RMSANZ
Rehabilitation Medicine Society of Australia and New Zealand

5 February 2021

Australian Competition and Consumer Commission (ACCC)
Submission Response – Application Number AA1000542
exemptions@accc.gov.au

Dear Sir or Madam,

Re: Honeysuckle Health and NIB application for Authorisation AA1000542 — interested party consultation.

The Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ)[1] represents the profession of consultant physicians who practice in the discipline of rehabilitation medicine (Consultant Physicians in Rehabilitation Medicine[2]). 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 at the RACP[3].

We represent the practice of rehabilitation medicine on a state national and international level. Our members lead the NSW COVID Community of Practice in Rehab Medicine, have participated in the MBS Review Taskforce and will be hosting the world congress in Rehabilitation Medicine of the International Society of Physical and Rehabilitation Medicine (ISPRM) In Sydney in 2024. Our members principally treat people with disabilities ranging from those due to arthritis and stroke to amputees and those with spinal cord injury and brain injury.

We are writing to response to the HH application AA1000542 because we are concerned regarding the impact that the above application may have on freedom of choice, for subacute care, in the private sector, for those Australians with disabilities.
We also are concerned that the above application may put the safety of health care consumers with disability at risk by limiting access to part of the market in subacute health care, or indeed diminish the number and breadth of services available to people living with disabilities.

Specifically, our concerns centre around but are not limited to the following points.

1. People living with disabilities and those with severely disability who live in rural and remote settings are reliant on small local hospitals (public and private) in order to receive therapy and "stop gap" subacute care (rehabilitation). The position of small rural hospitals is mentioned as having leverage in negotiations with the proposed consortium due to their location, however there are no safeguards in their document ensuring contracts of mutual benefit will be sought with all hospitals.
2. It is not uncommon to suffer an injury or illness leading to disability, or indeed receive super specialised treatments for a disability, in a geographically distant area from the person's home. For many clinical reasons people are advised to receive their subacute care (rehabilitation) in hospitals and health services closer to their home address. Particularly if the home needs to be renovated to permit wheelchair use or carer services need to be established as a workforce to maintain the person in their home. It is ideal for these parts of the rehabilitation process to take place in different hospitals from the ones in which the acute, treatment surgery, illness or injury is managed. The HH Application refers to contracts with hospitals but does not guarantee members of health funds access to hospitals of their choice (which may be outside of the contracted consortia of health services). As such there is a significant risk that newly disabled people may have to pay out of pocket costs to obtain services closer to their home and further that they may not be able to have rehabilitation in their own communities (thereby be separated by distance from their families) putting them at risk of worsening mental health.
3. For some conditions such as Spinal Cord Injury and Traumatic Brain Injuries it is usual practice for State departments of Health to identify a handful of specialised hospitals/units that deal uniquely with either Brain or Spinal Cord Injury[4]. It is in the interest of the consumers of these services to have a choice of these reduced but highly specialised options of care. The HH application deals, in a very cursory manner, with the public sector and leaves the option open for contract negotiations to exclude one or all of these very super specialised hospitals/unit.
4. Better value care is keenly supported by our members but what is unclear is how the process of hospital negotiation though HH and their partners, lead to processes of value-based care and better health outcomes for people. A framework for undertaking better value health projects and identifying their objectives in relation to patient outcomes is not referred to in the document. Research and planning in Better Value Care is primarily undertaken with the individuals, the services and the clinicians and often "patient reported outcomes measures" are identified as the criteria for value-based care. In the setting of disability many people suffer with cognitive impairment and the ethical management of capacity issues are a significant

aspect of our members work. Our members are duty bound to protect people living with disabilities from exploitation or reputational injury during their period of incapacity. There has been little evidence to date on how those with incapacity are able to describe patient reported outcomes. There are few Australian guidelines or research into the ability of the person responsible to take over that role or ways to explore any conflicts of interest.

5. In the HH Application there is a suggestion that a study will be undertaken in value-based care in order to align with DRGs (Diagnostic Related Groups). DRGs relate to acute care diagnoses and do not relate to subacute care (rehabilitation, palliative care and geriatrics). The Application makes no reference to the Australian National Subacute and Non-acute Patient Classification (SNAP) codes[5] which the Australian government uses to classify admissions for subacute care including rehabilitation. How value-based care can relate to improved patient outcomes in the subacute sector has been omitted from the application despite the significant role that rehabilitation plays in the private health industry is of concern.
6. Illustrative Clinical Scenario "St Vincent's Private Hospital Rehabilitation unit 2018-2021" –
    a. In 2017/8 St Vincent's Private Hospital opened a fast stream inpatient rehabilitation Unit. For a period of 2 years from 2018 – 2020 BUPA could not reach contract agreement with the Hospital for rehabilitation services, while many other funds were able to. For that period of time at least 10 – 20 patients per year, whose rehabilitation physicians indicated that they were suitable for inpatient rehabilitation, could not access the hospital's rehabilitation unit. Many were referred off site for rehabilitation in other hospitals and it was explained that their choices of rehabilitation physician and hospital were affected by the hospitals and the funds inability to achieve a contractual arrangement. Some patients, for their own reasons (about 2-5 per year) agreed to pay over $350/day to access a rehabilitation bed and remain with their doctor of choice. All rehabilitation physicians at Vincent's Private Hospital rehabilitation unit do not charge any out-of-pocket expenses to the patient. However, the fact remains that in order to exercise their choices to remain onsite at St Vincent's Private Hospital Rehabilitation Unit, they paid significant out of pocket expenses. A contract has now been agreed by all parties and BUPA members no longer have to pay any out-of-pocket costs for rehabilitation at St Vincent's Private Hospital Rehabilitation Unit.

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The Rehabilitation Medicine Society of Australia and New Zealand would like to express our concern regarding the need to protect the interests and safety of consumers in the private subacute health sector.

Our focus is on the safety and interest of those with disabilities who we believed have not been considered in this application and that their choices in the private health care market may be significantly curtailed and diminished by the plans indicated in the HH Application. Thank you for taking the time to read this application and considering disallowing the exemption applied for by the HH application AA1000542.

Yours Sincerely

Dr Michael Chou (President of RMSANZ)

[1] https://rmsanz.net/
[2] https://www.racp.edu.au/docs/default-source/advocacy-library/role-of-the-rehabilitation-physician.pdf
[3] https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-rehabilitation-medicine
[4] In NSW there are 2 Spinal Units POW, RNSH and 3 Brain Injury Units Royal Rehab, Westmead and Liverpool. All are in public hospitals. 50% of these injuries are caused by falls and not covered by third party payers.
[5] https://www.ihpa.gov.au/sites/default/files/Documents/an-snap_classification_version_4_user_manual.pdf