Out-of-hospital models of care in the private health system

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EXECUTIVE SUMMARY

Healthcare is constantly evolving, and government funding and regulation often struggle to keep pace. In Australia, the private health system is often at the forefront of this evolution, with the public system playing catch-up. When it comes to out-of-hospital care however, it is the public hospitals that are leading the way in delivering innovative hospital-type care out of the hospital, and the private system is lagging. This is likely because the public system has simpler, shared governance arrangements and flexibility of funding, whereas the funding arrangement of the private system are more complex.

Private health insurers have historically only provided cover for in-hospital treatments, with the exception of optional 'extras' packages. In recent years however — particularly in response to the COVID-19 pandemic — private health insurers have started expanding into delivering out-of-hospital care, however this has largely been driven by insurers on their own terms, in part due to a lack of legislative and public policy design. Most insurers will only provide select out-of-hospital schemes for their own policy holders (such as joint replacement rehabilitation at home), as this enables them to have more control over the services provided and the associated costs, and they can benefit from the savings of not funding inpatient treatment which is often more expensive. While expanding services in this way may improve the value proposition for private health insurance customers, these developments are strongly related to growing tendencies for for-profit private health insurers to vertically control services, in an attempt to gain greater control of treatment costs, which may be inadvertently leading Australia down a United States-style managed care pathway. This approach risks the principles of patient choice and clinical autonomy.

This expansion in the private out-of-hospital space has created a complex environment, where patients may not know what they are covered for and doctors must navigate complex funding and governance arrangements to get their patients the best care, if they want to access out-of-hospital services. This is a result of these new models not being consistently included in all insurance products, which means many privately insured patients whose insurer does not offer an out-of-hospital scheme are unable to receive out-of-hospital care unless they are prepared to pay large out-of-pocket costs. Consultation with major private healthcare providers revealed that around 40 per cent of patients are unable to access out-of-hospital care, either because their insurers do not have their own out-of-hospital program or do not have agreements with out-of-hospital providers.

It is clear that complexity, lack of transparency, and inconsistency in private health insurance is increasing and resulting in an environment that is similar to what existed before the 'gold, silver, bronze, basic' reforms which standardised in-hospital treatment coverage. One of the key reasons for this is the absence of standardised, national, and universally applicable regulations and safeguards for providing out-of-hospital care in the private system. This has resulted in divergent views on how out-of-hospital care should be delivered and significant variability in quality and safety frameworks, clinical pathways, deterioration protocols, and pricing mechanisms. In addition, it is unclear in the private system who is financially or clinically responsible for a patient once they leave the hospital environment.

Supporting the expansion of out-of-hospital care will benefit for patients and the health system. Studies show that eligible patients may experience equivalent or better clinical outcomes, reduced risk of infection, home comforts, reduced travel, enablement of work from home, and improved ability to manage caring responsibilities.[1,2] For the system, it can improve hospital efficiency by freeing up staff and beds and contribute to cost savings across the whole health system.

AMA analysis estimates that expanding access to out-of-hospital rehabilitation to all clinically eligible private patients having a total knee replacement would **save around 47,000 to 94,000 bed days and $31.3 million to $62.7 million per year (in 2024).** This provides an indication of the potential savings if out-of-hospital rehabilitation was available to clinically eligible patients across all possible procedure and treatment categories (such as other orthopaedic procedures, stroke rehabilitation, mental health, and palliative care). These potential savings would enable insurers to lower the rate of growth of private health insurance premiums, which could result in savings for government from reduced premium rebates, and increased uptake of private health insurance due to improved value proposition (which in turn, would lower the rate of growth of premiums further as part of a positive feedback loop).

The AMA would like to see true contestability of service in the private out-of-hospital system, that is, where patients can choose the best provider from a range of options under the guidance of their doctor, funded by their insurer. It is clear that a lack of leadership and coordination of reform in the private health system is holding back this reform. The AMA is calling for the establishment of a Private Health System Authority to provide leadership on reforming the system, and drive the 'deliberate design' of out-of-hospital models of care with patient choice at the centre.

WHAT IS OUT-OF-HOSPITAL CARE?

Definition of out-of-hospital care

For the purposes of this report, 'out-of-hospital' treatment refers to care that is initiated and delivered in a hospital as a default, but could be delivered outside the hospital (for example, at a patient's home or in a physiotherapist clinic) for clinically eligible patients.

It can be likened to a 'hospital substitution episode' and should be delivered to the same standard as if it took place in the hospital, and by appropriately qualified staff as advised by the treating medical practitioner. In some cases, the patient is considered to still be 'admitted' to the hospital, and in other cases they are considered non-admitted. 'Hospital in the home' is a type of out-of-hospital care, where the patient receives treatment at home however is often still considered an 'admitted' patient in the hospital. In this report, it is not intended for 'out-of-hospital' to include outpatient-style care[3] or primary care, or peri-operative management outside of prehabilitation and rehabilitation. It is however acknowledged that in some cases the lines are easily blurred, for example, between low intensity hospital substitution and outpatient care. This complexity is in part why uptake of out-of-hospital models of care in the private system is lagging and should be considered as part of reform efforts.

It is also important to note that some types of hospital treatment lend themselves to this model of care more than others. Home haemodialysis, chemotherapy, and palliative care have been options for some patients for decades. More recently, out-of-hospital care for rehabilitation (for example, after a joint replacement or a stroke), prehabilitation, and mental health treatment has gained traction, partly driven by the significant strides made during the COVID-19 pandemic with respect to telemedicine and virtual care.

What telemedicine and virtual care have made possible

The COVID-19 pandemic vastly accelerated the adoption of telemedicine and virtual care. While the technology has been available for decades, the pandemic created an urgency which eliminated many of the administrative and cultural barriers to its implementation. While telemedicine is not a substitute for face-to-face healthcare, it is a valuable addition to our healthcare system. For example, in some cases a treating practitioner will combine both telemedicine and face-to-face care, such as a telehealth consultation with a medical practitioner paired with an at-home visit with a nurse.

Now telemedicine is transforming the way we deliver healthcare in certain settings. For example, virtual emergency department services are being trialled in various locations in Australia, where suitable patients are triaged to receive virtual care, avoiding physical presentation at the emergency department, and potentially reducing overcrowding.[4] Patients can now have telemedicine appointments from home or work and receive diagnostic requests and prescriptions electronically, which is convenient for both the patient and their treating practitioner, particularly for patients who live in regional, rural, and remote locations.

The AMA would like to see these technological developments continue to be harnessed, but with careful and deliberate design of how they are use under a robust governance framework. Face-to-face interaction with healthcare professionals will always be an important part of healthcare and must be protected.

Ensuring safe use and delivery of telemedicine services

Telemedicine will be a key component in delivering comprehensive and patient-centred care into the future. There are however potential risks and limitations when removing or reducing in-person medicine. To address these risks and limitations, the AMA developed *The 10 Minimum Standards for Telemedicine* which are designed to protect the quality and safety of medical care.

Why out-of-hospital care?

For clinically eligible patients,[i] studies show that out-of-hospital care for patients recovering from a stroke[5] or a knee replacement[6] can result in equivalent or better clinical outcomes for the patient. Additionally, these patients can experience reduced risk of infection, home comforts, reduced travel, enablement of work from home, and improved ability to manage caring responsibilities.

From the funders' perspectives (government, private health insurers, and patients) it can be cheaper in some cases to deliver care outside of the hospital, due to the overheads involved when someone stays overnight occupying a hospital bed.[7]

[i]Eligibility for out-of-hospital care is determined by the treating medical practitioner, in consultation with the patient.

From the hospitals' perspective, it frees up a bed which could improve patient flow through the hospital, thereby reducing pressure and increasing efficiency, while also reducing waiting times for patients. For the broader health system, cheaper healthcare that produces equivalent or better health outcomes reduces pressure on private health insurance premiums and is better value for the taxpayer.

Recovery after stroke

For patients who have suffered a stroke, there is strong evidence to support early discharge with rehabilitation at home (also known as early supported discharge) for some patients, compared with the traditional approach where these patients receive a substantial part of their rehabilitation in hospital.

A systematic review of 14 randomised controlled trials found that early supported discharge for selected patients following a stroke can reduce long-term dependency and admission to institutional care, as well as the length of hospital stay (a reduction of seven days on average). Success was greater with good resourcing and governance, and in patients with less severe strokes.[8]

A subsequent study on 293 patients with stroke in the United Kingdom investigated how early supported discharge for patients with stroke is now working in practice. The study revealed that early supported discharge can result in equivalent of better outcomes for mild to moderate stroke, as well as significantly reduce the length of hospital stay. Additionally, early supported discharge accelerated the recovery of mild to moderate stroke over a one-year period, compared with non-early supported discharge patients.[9]

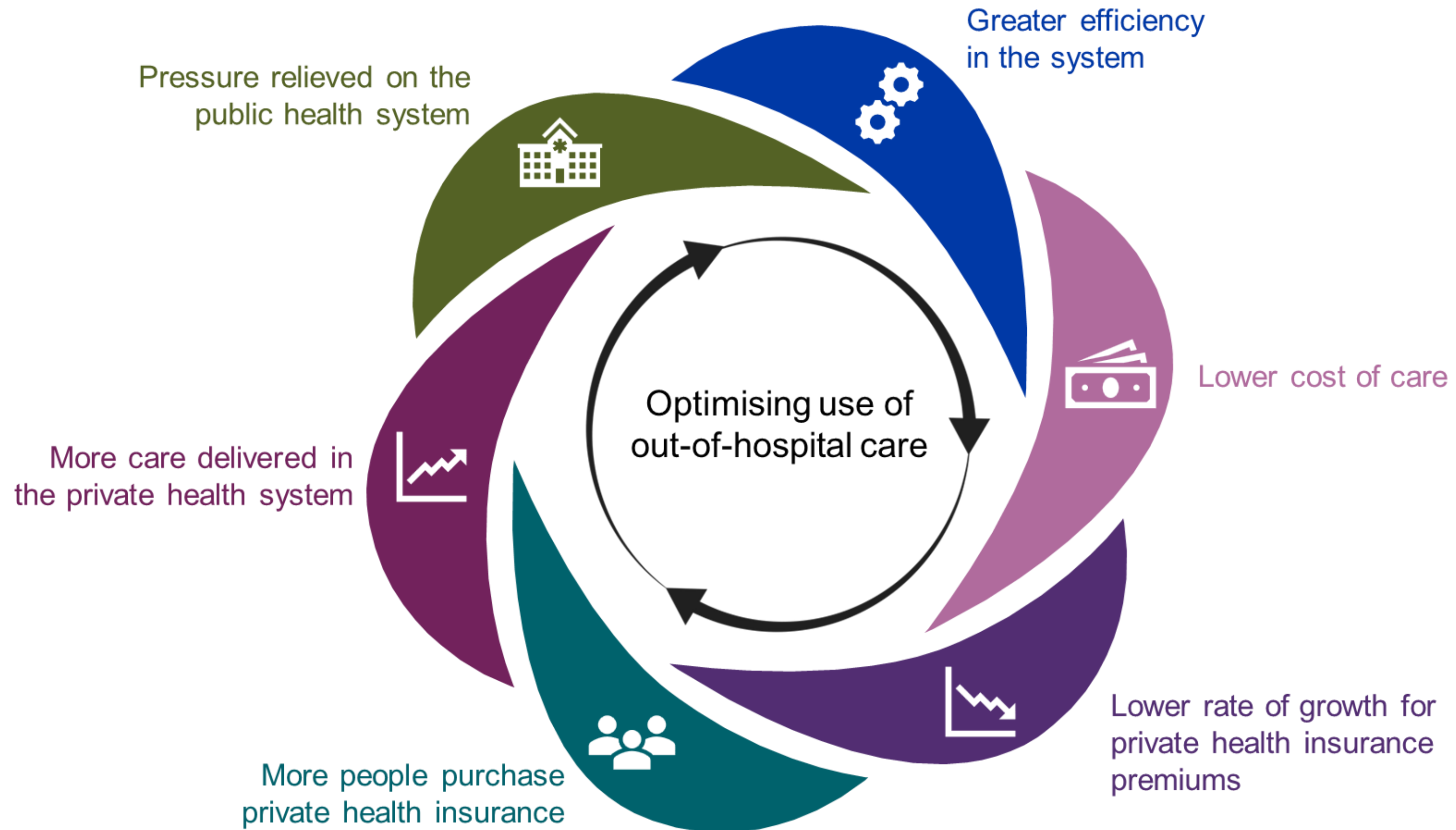
Care outside of hospital for mental illness

Mental illnesses are complex, which makes it challenging to conduct high-quality studies comparing the effectiveness of inpatient and out-of-hospital care. Patients with mental health issues have specific needs, and they often experience chronic illness punctuated with acute episodes, which blurs the line between aftercare and preventive care. These factors make it challenging to analyse clinical outcomes and the effectiveness of different models of care. Additionally, because of the differences in how mental health is delivered across healthcare settings and between different countries, interpreting research and applying learnings to a new context is challenging.

From the evidence that is available, studies suggest that high quality out-of-hospital psychiatric care (in its broadest sense, meaning any care that does not take place in a hospital) can lead to comparable[10] or improved health outcomes[11] for patients, and reduce re-admissions[12] and days spent[13] in hospital. Psychiatric treatment at home also has the potential to reduce the stress and disruption sometimes associated with an acute episode of illness, providing the patient is suitable for home care. Additionally, psychiatric care outside of hospital is likely to be lower cost,[14] though it could result in greater out-of-pocket costs for patients (compared to admitted care) if private health insurers are not required to cover the patient's bills.

It is clear that the benefits of out-of-hospital care are significant, and while not all patients are suitable, there are opportunity costs associated with keeping those that are suitable in hospital when they could have the same or even better health outcomes with out-of-hospital care. In a private hospital, beds that are used more efficiently allow patients to move through the system more quickly, thereby opening up space in the market and creating a more efficient private health system overall. As a result, capital expansion of the hospital (i.e. the creation of more beds) could be avoided or delayed. Having a more efficient private health system means that the cost per transaction in the private system is lowered. This would create a positive reinforcing cycle which would generate better value for government and the taxpayer (Figure 1). Australia's public-private hybrid system relies on a strong and thriving private health system, with private hospitals undertaking two thirds of elective surgeries,[15] and providing 34 per cent of Australia's intensive care capacity.[16] Improvements in the private system will relieve pressure on the public hospitals and the public system more broadly.

Figure 1: Positive reinforcing cycle of a more efficient private health system



The concept that out-of-hospital models of care would be effective in the private health system is not new. In 2016, the government established the Private Health Ministerial Advisory Committee (PHMAC), with the Improved Models of Care Working Group tasked with providing advice to PHMAC on options for the funding and provision of mental health and rehabilitation services in alternative settings to hospitals. While the working group met several times, the recommendations were not entirely operationalised by the sector,[17] and additional government-led reform was not undertaken following the 2019 federal election. In addition, the commitments in the 2020–21 federal budget to expand home and community-based mental health and rehabilitation care were not implemented in April 2020 as announced, and to date have not been progressed.[18] The lack of progress has led to calls from sector stakeholders including Catholic Health Australia and Private Healthcare Australia for government to take action. The 2023 Ernst and Young report *Study of private health insurance minimum and second-tier default benefit arrangements* — commissioned by the Commonwealth Department of Health and Aged Care — noted that:

> Hospital-in-the-home is a model of care that can be more cost efficient than in-hospital services, and the option to receive hospital-in-the-home care is valued by consumers.[19]

In developing this report, the AMA consulted with more than 30 stakeholders, including medical practitioners, insurers, peak bodies, private hospitals, day hospitals, and patients. It was clear from this consultation that the AMA is not alone in calling for reform to the out-of-hospital sector, with almost all stakeholders agreeing that reform would benefit patients and the health system. It is time for the sector to build on this common ground and deliberately design models of out-of-hospital care that are patient-centred and clinician-led.

Total knee replacement out-of-hospital rehabilitation

Rates of knee replacements in Australia (and internationally)[20] have been rising each year since 2003, with an increase of 174 per cent in the private system and 67.3 per cent in the public system between 2003 and 2021.[21] In 2021, 77.2 per cent of all knee replacement procedures reported were undertaken in private hospitals.[22] For total knee replacements specifically (also referred to as total knee arthroplasty), 59,474 were reported in 2021, of which 45,353 were performed in the private system.[23]

Total knee and hip replacements are the biggest cost to the healthcare system of all medical procedures, largely due to volume.[24] A significant portion of this cost is attributed to postoperative inpatient rehabilitation.[25] Naylor et al. (2017) reported that two large private insurers in Australia had indicated the cost of inpatient rehabilitation to be $8,400 ($700/night for 12 nights at 2015 prices).[26] This estimate aligned with the study's findings, which revealed a median cost of $9,978 ($7,599–11,841) for inpatient rehabilitation.[27] The duration of inpatient rehabilitation following a total knee replacement is estimated to be around 10 days.[28,29]

Studies show that, for clinically eligible patients, rehabilitation in the home can produce comparable recovery outcomes to inpatient rehabilitation,[30,31] often at a lower cost.[32] While studies on the proportion of clinically eligible patients in the private system are limited, consultation with industry experts in 2022–23 indicates that 70–80 per cent are eligible. This is consistent with an estimate for knee replacement (not specifically total knee replacement) of 79 per cent of patients being clinically eligible.[33]

With studies suggesting that around 60 per cent of total knee replacement patients currently receive out-of-hospital rehabilitation,[34] this suggests that the 'missed opportunity' is 10–20 per cent.

A recent report by Medibank estimated rehabilitation in the hospital to be $9,000, and rehabilitation in the home to be $2,800, a cost difference of $6,200 ($6,419 if adjusted to 2023 prices).[35] Studies also suggest that rehabilitation in the home is often more convenient and comfortable for patients, as it allows recovery in a familiar environment.[36,37] While the duration of inpatient rehabilitation — and therefore the cost difference between inpatient and in the home rehabilitation — will vary depending on the patient's specific circumstances and care requirements, consultation with industry experts in 2022–23 supports an average duration of 10 days for inpatient care.

The AMA estimates that if all clinically eligible patients received out-of-hospital rehabilitation for total knee replacements, it would save around 47,000–94,000 bed days and $31.3–62.7 million per year (in 2024).[38] The number of bed days (Figure 2) and the potential savings (Figure 3) would continue to grow each year. This provides an indication of the potential savings if out-of-hospital rehabilitation was available to clinically eligible patients across all possible procedure and treatment categories (such as other orthopaedic procedures, stroke rehabilitation, mental health, and palliative care). The positive economic impact would also be broader than this, as patients may also experience reduced risk of infection, reduced travel (when the patient receives care in the home), enablement of work from home, and improved ability to manage caring responsibilities.

Figure 2: Bed days saved from out-of-hospital rehabilitation for total knee replacements[39]

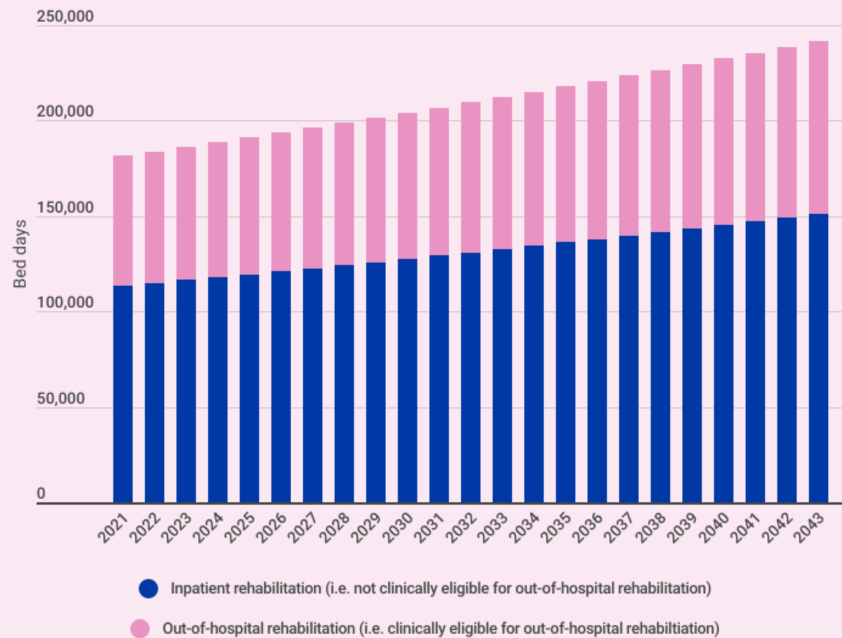
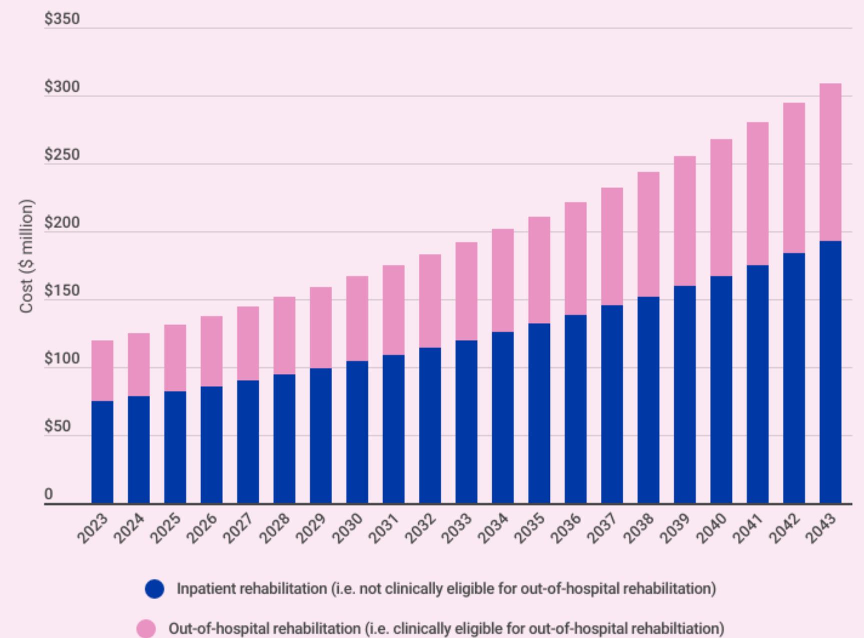


Figure 3: Savings from out-of-hospital rehabilitation for total knee replacements[40]



CURRENT PRIVATE OUT-OF-HOSPITAL MODELS

The following examples of out-of-hospital models of care demonstrate some of the approaches to delivering services outside traditional hospital settings.

Private hospital: Ramsay Connect, Hospital Care at Home and Rehab at Home

Ramsay Health Care is a group of private hospitals, and Ramsay Connect is a national provider of home and community-based healthcare and support, including hospital substitution programs such as Hospital Care at Home and Rehabilitation at Home. The Hospital Care at Home program enables patients to receive hospital services, such as wound care and intravenous antibiotics, in the comfort of their homes, and the Rehabilitation at Home program provides rehabilitation, reconditioning, and healthcare services following joint replacements, fractures, falls, neurological conditions, respiratory conditions, and cardiac conditions. Under both programs, patients can access nursing, physiotherapy, home care, personal care, meals, and occupational therapy services. Access to these programs requires a medical practitioner to determine that the patient is clinically eligible and to refer the patient into the program. Services are provided through Ramsay Health Plus and Remedy Healthcare.[41] Ramsay Connect has arrangements in place with some private health insurers, including some but not all major insurers.[42]

Private health insurer: Medibank Rehab at Home

Eligible Medibank policyholders can access the Rehab at Home program to receive rehabilitation at home after a total joint replacement or 'general rehab' after complications following surgery, medical conditions such as heart or lung disease, stroke, injuries or fractures following a fall, and recovery from cancer treatment. Following a total joint replacement, patients will receive between six and eight physiotherapy treatments and one to two nursing visits over a four to six week period. Under general rehab, patients will receive services for up to six weeks, depending on clinical complexity and progress. A referral from a treating health professional is required to access the program, as well as assessment that the patient is clinically appropriate.

Physiotherapy services are provided by the specialised in-home service provider Home Support Services, which, like many of the out-of-hospital services provided by Medibank, is owned by the Medibank group.[43]

Private health insurer: nib Health Care @ Home

The nib Health Care @ Home program offers eligible nib policyholders a range of at home services, including chemotherapy, orthopaedic rehabilitation, haemodialysis, intravenous therapy, and wound care. For each of these services, nib has partnered with various third-party providers, including Kinship and View Health chemo@home for chemotherapy, Honeysuckle Health for orthopaedic rehabilitation, Dialysis Australia for haemodialysis, and Vitalis for intravenous treatments and wound care.[44] These third-party providers also partner with several other private health insurers.

Private health insurer: Bupa Mind Care Choices

Eligible Bupa policyholders can receive mental health treatment in the community as an alternative to traditional hospital care as part of the Mind Care Choices program. Treatment and support can be delivered in a variety of ways, including home visits, in community settings, in-clinic appointments, telehealth, and group activities. For patients to be eligible, they must have Bupa hospital insurance with full cover for hospital psychiatric services, and they must have experienced one or more overnight admissions to a private hospital. Entry to the program is via invitation from Bupa or a referral from a treating psychiatrist or general practitioner. While having a current treating psychiatrist or general practitioner is one of the eligibility criteria for the program, it is not clear whether these doctors are involved in the program.[45]

Risks of current out-of-hospital models of care?

In the absence of independent leadership and oversight, it is clear that the current out-of-hospital options available to patient have been designed in isolation of each other, resulting in a piecemeal and fragmented landscape. Additionally, many of these insurer-led out-of-hospital models have been developed by for-profit insurers and are not always accessible to all clinically eligible patients.

Private health insurers have responded to a gap in the market and perceive out-of-hospital care programs as an effective means to enhance the value proposition of private health insurance for consumers, drive innovation in healthcare, while simultaneously reducing costs by minimising hospital stays.

While this may result in positive outcomes for particular patients and parts of the system more broadly, the mechanisms used to achieve this — selective or restrictive contracting and vertical control — may be leading Australia down a United States-style managed care pathway.[ii] Additionally, private health insurers are directing their policyholders to receive care from their own subsidiary companies or third-party providers, which may not be in the best interest of the patient.

This concern was also highlighted by Ernst and Young (2023):

> However, in the United States insurers with large market power and a large share of the consumer population are able to influence consumers to use only "in-network" providers that they contract with. Consumer influence occurs as insurer contracts provide discounts to the cost of "in-network providers" services while out-of-network providers have no associated benefits, potentially leading to higher costs for the consumer. A similar trend has been observed in some aspects of the Australian healthcare market (for example, with allied-health services such as no-gap dental treatments with insurer-approved providers).[46]

The report also raised concerns regarding private health insurers using contracting with medical practitioners to influence patient care pathways:

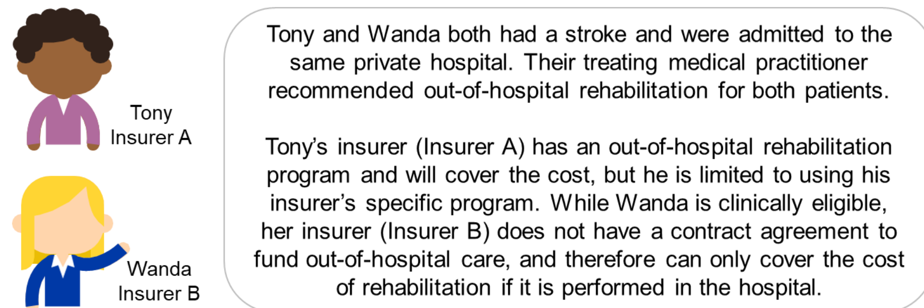
> There have been specific issues of varying severity that negatively impact the competitiveness and effectiveness of the private health industry. These include insurers using contracting with medical practitioners to disincentivise them operating in second-tier funded facilities, which arguably undermines the intent of default benefits in supporting consumer access.[47]

[ii]Managed care refers to a healthcare system or approach that aims to control and coordinate the delivery of medical services while also managing costs.

An unequal landscape

Insurer-led out-of-hospital care has created an unequal landscape for Australian health consumers, as their access to these models of care is contingent on their insurer's provision or coverage of these services (Figure 4). Consultation with major providers revealed that around 40 per cent of patients are unable to access out-of-hospital care either because their insurers do not have their own out-of-hospital program and/or do not have agreements with other out-of-hospital providers. This undermines the government's work in recent years to create easily comparable policies across insurers by implementing the 'gold, silver, bronze, basic' insurance reforms, and has made it challenging for patients to compare policies.

Figure 4: Impact of an unequal landscape



Absence of a safety net

For in-hospital treatment, patients are protected by a safety net, in the form of minimum default and second tier benefits (collectively referred to as default benefits).[iii] The safety net protects patient choice and clinical autonomy, as highlighted by Ernst and Young (2023):

> Overall, default benefit arrangements do support consumer access to and choice of services by:
>
> - Providing a safety net in the case that future contracts cannot be agreed, to support the continued provision of services for consumers.
> - Providing a safety net in the current inflationary environment, which may lead to more protracted and potentially disputed future contract negotiations, increasing the utilisation of second-tier default benefits.
> - Providing support for new hospitals until they are able to secure contracts with insurers. There may be some trade-off between reducing barriers to entry and potentially supporting an oversupply of services, which is difficult to decide between at this stage.
> - Providing funding for certain services, such as ophthalmology and rehabilitation, which are funded more often by second-tier default benefits.[48]

[iii]There are two types of 'default benefits': minimum benefits and second-tier default benefits. Minimum benefits are an amount the insurer is required to pay for a hospital admission that is covered on a private health insurance policy. Second-tier benefits are a benefit amount (85 per cent of the average hospital cost) paid to second-tier eligible hospitals where a contractual agreement between the insurer and hospital is not in place.

The report highlighted that out-of-hospital care does not have a similar safety net and concluded that the current contracting arrangements and default benefits do not encourage or support the provision of out-of-hospital care, resulting in inconsistencies in the accessibility of out-of-hospital programs for patients, which can "limit access and be confusing for consumers, as well as hospitals and insurers".[49] This means that a patient's private health insurer may not cover the cost of the out-of-hospital care if they don't have a contract arrangement with that private hospital (Figure 5).

Figure 5: Impact of no safety net for out-of-hospital care

Natasha

Natasha has been treated for an acute mental illness episode at a private hospital. Her treating medical practitioner recommends that she receive out-of-hospital treatment, however Natasha's insurer will only cover the cost of her care in hospital, as the insurer's contract with the hospital is weighted towards in-hospital treatment. This means if Natasha wants to receive out-of-hospital mental health treatment, her private health insurance will not be able to cover it.

The absence of a safety net for out-of-hospital care is currently preventing the out-of-hospital sector from developing further. This is because private health providers, medical practitioners, and patients need to know that private health insurers will pay for the treatment, before undertaking the extensive work of developing these models. This has resulted in a situation where many stakeholders in the sector feel there is too much financial risk to invest in and develop the out-of-hospitals sector, without any guarantee of uptake, as highlighted by Ernst and Young (2023):

> Hospital stakeholders have highlighted the large up-front investment required to establish hospital-in-the-home services to demonstrate their success to health insurers until they are able to negotiate contracts with each fund to pay for the innovative service.[50]

Undermining of clinical autonomy

The current piecemeal approach to designing out-of-hospital models of care has resulted in these models of care potentially undermining clinical autonomy. For example, consultation with stakeholders revealed that some patients are being offered out-of-hospital treatment programs by their insurer, without any consultation with the treating practitioner (Figure 6).

Figure 6: Impact of insurer-led out-of-hospital care undermining clinical autonomy

Steven

Steven received episodic care in a private hospital for a psychiatric condition, and was subsequently approached by his insurer to take part in an out-of-hospital program, provided by a subsidiary company of his insurer. He takes part in the program under the care of allied health practitioners, without the involvement of his treating psychiatrist and general practitioner. This disrupts his continuity of care and undermines the treatment plan that was developed with his treating team.

In addition, stakeholder consultation revealed that private health insurers may be influencing whether patients are selected for out-of-hospital care through clauses in the contracts between private hospitals and insurers, therefore undermining the decision made by the treating clinicians and the patient. For example, major providers reported that a private health insurer may refuse to pay for an out-of-hospital treatment (by rejecting the referral), and then subsequently refer the patient into their own insurer-led out-of-hospital program.

This is one of the risks of vertically controlled healthcare, as insurers have the ability to direct patients into their own programs, instead of the one chosen by the patient and their treating clinician, to reduce the overall cost of care. Stakeholder consultation revealed that in some cases, the treatment provided in the alternative program offered by the insurer may not be equivalent to that of the one initially chosen by the patient and their treating clinician (Figure 7).

Figure 7: Impact of insurers providing non-equivalent insurer-led out-of-hospital care

Jane had a hip replacement in a private hospital, and her treating medical practitioner recommended that she receives out-of-hospital rehabilitation through the private hospital. Her insurer declines the referral, and instead offers a non-equivalent service provided by a subsidiary company of the insurer. Jane's treating medical practitioner instead suggests that she undertake rehabilitation in the hospital to ensure she receives the appropriate care.

The need for deliberate design

The above examples illustrate how the current fragmented and piecemeal approach to designing out-of-hospital models of care has created a situation that puts consumer rights, patient choice, and clinical autonomy potentially at risk. The situation that we are in can, in part, be attributed to a lack of independent oversight and coordinated reform across the private health system.

If the benefits of out-of-hospital care are to be fully realised, we need deliberate design of these models of care that embodies the principles of the Australian health system and puts the patient at the centre. This includes ensuring out-of-hospital care is market-led and paid for by private health insurers and can be accessed by any private patient (providing they have the appropriate level of cover) regardless of who their private health insurer is. That is, no one owns or monopolises these models of care, but rather the patient can choose from a range of services under the guidance of their treating medical practitioner, with peace of mind that their insurer will cover the cost, providing the services meet the appropriate clinical standards, guidelines, and frameworks.

To achieve this, the AMA is calling for the establishment of an independent and well-resourced Private Health System Authority to create a platform for these reforms (see *A whole of system approach to reforming private healthcare*). The AMA's Private Health System Authority should be guided by key principles — that are collectively agreed upon by the sector — to underpin the deliberate design of private out-of-hospital care.

PRINCIPLES THAT SHOULD DEFINE PRIVATE OUT-OF-HOSPITAL CARE

The AMA believes the following principles should define out-of-hospital care:

Summary of the principles for out-of-hospital care

Quality and safety

To ensure equivalent or improved clinical outcomes for patients, compared to those who receive treatment in hospital

- Agreed quality and safety standards should be met by providers of out-of-hospital care.
- Treatment should be carried out by healthcare professionals of appropriate qualification and training, as advised by the treating medical practitioner.

Patient protection

To protect patients and also ensure that new models of care in the private health system do not create increased burden for the public health system

- Out-of-hospital care models should include protocols for managing patient deterioration/re-escalation of care. Among other elements, these should specify from a clinical governance perspective who is responsible for an adverse outcome and escalation of care, and include appropriate funding should the patient need readmission.
- Data capture, monitoring, and evaluation should be included in the design of all out-of-hospital programs, to measure efficacy and further develop the evidence-base on out-of-hospital care.

Patient choice and clinical autonomy

To ensure doctors have the freedom to make the best clinical decision in collaboration with their patients

- A minimum guaranteed payment scheme must be implemented to ensure that the private health insurer pays for any out-of-hospital service chosen by the medical practitioner and the patient the doctor and patient (provided they have the appropriate level of cover), within reasonable cost limits.
- Regulation must be implemented to prevent insurers and hospitals from influencing whether a patient is selected for in-hospital or out-of-hospital care.
- National, consistent guidelines must be developed for out-of-hospital programs to ensure private health insurance policies remain easily comparable.
- Patients should not be diverted to an out-of-hospital program, or to lower intensity care, without agreement from their treating medical practitioner.

Quality and safety

To ensure equivalent or improved clinical outcomes for patients, compared to those who receive treatment in hospital

Agreed quality and safety standards should be met by providers of out-of-hospital care.

Depending on how they are designed and implemented, models of care that shift treatment from the hospital to a patient's home or a community setting have the potential to impact the quality, safety, intensity, and frequency of care, and may therefore result in poorer clinical outcomes for the patient. Robust quality and safety standards, underpinned by clear clinical governance arrangements, must be implemented to ensure that out-of-hospital models of care do not result in lower quality care or inappropriate standards.

Agreed quality and safety standards should be met by providers of out-of-hospital care. Medical practitioners need to know that the programs they are referring their patients to are evidence-based and delivering a high standard of care. In particular, people with mental illness require clearly defined and properly coordinated care of both their physical and mental health via their general practitioner and psychiatrist. Delivery of this care must be underpinned by care from an appropriately skilled workforce that is governed by recognised accreditation standards. The responsibility of accreditation must not be entrusted to private health insurers, as they are not impartial (especially when they have a financial relationship with the healthcare provider). The accreditation process should be developed by an appropriate government body. The Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards could be leveraged to design quality and safety standards for out-of-hospital care.

Treatment should be carried out by healthcare professionals of appropriate qualification and training, as advised by the treating medical practitioner.

In out-of-hospital programs, there is the potential for healthcare professionals to be substituted with healthcare professionals from different professions than those typically used in a hospital setting for that specific condition and its severity (for example, psychiatrist to psychologist, or rehabilitation specialist to physiotherapist). It is essential that the qualification of the health professional matches the patient's need, as advised by the treating medical practitioner. Additionally, it is crucial that private health insurers do not substitute appointments or treatments or suggest alternative care pathways for patients without consulting the patient's treating practitioners.

Where access to community based mental healthcare is offered to patients in substitution for services that might otherwise be delivered in a private hospital setting, this should only be permitted where it is in the best interests of the patient as mental health hospitalisations are generally for very acute mental health issues. Arrangements that simply allow substitution of care to a lower intensity or less skilled practitioner where it is not in the best interests of that patient must not be supported. In some circumstances however, out-of-hospital models may offer increased opportunity to provide mental health at a clinically appropriate community level instead of requiring a hospital admission for a patient to access specialist treatment.

Patient protection

To protect patients and also ensure that new models of care in the private health system do not create increased burden for the public health system

Out-of-hospital care models should include protocols for managing patient deterioration/re-escalation of care. Among other elements, these should specify from a clinical governance perspective who is responsible for an adverse outcome and escalation of care, and include appropriate funding should the patient need readmission.

With all out-of-hospital models of care, there is a risk that patients may deteriorate at home and require re-escalation of care. This is particularly the case in mental health where a patient may have residual suicidality. It is crucial that out-of-hospital care models be designed so that patients who deteriorate and need to be readmitted to hospital know their options for care re-escalation, and who to contact for help.

Stakeholder consultation revealed that hospital-in-the-home programs result in an increase in public hospital emergency department presentations from patients whose conditions have deteriorated while in a hospital-in-the-home program. Out-of-hospital care models in the private health system must be designed so that if a patient's condition deteriorates, they are stewarded back to their private hospital through their own out-of-hospital team wherever possible, with presentation to an emergency department only when necessary. Achieving this will require implementation of an agreed stepped protocol so that patients and their treating team know what to do when a patient deteriorates in an out-of-hospital setting, or if a patient expresses a preference to transition to in-hospital care. Among other elements, protocols should specify from a clinical governance perspective who is responsible for an adverse outcome and escalation of care.

While a stepped protocol should mitigate some of the potential burden on public hospitals, public hospitals may still see an increase in emergency department presentations from patients in these out-of-hospital programs. Out-of-hospital programs must therefore work together with public hospitals (and other private hospitals that have private emergency departments) and ambulance services to ensure they are aware of this potential risk and are informed of the stepped protocol. This risk can also be mitigated through national eligibility guidelines (to select patients who are most likely to benefit from out-of-hospital care and whose condition is less likely to deteriorate in an out-of-hospital setting), which should be reviewed and updated through monitoring and evaluation. An array of guidelines currently exist for out-of-hospital programs delivered now across the public and private health systems and could be leveraged to support the development of national guidelines.

Additionally, the Improved Models of Care Working Group considered a range of industry guidelines, and this work could be continued under the leadership of a Private Health System Authority. In the event of an unplanned re-admission or presentation to an emergency department, it is crucial that patient records can be accessed by the relevant healthcare professions (including information regarding the patient's out-of-hospital care), and timely clinical handover is possible. Information regarding the patient's presentation to the emergency department must then be communicated back to the out-of-hospital care team. Additionally, patients receiving out-of-hospital care should not incur any out-of-pocket expenses that would have been otherwise avoided if had they deteriorated as an inpatient. The ACSQHC NSQHS Standards for Recognising and Responding to Acute Deterioration could be leveraged in the design of a stepped protocol.

In addition, a challenge with public hospital-in-the-home programs is that patients are unable to access other MBS services while they are in the program when they are classified as an in-patient (for example, a patient receiving rehabilitation in the home is unable to receive a rebatable MBS service from their general practitioner for care unrelated to their rehabilitation, such as a prescription). This creates significant challenges when delivering coordinated and patient-centred care. Out-of-hospital models of care in the private health system must therefore have no limitations on patients accessing services that are unrelated to their out-of-hospital care program.

Data capture, monitoring, and evaluation should be included in the design of all out-of-hospital programs, to measure efficacy and further develop the evidence-base on out-of-hospital care.

Data capture, monitoring, and evaluation — within a robust patient-outcome focused risk governance framework — should be included in the design of all out-of-hospital programs to ensure that these models of care achieve their intended goals of reducing costs of healthcare while also providing care that is more convenient for the patient. Monitoring and evaluation data should be used to update protocols, frameworks, and guidelines to ensure they remain contemporary and best-practice. For example, analysis of why a patient's condition may deteriorate can be used to update guidelines on eligibility for out-of-hospital models of care. Additionally, the impact of private out-of-hospital models of care on the public sector — in particular public hospital emergency departments — should be assessed to ensure that these models of care are not burdening other parts of the health system.

Patient choice and clinical autonomy

To ensure doctors have the freedom to make the best clinical decision in collaboration with their patients

A minimum guaranteed payment scheme must be implemented to ensure that the private health insurer pays for any out-of-hospital service chosen by the medical practitioner and the patient (provided they have the appropriate level of cover), within reasonable cost limits.

Ultimately, if Australia is to realise all the benefits of a mature private out-of-hospital sector, the checks and balances that exist in the form of default benefits for inpatient treatment to protect patient access and choice must be replicated across the out-of-hospital sector. These checks and balances have been refined and simplified over time and provide an ideal framework to introduce consumers to this new environment.

The regulatory mechanism might take the form of a style of minimum default, or an average fallback price (i.e. similar to second-tier benefits) to cover out-of-hospital care. Alternatively, a pricing framework for out-of-hospital care (similar to the framework that exists for public hospital services) could be developed, creating a price signal for the market and providing surety of funding and clarity for all stakeholders. The pricing framework could include a market price, a price list (similar to the idea behind the Protheses List), or the average efficient price of delivering the service (similar to the National Efficient Price used in the public hospital sector), or a default or fallback price (for example, 85 per cent of the average cost of delivering the service in a like setting, which is similar to the second tier benefits used in the private hospital sector).

It is worth noting that Ernst and Young (2023) recommended the introduction of an independently set funding model to determine default rates:

> Second-tier default rates (and optionally minimum default benefits) would be determined by an independent body using a funding model to determine a benchmark price alongside weighted activity units for services. This could be similar to the National Efficient Price (NEP) model which underpins activity-based funding for public hospital services.[51]

The report also noted:

> The independently set funding model could be designed to provide a framework for broader insurer funding of care types such as hospital-in-the-home where appropriate.[52]

There is therefore an opportunity to leverage this work as part of designing a safety net for out-of-hospital models of care. Regardless of the mechanism, a solution that provides surety of funding that protects patient access and choice must be legislated if these models are to be successful.

Regulation must be implemented to prevent insurers and hospitals from influencing whether a patient is selected for in-hospital or out-of-hospital care.

Stakeholder consultation revealed that private health insurers can currently influence whether patients are selected for out-of-hospital care through clauses in the contracts between insurers and private hospitals or doctors. This undermines clinical autonomy and will need to be prohibited and monitored through regulation. Patients and their treating medical practitioners must have the autonomy to choose whether a patient is suitable for out-of-hospital care, and what type of out-of-hospital care, to ensure that the patient receives the right care and the right time. Patients should also have the option to return to an in-hospital model.

National, consistent guidelines must be developed for out-of-hospital programs to ensure private health insurance policies remain easily comparable.

National, standardised, and consistent guidelines that include common terminology and definitions for out-of-hospital programs must be developed to ensure private health insurance policies remain easily comparable. These guidelines should be informed by all stakeholders in the private health system. Without these guidelines, the work undertaken by government to create easily comparable policies across insurers by implementing the 'gold, silver, bronze, basic' insurance reforms will continue to be undermined.

Patients should not be diverted to an out-of-hospital program, or to lower intensity care, without agreement from their treating medical practitioner.

Stakeholder consultation revealed instances where private health insurers have used patient data to recommend out-of-hospital programs, without agreement from the treating medical practitioner. This was especially notable among patients who frequently require in-patient psychiatric care, with these patients offered out-of-hospital programs involving allied health services, with the intention of lowering the overall cost of treatment.

While data collection is important for improving patient health outcomes, private health insurers should not be using patent data to recommend treatments or supports for a patient without consulting their treating medical practitioner. Diversion of patients without the knowledge of their treating medical practitioner poses significant risks, particularly for patients receiving ongoing treatment for mental illness. For the protection of the patient, no patient should be diverted to an out-of-hospital program, or to lower intensity care, without consultation with their treating medical practitioner. Decisions regarding a patient's care must be made by the patient and their treating medical practitioner, not the private health insurer or private hospital.

OTHER CONSIDERATIONS FOR REFORM

It is important to note that a greater move towards out-of-hospital care could result in costs being shifted onto the patient. This should be offset as much as possible, with private health insurers covering the full cost of rehabilitation, including equipment and medicines, just as they would do for in-hospital care.

Furthermore, private hospitals may face adverse consequences if the shift towards increased out-of-hospital care occurs too rapidly. If all the clinically simpler cases are directed towards out-of-hospital settings, and all more complex cases are managed in-hospital, private hospitals could encounter significant financial and workflow challenges. Consultation with stakeholders revealed that some private hospitals are currently struggling to remain viable, and therefore the transition will need to be carefully managed to ensure the continued financial sustainability of private hospitals. Ultimately, Australia’s health system relies on the health of the private system, and therefore private hospitals must be able to sustainably deliver all the care that cannot be delivered through these out-of-hospital models.

Additionally, implementing a sustainable approach would grant private hospitals additional time to adapt and establish their own out-of-hospital initiatives. The development of the out-of-hospital sector needs to be deliberately designed to fully realise its benefits while also protecting patients and private hospitals.

Careful consideration must also be given to the financial and workflow implications for medical practitioners and other healthcare professionals who participate in these programs. It is essential to ensure that reimbursement structures adequately compensate healthcare professionals for their services, covering the costs associated with providing high-quality care including via remote clinical oversight. Additionally, particularly for out-of-hospital programs that a patient may access for several months (such as mental health programs), sustainable funding models should be developed to support long term participation of healthcare professionals in these programs.

RECOMMENDATION AND CONCLUSION

The AMA is disappointed that little seems to have changed on out-of-hospital care since the Improved Models of Care Working Group reported on rehabilitation and mental health to the PHMAC in 2016. It is clear that the benefits of out-of-hospital care are significant, and while not all patients are suitable, there are opportunity costs associated with keeping those that are suitable in hospital when they could have the same or even better health outcomes with out-of-hospital care. Optimising use of out-of-hospital care in the private sector would create a positive reinforcing cycle which would generate better value for government and the taxpayer, and ultimately relieve pressure on public hospitals.

To create a platform for this reform, the AMA is calling for the establishment of an independent and well-resourced authority — a Private Health System Authority — to bring together all the players in the sector to build a better system. The Private Health System Authority would have the capacity, objectivity, and expertise to ensure robust mechanisms are in place to balance the interests of all sector stakeholders in the delivery of innovative, patient-centric, clinician-led care. The Private Health System Authority should be guided by key principles — that are collectively agreed upon by the sector — to underpin the deliberate design of private out-of-hospital care. Key to this will be a minimum guaranteed payment scheme for out-of-hospital care to create surety of funding and protect patient choice and clinical autonomy.

Australia's private health system is undeniably complex, and this complexity as well as a lack of leadership has contributed to the stagnation of reform efforts. There is however unanimous agreement in the sector that reform is needed, and the deliberate design of out-of-hospital models of care represents a promising avenue to demonstrate how the collective efforts of the sector can bring about meaningful change that is a win for everyone. Under the leadership of an independent Private Health System Authority, the sector can build on this common ground and deliberately design models of out-of-hospital care that are patient-centred and clinician-led. The AMA is committed to ensuring that this reform is not abandoned, as it holds the key to unlocking the full potential of Australia's private health system.

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39. This analysis projects the number of bed days needed for private inpatient total knee arthroscopy rehabilitation over the next 20 years, using the number of private total knee arthroscopies that took place in 2022 as a baseline (from the Australian Orthopaedic Association National Joint Replacement Registry). It assumes that 40 per cent of patients are currently having inpatient rehabilitation, the size of the missed opportunity for OOH rehabilitation is 19 per cent, and the difference in length of hospital stay between inpatient and OOH rehabilitation is 10 days. The analysis is in nominal terms, assuming a population growth of 1.3 per cent, indexation of 1.0 per cent, and inflation of 2.5 per cent. The projection has not been adjusted to account for the ageing population, which is related to the growth in knee replacement surgeries (all types) seen year on year since 2003. This means that the projected bed days saved are likely to be conservative estimates.

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40. This analysis projects the savings over the next 20 years if all private total knee arthroscopy patients clinically eligible for out-of-hospital rehabilitation were able to have it. It assumes 40 per cent of patients are currently having inpatient rehabilitation, the size of the missed opportunity for OOH rehabilitation is 19 per cent, the difference in length of hospital stay between inpatient and OOH rehabilitation is 10 days, and the difference in cost between inpatient and out-of-hospital rehabilitation is $9,604 (adjusted to $11,354 in 2022 prices). The analysis is in nominal terms, assuming a population growth of 1.3 per cent, indexation of 1.0 per cent, and inflation of 2.5 per cent. The projection has not been adjusted to account for the ageing population, which is related to the growth in knee replacement surgeries (all types) seen year on year since 2003. This means that the projected cost saving is likely to be conservative estimates.
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Note: Cost difference was adjusted from $9,604 in 2014-15 to $11,354 in 2022 prices.

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