehabilitation-physician.pdf
[2] https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-rehabilitation-medicine
[3] https://www.uow.edu.au/ahsri/aroc/
[4] https://webarchive.nla.gov.au/awa/20190208165705/http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac-rehabilitation-sub-group-meeting-1
[5] http://www.apha.org.au/wp-content/uploads/2016/08/Guidelines-for-Recognition-of-Private-Hospital_Based-Rehabilitation-Services-AUGUST-2016-FINAL.pdf

https://aci.health.nsw.gov.au/resources/rehabilitation/rehabilitation-model-of-care/rehabilitation-moc and https://aci.health.nsw.gov.au/resources/rehabilitation/rehabilitation-model-of-care/rehabilitation-moc/principles
[6] https://rmsanz.net/wp-content/uploads/2019/12/180503-FINAL-Positon-Statement-on-Rehabilitation-following-TKR-1.pdf
[7] https://www.racp.edu.au/docs/default-source/advocacy-library/rehabilitation-medicine-physicians-delivering-integrated-care-in-the-community.pdf?sfvrsn=8fb8091a_8
[8]
[9] http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=880 "Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of geriatric or rehabilitation medicine, as a member of a case conference team, to coordinate a case conference of at least 10 minutes but less than 30 minutes-for any particular patient, one attendance only in a 7 day period (other than attendance on the same day as an attendance for which item 832, 834, 835, 837 or 838 was applicable in relation to the patient) (H)"
[10] https://www.nhmrc.gov.au/health-advice/guidelines