NATIONAL PRIVATE REHABILITATION GROUP

C/- Government Relations Australia Advisory Pty Limited
Level 5, 80 William Street, East Sydney, NSW, 2011
PO Box 427, Kings Cross, NSW, 2011, **T 02 8353 0405; F 02 9360 9413**

Representing

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Alwyn Private Hospital, NSW
Belmont Private Hospital, Qld
Berkeley Vale Private Hospital, NSW
Brighton Rehabilitation Centre, Vic
Canossa Care Rehabilitation Unit, Qld
Cedar Court HealthSouth RH, Vic
Delmar Private Hospital, NSW
Donvale Rehabilitation Hospital, Vic
Eastern Suburbs Private Hospital, NSW
Epworth Hospital, Vic
Geelong Private Hospital, Vic
Griffith Rehabilitation Hospital, SA
Hirondelle Private Hospital, NSW
Holy Spirit Private Hospital, Qld
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Lady Davidson Private Hospital, NSW
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Metropolitan Rehab Hospital, NSW
Mt Olivet Community Services, Qld
Mt Wilga Private Hospital, NSW
Nepean Private Hospital, Vic
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Southern Highlands PH, NSW
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St Luke's Private Hospital, NSW
Sunnybank Private Hospital, Qld
Toronto Private Hospital, NSW
Victorian Rehab Centre (Northern), Vic
Victorian Rehab Centre (Eastern), Vic
Wolper Private Hospital, NSW

Submission

to the House of Representatives Committee on Ageing

Inquiry into Long Term Strategies to address the ageing of the Australian population over the next 40 years

"Medical Rehabilitation a key to Healthy Ageing"

29 November 2002

Executive summary

1. Introduction

The NPRG is a non-affiliated group of 36 private rehabilitation facilities around Australia representing over 90% of (ie, approximately 1,000) private rehabilitation beds nationally. The Group was formed in late 1997 in response to developments occurring both within and external to the private rehabilitation industry in Australia which required whole-of-industry attention at that time. Since then the NPRG has spearheaded and contributed to a number of seminal developments in relation to the national definition, classification, payment and benchmarking of (private) rehabilitation in Australia.

The NPRG has long argued the direct relevance of medical rehabilitation to the core policy propositions for healthy ageing set out in the *National Strategy for an Ageing Australia* ("the *National Strategy*") and long recognised the increasing community need for high quality medical rehabilitation over the ensuing decades to cater for the far reaching impacts of population ageing.

The NPRG understands the *National Strategy* will be a growing and changing policy platform over the years and is keen to assist the Government to meet the challenges set out in the Strategy.

2. What is medical rehabilitation?

2.1 Not always well understood

Medical rehabilitation has not always been well understood by the general public, governments or payers. This is partly explained by the fact that until recently, few indicators had been produced by the medical rehabilitation industry as to rehabilitation's unique characteristics, quality benchmarks, or varying patterns of resource consumption.

2.2 Description

Medical rehabilitation is the practice of helping people who have suffered functional loss to recover lost function and adapt to disability. It is a co-ordinated program of care directed by a consultant in rehabilitation medicine and recognised as a specialty clinical discipline. Medical rehabilitation targets people with loss of function or ability from any cause such as disease or strokes, or resulting from injury such as general accidents, sporting injuries, surgery, motor vehicle accidents, work accidents etc.

Effective medical rehabilitation *prevents* rather than *increases* further health care costs and as such acts to reduce ongoing dependence on and costs to the health and welfare systems.

2.3 New national definition

Recently a new national private sector definition of medical rehabilitation has been developed and is currently being considered for national implementation. This recommends that medical rehabilitation is an episode of care:

- Provided <u>in</u> a specialist rehabilitation unit (a separate physical space and a specialist rehabilitation team providing inpatient and/or ambulatory care) accredited as such by the Commonwealth Department of Health and Ageing; AND
- Provided <u>by</u> a multidisciplinary team which is under the clinical management of a consultant in rehabilitation medicine or equivalent; AND

- Provided for a <u>person</u> with an impairment and a disability and for whom there is reasonable expectation of functional gain; AND
- For whom the <u>primary treatment goal</u> is improvement in functional status
- which is <u>evidenced in the medical record by:</u>
  - an individualised and documented initial and periodic assessment of functional ability by use of a recognised functional assessment measure.
  - an individualised multidisciplinary rehabilitation plan which includes negotiated rehabilitation goals and indicative time frames.

This definition recognises that medical rehabilitation is *not*:

- Recuperative generic rehabilitation delivered at the tail end of an acute care episode;
- Respite, convalescent, maintenance or aged care, irrespective of whether such care is provided in a specialist rehabilitation unit or provided under the clinical direction of a rehabilitation physician or equivalent; or
- Broad based, primary care type rehabilitation practised by every general practitioner or undertake by a person's family and/or carers.

2.4 Contrast with acute care

A table in the body of this Submission outlines some key differences between acute care and rehabilitation and highlights the clear relevance of medical rehabilitation to healthy ageing.

2.5 Practice areas

Medical rehabilitation is commonly applicable to two broad areas:

- Acute catastrophic events requiring an initial period of rehabilitation which may or may not need long term follow up (eg, stroke, traumatic brain injury, spinal cord injury, orthopaedic rehabilitation, pulmonary rehabilitation);
- Progressive or chronic recurring conditions requiring bursts of rehabilitation over a long period of time (eg, Parkinson's Disease; Multiple Sclerosis).

2.6 Co-ordinated service provision

A co-ordinated system of rehabilitation settings throughout an area is necessary to service people requiring medical rehabilitation. Services should encompass:

- Inpatient care (in an inpatient rehabilitation unit);
- Ambulatory care (in a rehabilitation unit); and
- Community care.

2.7 Practice examples

A range of practice examples applying to some of the most common disabilities experienced by Australians are set out in the body of this Submission.

2.8 The development of medical rehabilitation over recent years

<u>In 1995</u> resulting from amendments to the *Health Legislation* (Private *Health Insurance Reform) Amendment Bill 1995* during its passage through Parliament, mandatory cover for private psychiatric, palliative care and rehabilitation services was introduced requiring that that health insurance funds provide for benefits to be payable in respect of psychiatric, palliative care and rehabilitation in every health insurance hospital table. This was a welcome development in relation to private rehabilitation services as it

recognised that provision and funding of private rehabilitation can be more uncertain than other areas of health care as it is usually longer term, less predictable and often more expensive relative to other services.

In 1997 the Australian National Sub-Acute and Non-Acute Patient Classification Study (AN-SNAP) was published which advocated a new national casemix classification system for sub-acute and non-acute care provided in a variety of treatment settings. It demonstrated 32 classes for overnight rehabilitation and 15 classes for ambulatory rehabilitation (as opposed to the two existing DRG classes of rehabilitation). The study represented an important sea-change in the industry in classifying medical rehabilitation and potentially revolutionised the way in which medical rehabilitation could be defined, costed, administered and funded.

In July 1997 Federal Cabinet decided, after representations by private rehabilitation providers, that mandatory cover should be retained for the time being but reviewed in two years subject to industry strengthening and professionalising itself. This followed a recommendation by the Industry Commission to remove the mandatory cover.

In late 1997 the National Private Rehabilitation Group ("NPRG") formed to address industry concerns and begin the work of developing up the industry in Australia. It set itself tangible goals relating to the definition, classification, payment and accountability of medical rehabilitation in Australia.

In July 1998 the NPRG approached the (then) Department of Health and Aged Care which agreed to undertake policy work required to assist the private rehabilitation industry to achieve these goals. The Private Rehabilitation Working Group (PRWG) was formed with representatives from the Department (as Chair and Secretariat), private rehabilitation providers (the NPRG), health insurance funds, the Australasian Faculty of Rehabilitation Medicine, and consumers.

Between 1998 and the present time, as a result of this policy work the PRWG has authorised and presided over significant substantive theoretical work in relation to the national data collection, classification and payment of (private) medical rehabilitation episodes which has today resulted in a new classification system for rehabilitation (currently being implemented nationally), imminent new payment arrangements for private rehabilitation, and the establishment in July 2002 of an inaugural national rehabilitation data bureau, the Australasian Rehabilitation Outcomes Centre ("AROC") with wide public and private industry representation to enable national benchmarking of both public and private rehabilitation outcomes and evidence-based improvements to rehabilitation service delivery.

Some of this technical work is recognised as having wider application for other sub-acute services and services for older people.

In October 2002 the Government confirmed that the mandatory cover for rehabilitation introduced in 1995 would not be removed for the time being and agreed to consider introducing a mechanism to scrutinise health fund practices against the mandatory cover legislation to ensure compliance and intervene in cases where non-compliance is demonstrated.

3. Relevance of medical rehabilitation to the *National Strategy for an Ageing Australia*

Medical rehabilitation is particularly relevant to the goals of three areas addressed in the *National Strategy* – Australia's workforce; Australia's economy; and healthy ageing.

3.1 Relevance to the workforce

3.1.1 A skilled health care workforce

The NPRG agrees that a skilled workforce should include both a skilled health care workforce to service the growing aged care sector, and a growing skilled mature age workforce to contribute to their own and the country's productivity and economic growth.

In terms of a skilled health care workforce, of particular importance to rehabilitation will be having sufficient numbers of rehabilitation clinicians in proportion to the growing need for rehabilitation treatment for Australia's ageing population. Currently there is an under-supply of medical rehabilitation specialists in Australia. While this is being addressed at the state and territory level, it will need to be considered in policy planning for an ageing Australia. It also needs to be recognised that, in certain circumstances, other disciplines, including neurologists, rheumatologists and cardiologists, may be able to provide quality rehabilitation care, particularly where some rural and regional locations are unable to permanently retain a rehabilitation specialist.

3.1.2 A skilled mature age workforce

In terms of a skilled mature age workforce, medical rehabilitation can also assist in adding to the supply of older people for national productivity and assisting them to continue working, contributing to their incentive to remain in the workforce and age positively. It can do this by:

- Assisting to improve the functionality of younger workers over the work-life period to better prepare them to more productively contribute as mature age workers;
- Assisting to turn mature age workers into better functioning mature age workers by restoring functional ability, reducing physical dependence, minimising the impact of injury, ill health and chronic disease, and building and maintaining confidence about their ability to better manage ongoing illness and/or disability.

3.2 Relevance to the economy

3.2.1 Direct savings

Medical rehabilitation can enable direct savings through:

- Increased tax revenues;
- Reduced demand for a range of pensions and benefits including unemployment benefits and disability and carer pensions; and
- Reduced medical treatment and care costs in the residential and acute hospital systems incurred during periods of disability that are necessarily prolonged or arise from preventable loss of function or disability.

3.2.2 Indirect savings

And indirect benefits, including:

- Reduced demand for government funding for long-term medical and accommodation facilities;
- Reduced costs related to carer stress, family dysfunction and carers' loss of earning capacity;
- Compounding benefits where people return to the workforce and avoid prolonged periods off work;

- Savings to industry of training new workers and replacements during periods of incapacity; and
- Lower consumption of health resources by the families of workers who have not returned to work.

3.2.3 Proven cost savings

3.2.3.1 Overseas studies

A number of overseas studies have demonstrated clear cost savings from medical rehabilitation. These are reported in the body of this Submission.

3.2.3.2 Australian studies

It is expected that in coming years as the recently established Australasian Rehabilitation Outcomes Centre – AROC - develops its own extensive database of Australian and Australasian rehabilitation episodes, up-to-date local evidence will be able to be documented and demonstrated.

3.3 Relevance to healthy ageing

3.3.1 The healthy ageing of younger people

For younger people, medical rehabilitation helps to maintain health, mitigate the effects of injury and chronic disease, restore functional ability, assist in managing ongoing disability thus improving earning power over the work-life period.

3.3.2 The healthy functioning of older people

For older people, medical rehabilitation helps to maintain and improve health, reduce subsequent illness, delay the disabling effects of conditions associated with ageing, increase independence, and promote greater activity - thus prolonging healthy functioning life and enabling a greater number of older people to remain healthy and independent for as long as possible.

4. Recognition of private sector contributions to consumer access and healthy ageing

4.1 Recognition of the private sector

The NPRG is pleased this Government recognises that both public and private contributions are required to meet the needs and aspirations of an older Australia and that the private sector is essential and should robustly complement the public system.

4.2 Importance of appropriate regulation for private medical rehabilitation

While too much regulation could conversely lead to a risk-averse and possibly stagnant industry, the appropriate degree of regulation is paramount for desirable rehabilitation industry outcomes and performance. This is because of both intrinsic and extrinsic features of medical rehabilitation. Intrinsic features such as: the variability in patterns of need, care and lengths of stay; the need for inpatient treatment; the cost structure; rehabilitation consumers' risk rating behaviour; and the position of rehabilitation outside of the acute care framework. And extrinsic features such as: the fact that programs costing the same in rehabilitation are generally reimbursed less than in acute care; the little understood short and long term advantages of treatment; the greater risk transfer; greater consumer exposure since the 1995 *Amendment Act* reforms; and the degree of industry transition.

4.3 Establishing more equitable risk sharing parameters for payers and private rehabilitation providers to protect consumer access to medical rehabilitation

4.3.1 Ensuring compliance with mandatory cover provisions for private rehabilitation in the legislation

As mentioned earlier, in 1995 resulting from amendments to the *Health Legislation* (Private *Health Insurance Reform) Amendment Bill 1995* during its passage through Parliament, mandatory cover for private psychiatric, palliative care and rehabilitation services was introduced. Despite this welcome development, the legislation is able to be easily circumvented and lacks a structure to ensure compliance. The impact of this is increasingly significant in light of the Government's recognition of the growing relevance of (private) rehabilitation services to healthy ageing policies. Recently the Government agreed to consider introducing a mechanism to scrutinise health fund practices against the mandatory cover legislation to ensure compliance.

4.3.2 Implementing the Blended Payment Model for private rehabilitation services as a single industry-wide model

The NPRG is particularly keen to see the Blended Payment Model for Private Rehabilitation (a) implemented within the industry; and (b) implemented as a single industry-wide model.

The reason it should be implemented is because it contains far more suitable incentives regarding lengths of stay than existing models; contains more theoretical accuracy than existing payment models; and provides for more equitable risk sharing between providers and payers thus promoting consumer access to rehabilitation services.

The reason it should be implemented as a single industry-wide model is because it would permit common software systems and casemix modeling; common measures of burden of care and outcome; the benchmarking of future outcomes; administrative simplicity where the sector lacks the capacity to manage multiple models each requiring their own billing systems, associated administrative infrastructure and training; a sufficient volume of data to be developed across all patient groups for required policy development, health care planning and outcomes benchmarking; and greater incentive for hospitals to continue to improve AN-SNAP data (rehabilitation branch).

4.3.3 Mandating a single level of purchasing for private rehabilitation

A development the NPRG has been particularly concerned about is the increasing and aggressive introduction of 'Episode of Illness' contracts. These are contracts involving one or more Episodes of Care where acute and rehabilitation care are bundled together and payment is made by the health fund to the acute provider for subsequent apportioning to the rehabilitation provider. Episode of Illness contracts do not recognise that patterns of care and thus costs and resource intensity in rehabilitation are more varying and not as predictable as those in acute care, do not therefore allow for risks to be appropriately shared between providers and payers, and create perverse financial incentives to treat only the most simple rehabilitation cases and place too much emphasis on the acute care phase when the real focus should be on the rehabilitation phase.

4. Conclusion

Medical rehabilitation improves lives and saves money in acute health care, long-term social security, community care and supported accommodation, and results in a wide range of other indirect economic benefits.

The goal of the private medical rehabilitation industry today is to ensure that every Australian with private health insurance cover who needs medical rehabilitation care receives appropriate and cost effective medical rehabilitation care. To establish the parameters for healthy ageing, private rehabilitation care must be part of the basic package of health services guaranteed to every health insured person.

Private rehabilitation providers are committed to continuing to work with all Governments and health funds to improve their understanding of private rehabilitation and its role in meeting Australians' clinical needs and in policies associated with an ageing Australia.

5. Recommendations

Recommendations are set out on page 19 of this Submission.

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1. Introduction

The NPRG is a non-affiliated group of 36 private rehabilitation facilities around Australia representing over 90% of (ie, approximately 1,000) private rehabilitation beds nationally. The Group was formed in late 1997 in response to developments occurring both within and external to the private rehabilitation industry in Australia which required whole-of-industry attention at that time. Since then the NPRG has spearheaded a number of seminal developments in relation to the national definition, classification, payment and benchmarking of (private) rehabilitation in Australia.

The NPRG is encouraged that the Government recognises that population ageing is the biggest economic and social issue facing Australia today and that through this Committee's inquiry process, the *National Strategy for an Ageing Australia* ("the *National Strategy*") and its associated discussion papers and emerging policy infrastructure, the Government recognises the need to take a strategic whole-of-government approach to population ageing over the next several decades.

The NPRG is pleased that this aims to develop health and aged care policies that provide future infrastructure, services and programs to encourage mature age employment, develop and strengthen preventative programs, take a more coordinated lifelong approach to disease and disability prevention and management, encourage people to remain healthier for longer, reduce physical dependence, participate for longer in the workforce, and better utilise the skills and experiences of mature age people.

And we are encouraged that both public and private sector contributions are recognised as being important to meeting the needs and aspirations of an older Australia.

The NPRG has long argued the direct relevance of medical rehabilitation to these core policy propositions for healthy ageing and long recognised the increasing community need for high quality medical rehabilitation over the ensuing decades to cater for the far reaching impacts of population ageing.

Although projections vary about increases in population numbers over the next 10-15 years and beyond, all projections agree there will be significant increases in population numbers of people aged 65 years and an almost doubling of the numbers of people aged 80 years and over.

There are tangible economic benefits, quality of life improvements and demonstrable cost benefits from the provision of high quality medical rehabilitation. Medical rehabilitation plays a powerful role in keeping people of all ages functional and independent, assisting people to better utilise important skills for sustained economic growth, and contributing to healthy and positive ageing across the life course.

The NPRG is pleased to contribute to the House of Representatives' Committee's Inquiry in order to draw to the Committee's attention the relevance of medical rehabilitation to Australia's ageing population and the goals of the *National Strategy*. The NPRG understands the *National Strategy* will be a growing and changing policy platform over time and is keen to assist the Government to meet the challenges set out in the *National Strategy* and contribute to the strategic whole-of-government planning framework.

This submission explains what medical rehabilitation is and its broad-based applicability, sets out some of the more significant developments in the (private) medical rehabilitation industry over the last five years and their relevance to the goals of the *National Strategy*, outlines the specific relevance of medical rehabilitation to the goals of three areas addressed in the *National Strategy* – Australia's workforce; Australia's economy; and healthy ageing, and makes recommendations about ways to appropriately target medical rehabilitation to the goals of the *National Strategy*.

2. What is medical rehabilitation?

2.1 Not always well understood

Medical rehabilitation has not always been well understood by the general public, governments or payers. This is partly explained by the fact that until recently, few indicators had been produced by the medical rehabilitation industry as to rehabilitation's unique characteristics, quality benchmarks or varying patterns of resource consumption. This in turn had led to intrinsic difficulties in quantifying costs and arriving at standard payment structures and definitions for (private) medical rehabilitation. Over the last five years however several important industry initiatives have addressed this issue and will continue to address it into the future. Much, although not all, of this has been initiated by the NPRG with the assistance of the Private Sector Industry Branch of the (now) Commonwealth Department of Health and Ageing, specifically through the industry working group known as the Private Rehabilitation Working Group ("PRWG").

2.2 Description

Medical rehabilitation is the practice of helping people who have suffered functional loss to recover lost function and adapt to disability. It is a co-ordinated program of care directed by a consultant in rehabilitation medicine and recognised as a specialty clinical discipline. Medical rehabilitation is an integral and vital component of many health care episodes and of returning people to productive lives.

Medical rehabilitation targets people with loss of function or ability from any cause such as disease or strokes, or resulting from injury such as general accidents, sporting injuries, surgery, motor vehicle accidents, work accidents etc. It assists in the improvement of function and/or prevents deterioration of function to bring about the highest possible level of independence – physically, psychologically, socially and economically - to maximise quality of life and minimise long term health care and community support needs.

Numerous studies have shown the benefits of rehabilitation are real both clinically and financially. (This is set out in more detail page 13 of this Submission). In America it has been proven that rehabilitation provides a ten fold return on investment and in Australia the *Beggs Report* commissioned by the Commonwealth Government in the late 1980s, concluded that rehabilitation returns $2.25 for every budgeted dollar spent on it.

Effective medical rehabilitation *prevents* rather than increases further health care costs and as such acts to *reduce* ongoing dependence on and costs to the health and welfare systems.

2.3 New national definition

The articulation of the following national private sector definition of rehabilitation is currently being considered for adoption in the private rehabilitation sector. It was developed for the November 1999 Report by the Centre for Health Services Development (University of Wollongong), *A National Classification System and Payment Model for Private Rehabilitation Services*, November 1999 ("1999 CHSD Report"). This new single national definition effectively replaces a range of previously compiled non-standardised functional definitions established for payment purposes.

As defined in the 1999 CHSD Report, medical rehabilitation is an episode of care:

- Provided in a specialist rehabilitation unit (a separate physical space and a specialist rehabilitation team providing inpatient and/or ambulatory care) accredited as such by the Commonwealth Department of Health and Ageing; AND
- Provided by a multidisciplinary team which is under the clinical management of a consultant in rehabilitation medicine or equivalent; AND
- Provided for a person with an impairment and a disability and for whom there is reasonable expectation of functional gain; AND
- For whom the primary treatment goal is improvement in functional status
- which is evidenced in the medical record by:
  - an individualised and documented initial and periodic assessment of functional ability by use of a recognised functional assessment measure.
  - an individualised multidisciplinary rehabilitation plan which includes negotiated rehabilitation goals and indicative time frames.

2.3.1 Inclusions

The definition includes:

- Rehabilitation care provided to both admitted and non-admitted patients; and
- Single therapy care if:
  - it is consistent with the patient's rehabilitation goal and their care plan; AND
  - it is in planned continuity with a multidisciplinary rehabilitation episode AND
  - it is ordered before the completion of the multidisciplinary program by the treating rehabilitation doctor and is supervised by the treating rehabilitation doctor

2.3.2 Exclusions

The definition excludes:

- Recuperative generic rehabilitation delivered at the tail end of an acute care episode;
- Respite, convalescent, maintenance or aged care, irrespective of whether such care is provided in a specialist rehabilitation unit or provided under the clinical direction of a rehabilitation physician or equivalent; and
- Broad based, primary care type rehabilitation practised by every general practitioner or undertake by a person's family and/or carers.

2.4 Contrast with acute care

This new national definition is useful not only in providing a single definition which can be used for both clinical and payment purposes, but in helping to highlight the contrast between rehabilitation care and acute care.

This contrast is significant because until recently rehabilitation had historically not been separated from 'acute' health care episodes from the point of view of classification and funding, and this had negative implications for a range of dependent variables including the identification, classification, costing, and funding medical rehabilitation. The historical lack of separation between the two different care types failed to acknowledge the unique care patterns and resource consumption in medical rehabilitation and consequently produced ongoing anomalies in its classification and payment. As a result of recent development work undertaken within the rehabilitation industry, this inaccuracy is now acknowledged and is in the process of being corrected in practice. (This is more fully explained later in the Submission).

The table over the page outlines some of the key differences between the acute care and rehabilitation frames of reference. This snapshot is also useful in highlighting the clear relevance of medical rehabilitation to healthy ageing.

Acute Care Frame of Reference	Rehabilitation Frame of Reference
Primary focus is recovery from illness or injury	Primary focus is functional gain
Patient is passive	Patient is active and interactive
Treatment is for disease	Treatment is for disability
Treatment is usually provided by a primary acute treating doctor with little active family or carer involvement	Treatment is always provided by a team of rehabilitation specialists and allied health professionals with active family and carer involvement
Intervention therapy is usually uni-disciplinary	Intervention therapies are multidisciplinary and integrated
Model is illness	Model is wellness
Focus is medial	Focus is medical, psychological, functional, physical, social, vocational
Primary goal is stabilisation of patient's medical/surgical needs, and survival	Primary goals is enhancement of functional ability, independence level and quality of life
Saves lives	Determines quality of life, deters secondary disabilities and medical sequalae and assists future employability
Rehabilitation in the acute setting represents broad based primary or recuperative care to prevent or minimise secondary complications and speed recovery	Rehabilitation in the specialist rehabilitation setting represents multidisciplinary care to maximise function
Prevailing view is that if medical rehabilitation is not required in the acute setting, it should only be available in outpatient settings (including ambulatory and/or community settings)	Reality is that while ambulatory and acute settings meet some medical rehabilitation needs, the needs of people requiring more coordinated, intensive programs of multiple rehabilitation can only be provided for in specialist inpatient and ambulatory rehabilitation settings
Intervention requirements are driven by medical diagnosis	Intervention requirements are driven by functional impairments which in many cases do not correspond with medical diagnoses. Rehabilitation is in fact a whole phase of care after many DRGs (and not a DRG in itself).
Patient cost curves usually decrease over time	Patient cost curves usually remain flat over time

2.5 Practice areas

Medical rehabilitation is commonly applicable to two broad types of conditions:

- Acute catastrophic events requiring an initial period of rehabilitation and may or may not need long term follow up (eg, stroke, traumatic brain injury, spinal cord injury, orthopaedic rehabilitation, pulmonary rehabilitation);
- Progressive or chronic recurring conditions requiring bursts of rehabilitation over a long period of time (eg, Parkinson's Disease; Multiple Sclerosis).

2.6 Co-ordinated service provision

A co-ordinated system of rehabilitation settings throughout an area is necessary to service people requiring medical rehabilitation. Services should encompass:

- Inpatient care (in an inpatient rehabilitation unit);

- Ambulatory care (in a rehabilitation unit); and
- Community care.

The NPRG recommends that planning for rehabilitation services recognises they should be provided in a co-ordinated system throughout an area encompassing inpatient care, ambulatory care and community care.

2.7 Practice examples

The *National Strategy* states that currently over 70% of the burden of illness and injury experienced by the Australian population is associated with the national health priority areas of cardiovascular disease, cancers, injuries, mental health problems, diabetes and asthma. It goes on to say that for people aged 65 years and over these diseases, combined with respiratory illness, are the major causes of death. It also says that also affecting the health of ageing people are sensory loss, musculo-skeletal conditions, falls, and conditions associated with brain ageing. And it acknowledges that for people of all ages physical inactivity is also a major determinant of ill health and the effects of physical activity on reducing the risk of mortality from all causes are well documented.

Many of these most commonly occurring conditions respond very well to medical rehabilitation treatment in people of all ages.

As alluded to on the previous page the most common medical conditions treated by medical rehabilitation include neurological (stroke, acquired brain injury, spinal cord dysfunction, multiple sclerosis, Parkinson's disease etc); musculo-skeletal conditions (orthopaedic, amputation, pain, arthritis etc); multiple trauma, cardiac and respiratory conditions, and a range of other debilitating illnesses and conditions.

The following examples describe the benefits for some of these disabilities.

Traumatic brain injury

A young married man with two children, a local industry project manager and an active member of a town football club fell from a ladder, serioiusly injuring his head. Without medical rehabilitation he would be likely to remain unemployed, severely socially handicapped, suffer a deteriorating family life with reduced concentration, increased aggressiveness, and perhaps heavy drinking. His family may experience stress-related health and social problems and he would be likely to experience ongoing psychosocial and economic difficulties. With medical rehabilitation he is likely to maintain functional ability and memory, be able to return to work, to maintain stability in his family life and continue to be a productive member of the community, local industry and society.

Spinal cord injury

A 20 year old woman incurred a severe spinal cord injury in a sporting accident. Without medical rehabilitation she would be dependent on others for the rest of her life for all aspects of living. She may well be unemployable and could expect to have numerous hospital re-admissions for secondary problems with bladder and bowel and pressure areas due to her and her carers not being properly equipped to prevent these problems. With medical rehabilitation she can expect to have an almost normal lifespan and gain significant mobility in a wheelchair and in learning to drive a modified car. She will learn skills which will make her employable or self-employable. And she and her carers will be taught how to prevent the development of secondary problems developing thus minimising inpatient care and enabling longer term savings to both the health and social security systems.

A 28 year old man fractured his cervical spine diving into a river, suffering an incomplete C5 tetraplegia. His problems included neurogenic bowel and bladder, patchy loss of sensation below the upper chest, painful limb spasticity and psychological depression. Without medical rehabilitation he could not be expected to move in bed without help, move from bed to chair, dress himself or propel a chair, and would probably live most of his life in residential care. With medical rehabilitation, he will learn to feed himself with aids, independently transport himself from bed to chair, dress with minimal help, drive a modified car, return to community life and, with vocational training, be able to return to open employment. Rehabilitation will also minimise any bowel, bladder and skin complications associated with his injury.

Stroke

A 45 year old professional man was admitted to an acute hospital suffering from a stroke resulting in arm and leg paralysis and marked speech disturbance. Without medical rehabilitation, while he may regain some communication and limb movement, he would lie, for the rest of his life, in a hospital or nursing home bed and quite probably acquire secondary disabling conditions such as muscle atrophy, obesity, ulcers, contracture and depression. With medical rehabilitation he is is likely to have a vastly reduced need for long term hospitalisation or readmission, be able to again fully communicate, become independently mobile, be independent of family or other care givers, undertake meaningful work, in some cases drive a car, and generally resume a productive and satisfying life.

Multiple Sclerosis

A 40 year old female university lecturer, married with a school aged family, was diagnosed with multiple sclerosis at age 25. Her disease progressed to the point where she became dependent on an electric wheelchair for mobility and on intermittent self-catheterisation for urinary continence management. Without medical rehabilitation over this time she would most likely have been unemployed, have required hands-on support from her family and have lived her life in residential care. With medical rehabilitation she has been able to implement energy conservation techniques and negotiate work modifications to enable her to work part time and use a work station at home. Home modifications have provided a safe bathroom environment and intermittent therapy has helped her to maximise mobility. She has thus remained a productive member of the family and workforce and lives at home without hands-on family support.

Orthopaedic rehabilitation

A 74 year old woman living alone fell and fractured her right neck of femur. She was admitted to an orthopaedic ward but her post-operative recovery was complicated by cardiac failure, a deep vein thrombosis and pneumonia. Furthermore, treatment of the cardiac failure resulted in postural hypotension, making it difficult for her to stand. Without medical rehabilitation she would be left with poor mobility, incontinence, poor exercise tolerance, reduced ability to undertake the normal activities of daily living, and spend the rest of her life in a nursing home. With medical rehabilitation she was able to gain sufficient mobility and independence to return to her home with community supports including home help, meals on wheels and district nursing. The cost of long term aged or residential care was avoided or deferred.

Pulmonary rehabilitation

A 65 year old male veteran and former heavy smoker had had numerous hospital admissions, particularly over winter, with acute exacerbations of chronic obstructive pulmonary disease. He also had ischaemic heart disease, peripheral vascular disease and prostatism. As a result, his lifestyle had been extremely limited and he was largely

confined to his home. With medical rehabilitation his symptoms markedly improved and his exercise tolerance and quality of life increased, resulting in 10% less time spent in hospital and a corresponding 10% saving in hospital costs and deferred support services.

2.8 Brief history of the development of medical rehabilitation over recent years

2.8.1 The last fifty years

Milestones in the early development of medical rehabilitation include the emergence of the concept of the multidisciplinary team, the integration of rehabilitation into the continuum of patient care, and the inclusion of cognitive rehabilitation therapy into physical therapy.

2.8.2 The last fifteen years

The last ten-fifteen years saw increased efforts to professionally account for medical rehabilitation and develop standards of excellence in terms of:

- Admission criteria - patient, program and facility admission criteria as quality controls; and
- Classification - data collection methodologies and measurement yardsticks to classify medical rehabilitation and meaningfully clarify costs and funding methods.

Nevertheless there was a growing awareness that the fact that medical rehabilitation had historically been classified according to the acute care medical model failed to recognise the unique care patterns and resource consumption in medical rehabilitation and continued to produce anomalies in the classification and payment of medical rehabilitation. (This is referred to earlier).

There was also growing frustration about the fact that very few reliable industry indictors had been nationally collected or reported for medical rehabilitation and that this restricted the ability to positive impact on future care planning, clinical improvements and practice accountability.

2.8.3 The last ten years

The last ten years saw unprecedented marketplace change occurring in private rehabilitation in particular brought about by a combination of the Government stimulating demand in the private sector, normal industry growth and the more competitive contracting environment operating since 1995.

Changes occasioned by increasing demand included private rehabilitation becoming a viable alternative to public rehabilitation where it once merely complemented public rehabilitation with less sophisticated episodes of care.

Changes occasioned by industry growth included some industry re-structure where some providers became stronger, others dissolved and others consolidated into networks of larger groups, where competition moved towards greater emphasis on cost and service, where the need emerged for reduced costs and increased quality and quantity in adapting to increased competition, altered pricing where the ability to price rationally became more critical, cost analysis became increasingly important to rationalise service mix and price correctly, and where an enhanced level of 'financial consciousness' became necessary.

And changes occasioned by the more competitive contracting environment began to see some concerning developments including a progressive decline in rehabilitation industry profitability in real terms, increasing cost pressures, often a less than co-operative contracting environment with payers, inequitable risk bearing by providers, reduced provider market power, health funds increasingly using the default rate as a substitute to contracting, costs shifting to the public sector, and consumers often being by-passed in the promotion of competition.

Two welcome developments at this point are worth noting for their relevance to the overall development of private rehabilitation service provision and the implications of this for consumer access.

In 1995 resulting from amendments to the *Health Legislation* (Private *Health Insurance Reform) Amendment Bill 1995* made during its passage through Parliament, mandatory cover for private psychiatric, palliative care and rehabilitation services was introduced. This legislation is contained at Schedule 2, 98 (bf) of the *Health Legislation (Private Health Insurance Reform) Amendment Act, 1995*. It requires that health insurance funds must provide for benefits to be payable in respect of these care types in every health insurance hospital table. This was a welcome development as, in the case of rehabilitation, it recognised the higher levels of uncertainty in the provision and funding of private rehabilitation care compared with other areas of health care as it is usually longer term, less predictable and often more expensive.

The challenge remained however to ensure that health funds complied with this legislation, and early signs emerged that the legislation was relatively easy to circumvent in practice and was in fact being circumvented by a range of payment practices being introduced.

In 1997 the Australian National Sub-Acute and Non-Acute Patient Classification Study (AN-SNAP) was published which advocated a new national casemix classification system for sub-acute and non-acute care provided in a variety of treatment settings. The study represented an important sea-change in the industry in classifying medical rehabilitation and potentially revolutionised the way in which medical rehabilitation could be defined, costed, administered and funded. The study was conducted in 1995 by the Centre for Health Service Development, University of Wollongong and funded jointly by the (then) Commonwealth Department of Health and Family Services and the NSW Health Department [1]. This too was a welcome development as it provided much needed theoretical acknowledgement that rehabilitation is more accurately a function of functionality and not diagnosis and should not therefore be classified according to the DRG system in the acute care health model. It addressed the historical problem referred to earlier of rehabilitation being defined as part of the acute care model.

The challenged remained however to see to it that the AN-SNAP Classification System (rehabilitation branch) became nationally implemented.

2.8.4 The last five years

The private rehabilitation industry's concern about the negative effects of contracting and about internal industry weaknesses of still being classified according to the acute care model (AN-SNAP Classification System did not commence being implemented until 2000) and the lack of reliable industry indictors was heightened by the Industry Commission's 1997 Report, *Private Health Insurance.*[2] One of its recommendations was

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[1] Centre for Health Service Development, University of Wollongong, *The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP) Report of the National Sub-Acute and Non-Acute Casemix Classification Study*, August 1997.

[2] Industry Commission, *Private Health Insurance*, Report No 57, 28 February 1997, PX.

that the mandatory coverage for in-hospital rehabilitative care introduced into the *1995 Amendment Act* (referred to above) should no longer be required in every hospital table.

Although some sectors of the industry supported this recommendation, there was concern in other sectors, particularly providers, that the recommendation would lead to more uncertainty about the provision and payment of private rehabilitation at a time when uncontrolled risk had already begun to be shifted from payers to providers.

In July 1997 Federal Cabinet decided, after representations by private rehabilitation providers, that mandatory cover should be retained and reviewed in "two years" (July 1999) subject to appropriate hospital admission criteria regarding rehabilitation being developed between health funds, hospitals and clinicians. This provided a welcome fillip to enable the industry to continue on its development path and theoretically protect private rehabilitation consumers from being further marginalised by the more competitive contracting environment.

In late 1997 the National Private Rehabilitation Group ("NPRG") formed to address these concerns and begin the work of developing the industry in Australia. The NPRG defined its principal mission as being to ensure the future ability of all private rehabilitation patients to access high quality, cost-efficient medical rehabilitation in response to clinically assessed needs. The NPRG defined its principal goals as being to:

1. Permanently retain mandatory cover for rehabilitation in all private health insurance hospital tables, to ensure that rehabilitation patients continue to have access to high quality rehabilitation based on clinical need and in recognition that people customarily assess too low their risk of needing rehabilitation;
2. Advocate for an appropriate rehabilitation-type classification structure so the empirical basis of rehabilitation can be more accurately identified, costed and paid for;
3. Put forward appropriate principles for the payment of medical rehabilitation, based on an accurate classification system, to more fairly remunerate private rehabilitation providers and more equitably share risk between payers and providers;
4. Acquire support for the establishment of a national database for the standard classification, collection, measurement and reporting of rehabilitation episodes; and
5. Validate medical rehabilitation with stakeholders.

In July 1998 the NPRG approached the (then) Department of Health and Aged Care which agreed to undertake policy work required to assist the private rehabilitation industry to achieve these goals. The Private Rehabilitation Working Group (PRWG) was formed with representatives from the Department (as Chair and Secretariat), private rehabilitation providers (the NPRG), health insurance funds, the Australasian Faculty of Rehabilitation Medicine (AFRM), and consumers. Based on representations by the NPRG, the PRWG agreed to progress the improvement of arrangements for private rehabilitation services by recommending a national system for the classification for private rehabilitation, and a national system of payment of private rehabilitation services based on the classification system. The NPRG believed that these goals, rather than the issue of 'appropriate hospital admission criteria' per se, more accurately addressed some of the industry's weaknesses.

Between 1998 and the present time, as a result of this policy work:

- In November 1999, project consultant Professor Kathy Eagar developed a new payment model for private rehabilitation and handed down a report recommending the national implementation of a Blended Payment Model for private rehabilitation

services[3]. The recommendations from her report were agreed to by the Department subject to a trial of the payment model;

- In May 2000 the then Minister for Health and Aged Care endorsed the AN-SNAP Classification System (Rehabilitation Branch) as the most suitable classification system for private rehabilitation nationally (based on it being the best predictor of cost and outcomes for rehabilitation services). In 2002 the AN-SNAP Classification System (Rehabilitation Branch) is in the process of being nationally implemented throughout the private rehabilitation sector and it is hoped will progressively become the basis for contracting between health funds and private rehabilitation providers. Over the last two years, the AN-SNAP Classification System has also been progressively endorsed by state and territory health departments for use in the public health sector;
- Between October 2000 and July 2001 the Blended Payment Model recommended by Professor Eagar was formally trialed in the private rehabilitation industry to evaluate its suitability for national implementation; and
- From July to September 2001 the trial of the Blended Payment Model was professionally evaluated and it was recommended that the Blended Payment Model be implemented nationally forthwith. The NPRG strongly argued for the Blended Payment Model to be mandated so the small and marginalised rehabilitation industry could experience much needed benefits of having a single industry-wide model, however consensus on the PRWG was not reached on mandation, although consensus was reached to have optional implementation of the Blended Payment Model. The PRWG continues to meet to address optional implementation of the Blended Payment Model (and other industry issues) and private rehabilitation providers are seeking to encourage health funds to commence adopting it as the single industry-wide model.

Some of the technical work relating to this raft of reforms is recognised as having direct application for other sub-acute services including services for older people and is therefore relevant to the goals of the *National Strategy for an Ageing Australia*.

In separate but related developments:

- In July 2001 the AN-SNAP classification system was recognised as the basis of calculating rehabilitation benefits in the new 2nd Tier Default Benefit schedule.

- In July 2002 an inaugural national rehabilitation data bureau, the Australasian Rehabilitation Outcomes Centre ("AROC") with wide public and private industry representation, was established under the auspices of the AFRM to enable national benchmarking of both public and private rehabilitation outcomes and evidence-based improvements to rehabilitation service delivery. AROC is being run by the AFRM out of the Centre for Health Service Development at Wollongong University and is a most welcome development from the point of view of public and private rehabilitation providers and payers.

The Minister for Health and Ageing, Senator Patterson, recently formally recognised the benefit of this progressive work and its relevance to future service planning for older people.

- In October 2002 the Government confirmed that the mandatory cover for rehabilitation introduced in 1995 and contained in Schedule 2, 98 (bf) of the *Health Legislation (Private Health Insurance Reform) Amendment Act, 1995* would not be removed as an outcome of the Government's April to September 2002 Interdepartmental Review of Health Insurance Regulation. The Government also

[3] Eagar K, *A National Classification System And Payment Model For Private Rehabilitation Services,* Centre for Health Service Development, University of Wollongong, November 1999.

agreed to consider introducing a mechanism to scrutinise health fund practices against the mandatory cover legislation to ensure compliance, and intervene in cases where non-compliance is demonstrated. This is a welcome development.

These developments have in important ways positioned private rehabilitation to respond to and meaningfully contribute to policy planning associated with the *National Strategy*.

3. Relevance of medical rehabilitation to the *National Strategy for an Ageing Australia*

By returning people quickly and efficiently to home, school, work, and meaningful lives, medical rehabilitation not only improves quality of life for people of all ages but also provides benefits which far exceed the cost of rehabilitation.

This impacts favourably on the workforce, the economy, and healthy ageing - important areas referred to in the *National Strategy* and areas singled out for focus in this submission.

3.1 Relevance to the Workforce

As acknowledged by the Minister for Ageing and in the *National Strategy*, the future of the aged care sector rests on having a skilled and flexible workforce. Due to growth in the supply of mature age workers, their continuing participation in the workforce will be an important factor in providing for their current and future economic and social needs.

The NPRG agrees that a skilled workforce should include both a skilled health care workforce to service the growing aged care sector, and a growing skilled mature age workforce to contribute to their own and the country's productivity and economic growth.

Medical rehabilitation can benefit both these workforce categories.

3.1.1 A skilled health care workforce

Of note in the *National Strategy* is the stated 'Action' to "develop a well-structured and distributed health care workforce that has the skills and capacity to support healthy ageing."

Of particular importance to rehabilitation will be having sufficient numbers of rehabilitation clinicians in proportion to the growing need for rehabilitation treatment for Australia's ageing population.

Currently there is an under-supply of allied health staff in Australia but particularly medical rehabilitation specialists. In the Australian Medical Workforce Advisory Committee (AMWAC) Report, *The Rehabilitation Medicine Workforce in Australia*, June 1997, P6, AMWAC states that, based on several indicators, the ideal consultant-to-population ratio of rehabilitation specialists should be 1 in 50,000 head of population, whereas the current consultant-to-population ratio is 1 in 108,220 head of population, ie, 270 Fellows Australia-wide.

Some state and territory governments are addressing this issue to some extent through their state and territory AFRM counterparts. The NPRG recommends that the abovementioned 'Action' is applied to this area and that Commonwealth and state and territory governments therefore support a well structured and distributed supply of rehabilitation specialists to cater for an ageing population and to ensure that eligible people will have equitable access to private rehabilitation treatment regardless of geographic location.

The NPRG believes it needs to be recognised that in certain circumstances other disciplines including neurologists, rheumatologists and cardiologists, may be able to provide quality rehabilitation care, particularly where some rural and regional locations are unable to permanently retain a rehabilitation specialist.

The NPRG recommends that the Commonwealth and state and territory governments support a well structured and distributed supply of rehabilitation specialists and allied health workers to cater for an ageing population and to ensure that eligible people will have equitable access to private rehabilitation treatment regardless of geographic location.

3.1.2 A skilled mature aged workforce

Medical rehabilitation can also assist in adding to the supply of older people for national productivity by assisting older people to continue working and contributing to older people's incentive to remain in the workforce and age positively. It can do this by:

- Assisting to improve the functionality of *younger workers* over the work-life period to better prepare them to more productively contribute as mature age workers;
- Assisting to turn *older workers* into better functioning older workers by restoring functional ability, reducing physical dependence, minimising the impact of injury, ill health and chronic disease, and building and maintaining confidence about older people's ability to better manage ongoing illness and/or disability.

The NPRG strongly supports all the actions required to meet goals 1 and 2 of the *National Strategy*'s 'A Changing Workforce' strategy. We recommend that an additional 'Action' to those stated in the 'Changing Workforce' strategy be included, as follows:

- "Boosting the availability of services to support the ongoing functional capacity of older Australians to contribute to future productivity and economic growth."

The NPRG recommends an additional 'Action' to those actions stated in the 'Changing Workforce' strategy be included, as follows: "Boosting the availability of services to support the ongoing functional capacity of older Australians to contribute to future productivity and economic growth".

3.2 Relevance to the Economy

The *National Strategy* assesses that by 2041-42 the proportion of the population aged over 65 will be double current levels, significantly increasing the proportion of the population eligible for the age or service pension.

While the impact of this on Commonwealth expenditure is expected to be ameliorated by a number of factors including welfare reforms, productivity growth promotion, fiscal objectives, and superannuation policies, even with the best prevention strategies, as earlier acknowledged, demographic patterns will still mean a much larger future population of older people and disabling injury and disease will likely continue as major Australian health problems. Effective medical rehabilitation provides a vital tool to manage and improve the effects of disabling injury and disease and bring both direct and indirect savings to the economy.

3.2.1 Direct savings

Medical rehabilitation can enable direct savings through:

- Increased tax revenues;
- Reduced demand for a range of pensions and benefits including unemployment benefits and disability and carer pensions; and
- Reduced medical treatment and care costs in the residential and acute hospital systems incurred during periods of disability that are necessarily prolonged or arise from preventable loss of function or disability.

3.2.2 Indirect benefits

And indirect benefits, including:

- Reduced demand for government funding for long-term medical and accommodation facilities;
- Reduced costs related to carer stress, family dysfunction and carers' loss of earning capacity;
- Compounding benefits where people return to the workforce and avoid prolonged periods off work;
- Savings to industry of training new workers and replacements during periods of incapacity;
- Taxation gained from the higher income of people on full wages; and
- Lower consumption of health resources by the families of workers who have not returned to work.

3.2.3 Proven cost savings

3.2.3.1 Overseas studies

A number of overseas studies have demonstrated clear cost savings from medical rehabilitation:

- American studies of vocational rehabilitation have found that the benefits outweighed the costs by a factor of at least 8[4];
- A New Zealand program targeted twenty people with mild to moderate disability who had been off work for six months or more. A fitness-based program enabled ten to return to work. The benefit:cost ratio was calculated at least 1.9:1 in the second year after the program, rising to 4.1:1 in the fifth year and 6.67:1 in the tenth year. The authors suggest that these calculations probably underestimate the true benefit as a range of invisible benefits are not included[5];
- A community-based rehabilitation program has been shown to achieve a ten-fold return on investment by reduction in income support and gain from the income tax paid by those who achieved employment[6];
- A Canadian study showed unequivocal benefit from early injury management among workers, with significant savings in compensation after deducting slight increases in

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[4] Cowley RW, *A benefit cost analysis of the vocational rehabilitation program*. Journal of Human Resources 4 (spring), 1969, pp 226-252.

[5] Caradoc-Davies MA, Wilson BD, Anson JG, *The cost benefit of rehabilitation of injured workers in New Zealand*. Australasian College of Rehabilitation Medicine XIIth Annual Scientific Meeting, April 1992, pp 127-130.

[6] Symington DC, Weston K, *Eighteen years' experience with a community-based vocational rehabilitation program*. Intellectual Disability Studies 9, 1987: pp 106-9.

health costs. The study resulted in legislation being passed in Ontario requiring all injured workers to be assessed at rehabilitation centres within 45 days after injury[7];

- Statistics on the thousands of disabled persons being rehabilitated in the US under state and federal programs for vocational rehabilitation show that their earning capacities increased substantially and the amount of federal, state, and local income taxes collected increased accordingly. Of those on relief, approximately one in six rehabilitated persons ceases to be a public burden. The US federal government estimates an $11 return for every dollar invested in rehabilitation[8];
- The *Beggs Report* in the late 1980s investigated the cost-effectiveness of the Commonwealth Rehabilitation Service and concluded that the government received $2.25 back for every budget dollar spent on rehabilitation[9];
- A Swedish study showed that cardiac rehabilitation for men of working age achieved direct savings of US$12,000 per patient over five years[10].

3.2.3.2 Australian studies

It is expected that in coming years as the recently established Australasian Rehabilitation Outcomes Centre – AROC (introduced on page 10 of this Submission) - develops its own growing database of Australian and Australasian rehabilitation episodes, up-to-date local evidence will be able to be documented and demonstrated.

The NPRG recommends the Commonwealth Government supports studies and modelling by AROC or other approved bodies to assess the impact resulting from medical rehabilitation treatment.

The NPRG recommends the Commonwealth Government supports studies and modelling by AROC or other approved bodies to assess the impact resulting from medical rehabilitation treatment.

3.3 Relevance to healthy ageing

Two of the *National Strategy*'s goals relevant to healthy ageing are:

- to develop population health strategies across the lifespan by optimising opportunities for people to have physical, social and mental wellbeing throughout their lives, reducing the incidence of preventable diseases, delaying the onset of conditions associated with ageing, and effectively managing those illnesses which do occur;

- to maximise the capacity of older people to participate and contribute through better health by preserving function and quality of life, preventing disease and minimising the length and impact of ill health on their lives.

Medical rehabilitation enables both younger and older lives to be bettered by improved length and quality and can directly contribute to both the healthy ageing of younger people and the healthy functioning of older people.

[7] Mitchell RI, Carmen GM, *Results of multicentre trial using an intensive active exercise program for the treatment of acute soft tissue and back injuries*. Spine 15, 1990, pp 514-52.
[8] England B, *Medical rehabilitation services in heatlh care institutions*. American Hospital Publishing, 1986, Chicago.
[9] Beggs JJ, *An investigation of the measurable economic value provided by the Commonwealth Rehabilitation Service*. Department of Community Services and Health, Canberra (undated).
[10] Levin LA, Perk J, Hedback B, *Cardiac rehabilitation: a cost analysis*. Journal of Internal Medicine 230, 1991, pp 427-434.

3.3.1 The healthy ageing of younger people

For younger people, medical rehabilitation helps to maintain health, mitigate the effects of injury and chronic disease, restore functional ability, assist in managing ongoing disability thus improving earning power over the work-life period.

3.3.2 The healthy functioning of older people

For older people, medical rehabilitation helps to maintain and improve health, reduce subsequent illness, delay the disabling effects of conditions associated with ageing, increase independence, and promote greater activity - thus prolonging healthy functioning life and enabling a greater number of older people to remain healthy and independent for as long as possible.

These benefits are obtained for a very small percentage of the health insurance premium dollar.

The NPRG recommends that policies emanating from the *National Strategy for an Ageing Australia* support the Commonwealth, state and territory governments further promoting and facilitating the role of rehabilitation in preventing and managing disease and injury and maintaining the productivity and wellbeing of Australians across the lifespan.

The NPRG recommends that health and aged care services provided by state and territory governments optimise their awareness of the relevance of rehabilitation to functionality and independence in older people and their awareness of (private) rehabilitation when making their assessments.

The NPRG recommends that Commonwealth, state and territory governments design appropriate incentives and regulations to encourage reasonable access for all Australians to appropriate rehabilitation services.

4. Importance of private sector contributions to consumer access and healthy ageing

4.1 Recognition of the private sector

The NPRG is pleased this Government in all its terms of office has recognised that both public and private contributions are required to meet the needs and aspirations of an older Australia and that the private sector is essential and should robustly complement the public system.

Indeed, in our view refining the existing system to cope with older age population growth will be best achieved via an optimal mix of public and private services and funding. Given the public health system is already over-burdened in providing necessary rehabilitation services to the public, and given the more sophisticated and more medically challenging episodes of care being treated in the private sector today, in our view the private rehabilitation sector must continue to be regarded as a viable *complement,* and increasingly where relevant a viable *substitute* to the public system.

The NPRG recommends that the private rehabilitation sector continues to be regarded as a viable *complement* and increasingly where relevant a viable *substitute* to the public sector.

4.2 Importance of appropriate regulation for private medical rehabilitation

Certain 'free market' conditions will be favourable to the provision of appropriate private rehabilitation care, such as premier location, good facilities, capacity to attract doctors, technological developments, supply of rehabilitation specialists, and cost efficiency. Broader factors will of course also have an influence, including income levels and dispersion, population growth and the age structure of the population, and technology capacity. The industry believes these aspects of the normal market should prevail.

Certain free market conditions however, such as the assumption that rehabilitation consumers have perfect knowledge and will accurately assess their risk of needing rehabilitation or the assumption that risk will automatically be equitably shared between payer and provider, would not be favourable to the provision of appropriate care and would lead to the risk of access problems and limited consumer health outcomes if allowed to prevail unchecked.

While too much regulation could conversely lead to a risk-averse and possibly stagnant industry, the appropriate degree of regulation is paramount for desirable rehabilitation industry outcomes and performance.

In the case of rehabilitation, regulatory incentives are needed to utilise rehabilitation services and in many cases there have been active disincentives to transfer to rehabilitation.

The NPRG recommends that the Government supports regulatory incentives which support the utilisation of rehabilitation services and consumer access to high quality medical rehabilitation.

4.3 A critique of some existing regulation

4.3.1 Ensuring compliance with mandatory cover provisions for private rehabilitation in the legislation

As first mentioned on page 8 of this Submission, in 1995 resulting from amendments to the *Health Legislation* (Private *Health Insurance Reform) Amendment Bill 1995* during its passage through Parliament, mandatory cover for private psychiatric, palliative care and rehabilitation services was introduced.

Despite this welcome development, an assessment of its effects on consumer access to private rehabilitation since its introduction reveals that the legislation is able to be easily circumvented in various ways in practice and also that the legislation lacks a structure to ensure compliance. This means that where this occurs, unchecked, consumers are being denied access to appropriate rehabilitation services.

The impact of this is of increasing concern in light of the growing need for rehabilitation over the next few decades and the Government's recent formal recognition of the increasing relevance of (private) rehabilitation services to policies relating to healthy ageing.

Recently the Government supported the ongoing existence of the legislative mandatory cover for private rehabilitation in all private health insurance hospital tables. The Government also recently agreed to consider introducing a mechanism to scrutinise health fund practices against the mandatory cover legislation to ensure compliance, and intervene in cases where non-compliance is demonstrated.

This is a welcome development and the NPRG recommends that the Government continue to support these measures to protect consumer access to medical rehabilitation services by privately insured Australians.

The NPRG recommends that the Government continues to support:

- **the ongoing existence of the legislative mandatory cover for private rehabilitation in all private health insurance hospital tables; and**
- **the effective operation of a compliance strategy to ensure health funds comply with this legislation,**

to enable access to medical rehabilitation services by privately insured Australians.

The NPRG recommends that the Government considers incentives to encourage health funds to pay for an increasing number episodes of private rehabilitation treatment over time in recognition of the role of rehabilitation in prevention and cost savings relative to an ageing population.

4.3.2 Establishing more equitable risk sharing parameters for payers and private rehabilitation providers

Despite the intentions of the *Health Legislation (Private Health Insurance Reform) Amendment Act* 1995 – introduced to establish greater impetus in purchaser-provider contractual agreements to establish a more explicit contracting environment - the bargaining position of private rehabilitation providers has increasingly weakened or become non existent over recent years.

The NPRG believes that some of this imbalance could be rectified by (a) the industry implementing the Blended Payment Model for private rehabilitation services as a single industry-wide model; and (b) the Government mandating a single level of purchasing for private rehabilitation services.

4.3.2.1 Implementing the Blended Payment Model for private rehabilitation services as a single industry-wide model

As mentioned on page 10 of this Submission, the Government-chaired industry working group the PRWG accepted the 1999 CHSD report recommending the implementation of the Blended Payment Model for private rehabilitation services but did not agree to mandate it. This was a disappointing outcome for the NPRG and while the NPRG accepts the Blended Payment Model will not be mandated, the NPRG is particularly keen to see the Blended Payment Model (a) implemented within the industry; and (b) implemented as a single industry-wide model.

The reason the Blended Payment Model must be implemented within industry in the NPRG's view is because it:

- contains far more suitable incentives regarding lengths of stay than existing payment models which are based on the acute care paradigm. (You will recall that rehabilitation can have longer lengths of stay and be more unpredictable than other health services);
- contains more theoretical accuracy than existing payment models (in that it is based on the more theoretically accurate AN-SNAP Classification System for rehabilitation);
- provides for more equitable risk sharing between providers and payers (which has deteriorated since the introduction of payer-provider contracting).

Ultimately the Blended Payment Model provides for improvements to the basis on which payers and providers can negotiate commercial prices which would in turn allow for more sustainable competition between health funds and private rehabilitation providers and greater access to rehabilitation by consumers.

The reason the Blended Payment Model should be standardised as a single industry-wide model in the NPRG's view is because it would permit:

- common software systems, joint training and casemix modelling;
- common measures of burden of care and outcome;
- the benchmarking of future outcomes;
- administrative simplicity where the sector is recognised as lacking the capacity to manage multiple models each requiring their own billing systems, associated administrative infrastructure and training;
- a sufficient volume of data to be developed across all patient groups for required policy development, health care planning and outcomes benchmarking;
- greater incentive for hospitals to continue to improve AN-SNAP data (rehabilitation branch).

The NPRG recommends that the Government supports the implementation of the Blended Payment Model across the private rehabilitation industry and the use of the Blended Payment Model as a single industry-wide model.

4.3.2.2 Mandating a single level of purchasing for private rehabilitation

A development the NPRG has been particularly concerned about, chiefly in Victoria and South Australia although also in other states and territories, is the aggressive introduction of 'Episode of Illness' contracts. These are contracts involving one or more Episodes of Care where acute and rehabilitation care are bundled together and payment is made by the health fund to the acute provider for subsequent apportioning to the rehabilitation provider. An Episode of Care is defined as, "a period of contact between a patient and a facility that occurs in one setting [either overnight, same day, outpatient or community] and in which the patient meets the criteria for Rehabilitation" – 1999 CHSD Report.

In providing the rationale for introducing the Blended Payment Model for private rehabilitation services the 1999 CHSD Report specifically recommended (Rec 10) that the Episode of Care rather than the Episode of Illness be adopted as the single level of purchasing and reporting in private rehabilitation and that if a patient has an acute episode followed by a rehabilitation episode, that should be defined as two distinct episodes (where the first would be classified by DRG and the second by AN-SNAP).

This because Episode of Illness payments:

- Do not recognise that patterns of care and thus costs and resource intensity in rehabilitation are more varying and not as predictable as those in acute care; and
- Do not therefore allow for risks to be appropriately shared between providers and payers.

This creates perverse financial incentives to treat only the most simple rehabilitation cases, place too much emphasis on the acute care phase when the real focus should be on the rehabilitation phase, and remove the opportunity to examine the contribution of each phase of treatment to the patient's overall outcomes (given that the unit of counting determines not only the payment period but also the period over which outcomes are measured)".

The NPRG therefore recommends that:

- the ‘Episode of Care’ as defined in the 1999 CHSD Report, be adopted as the single level of purchasing and reporting within the industry,
- the ‘Episode of Illness’ ceases to be permitted in contracts between payers and private providers; and
- the Government mandates for the ‘Episode of Care’ to be adopted as the single level of purchasing and reporting within the private rehabilitation industry.

The NPRG recommends that the Government mandates that the ‘Episode of Care’ as defined in the 1999 CHSD Report be adopted as the single level of purchasing and reporting within the private rehabilitation industry and the ‘Episode of Illness’ cease to be permitted in contracts between payers and private rehabilitation providers.

5. Conclusion

Medical rehabilitation improves lives and saves money in acute health care, long-term social security, community care and supported accommodation, and results in a wide range of other indirect economic benefits.

Medical rehabilitation is an integral part of basic, cost-effective health care and is much more accurately an entire stage of health care following many acute health care episodes rather than being an acute diagnostic category in itself as historically defined in the AN-DRG System. In addition to this being recognised in appropriate classifications as is currently occurring, it must be treated as such by public policymakers and payers.

The goal of the private medical rehabilitation industry today is to ensure that every Australian with private health insurance cover who needs medical rehabilitation care receives appropriate and cost effective medical rehabilitation care. To establish the parameters for healthy ageing, private rehabilitation care must be part of the basic package of health services guaranteed to every health insured person.

Private rehabilitation providers are committed to continuing to work with all Governments and health funds to improve their understanding of private rehabilitation and its role in meeting Australians’ clinical needs and in policies associated with an ageing Australia.

In doing so, the private rehabilitation industry appeals to the Government not to allow short term cost pressures to threaten long term economy. Rehabilitation planning for an ageing Australia should be undertaken with a long term view of access, costs and benefits. Policymakers should consider direct and indirect effects on other social service budgets and the general economy. Such considerations mandate expanded, rather than reduced, access to cost-effective private medical rehabilitation and the inclusion of essential rehabilitation services in the medical care offered to all health insured Australians.

6. Recommendations

The NPRG recommends that:

1. **Planning for rehabilitation services recognises they should be provided in a co-ordinated system throughout an area encompassing inpatient care, ambulatory care and community care.**

2. **The Commonwealth and state and territory governments support a well structured and distributed supply of rehabilitation specialists and allied care**

workers to cater for an ageing population and to ensure that eligible people will have equitable access to private rehabilitation treatment regardless of geographic location.

3. **An additional 'Action' to those actions stated in the 'Changing Workforce' strategy be included, as follows: "Boosting the availability of services to support the ongoing functional capacity of older Australians to contribute to future productivity and economic growth".**

4. **The Commonwealth Government supports studies and modelling by the newly established Australasian Rehabilitation Outcomes Centre (AROC) or other approved bodies to assess the impact resulting from medical rehabilitation treatment.**

5. **Policies emanating from the *National Strategy for an Ageing Australia* support the Commonwealth, state and territory governments further promoting and facilitating the role of rehabilitation in preventing and managing disease and injury and maintaining the productivity and wellbeing of Australians across the lifespan.**

6. **That health and aged care services provided by state and territory governments optimise their awareness of the relevance of rehabilitation to functionality and independence in older people and their awareness of (private) rehabilitation when making their assessments.**

7. **Commonwealth, state and territory governments design appropriate incentives and regulations to encourage reasonable access for all Australians to appropriate rehabilitation services.**

8. **The private rehabilitation sector continues to be regarded as a viable *complement* and increasingly where relevant a viable *substitute* to the public sector.**

9. **The Government supports *regulatory* incentives which support the utilisation of rehabilitation services and consumer access to high quality medical rehabilitation.**

10. **The Government continues to support:**

    - **the ongoing existence of the legislative mandatory cover for private rehabilitation in all private health insurance hospital tables; and**
    - **the operation of a compliance strategy to ensure health funds comply with this legislation,**

    to enable access to medical rehabilitation services by privately insured Australians.

11. **The Government considers incentives to encourage health funds to pay for an increasing number of episodes of private rehabilitation treatment over time in recognition of the role of rehabilitation in prevention and cost savings relative to an ageing population.**

12. **The Government supports the implementation of the Blended Payment Model for Private Rehabilitation Services for use across the private rehabilitation industry and the use of the Blended Payment Model as a single industry-wide model.**

13. **The Government mandates that the 'Episode of Care' as defined in the 1999 CHSD Report be adopted as the single level of purchasing and reporting within private rehabilitation and the 'Episode of Illness' cease to be permitted in contracts between payers and private rehabilitation providers.**

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