RMSANZ
Rehabilitation Medicine Society of Australia and New Zealand

Monday 15th January 2024

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Dear Mr Richard Beasley SC

Submission of the Rehabilitation Medicine Society of Australia and New Zealand to the special commission of inquiry into Health Care funding.

Our submission will restrict itself to matters raised in the terms of reference and will briefly familiarise the commission of inquiry on our role in the NSW healthcare sector.

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Rehabilitation Medicine Society of Australia and New Zealand

Executive Summary

1. Every major hospital in NSW has a department of rehabilitation medicine (subacute care), which delivers aspects of the NSW model of care in rehabilitation and manages 10 -15% of the inpatient bed base in the state.
2. NSW hospital rehabilitation infrastructure treat people who suffer disabilities as a result of illness or injury in 4 settings (in- reach – while in acute hospitals, in inpatient rehabilitation wards/hospitals, in the community through outpatient departments and in the home).
3. Rehabilitation service enhancement was shown to improve efficiencies, patient flow, access and produce cost savings through the 2009-2013 subacute enhancement initiatives funded by the Gillard – Rudd Government. In one study of this COAG initiative, for *every $1 spent $4.85 was saved* through improved hospital capacity (17.9 virtual beds in one hospital).
4. NSW health has only variably and partially supported those initiatives since federal funding was ceased in 2013 which has led to worsening access.
5. Over 10% of inpatient rehabilitation beds are occupied by people with new or existing disability, who are awaiting NDIS services or accommodation, with an average extended length of stay of 22-36 days. These costs are not currently recouped from the federal government and represent tens of millions of dollars of potential revenue annually.
6. CEO's are conflicted when having to prioritising resource allocation and capex funding between the acute services sector and the subacute rehabilitation sector. This often results in underfunding of subacute services in order to enhance or continue funding acute services in tertiary hospitals.
7. Hospital boards do not specifically require any member to have understanding of rehabilitation in the subacute sector.
8. There is no rehabilitation directorate or responsible department in the Federal Department of Health. As such all administrative matters, matters relating to the integration of hospital services and NDIS, access to private insurance entitlements by patients in public hospital rehabilitation units and the follow up of any national subacute initiatives must all be directed to the Minister for decision, leading to complex governance structures and a lack of support for subacute rehabilitation services.
9. Workforce issues indicate an underutilisation of allied health assistants and an undersupply of clinical nurse consultants and nurse practitioners in rehabilitation. When they are added to rehabilitation teams, there are significant efficiencies in service delivery.
10. Rehabilitation in the home services are underfunded in NSW leading to an inability to discharge people living with disabilities, earlier from hospital and better integrate them into

community services. Only two services currently operate in NSW hospitals (Campbelltown and Royal Rehab).

Recommendations

Recommendation 1: That dedicated funding be allocated to subacute rehabilitation services for the creating of a suite of rehabilitation services (including in reach services, enhanced inpatient and outpatient capacity and services and a rehabilitation in the home bed base) in order to improve efficiencies and capacity of acute services in NSW public hospitals.

Recommendation 2: That funding to LHDs for subacute services be quarantined for those purposes to ensure an efficient, safe and optimal egress from acute services.

Recommendation 3: That a review take place on the need for capital funding of rehabilitation facilities in state hospitals so that they are fit for purpose.

Recommendation 4: That one member of every LHD board have experience and be familiar with rehabilitation services in the subacute care either as a hospital worker or a consumer.

Recommendation 5: That the NSW government advocate for a subacute care -rehabilitation directorate in the Federal Government's Department of Health to work with NDIS to improve rehabilitation for young people or restorative care in aged care. Further to ensure that there is federal governance and support for the delivery of subacute services including rehabilitation with a focus on the smooth integration of community services such as the NDIS with the state based hospital systems.

Recommendation 6: That the NSW government advocate for the federal government to review the hospital substitution programs for privately insured patients in public hospitals so that medical governance and remuneration of treating doctors are set out and clarified in law (Private Health Insurance Act 2007 and associated regulations).

Recommendation 7: That NSW Health move to recoup the costs of inpatients in public hospital on maintenance care type while awaiting NDIS accommodation and services by negotiating the retrieval of these costs from the Federal Government or have the Federal government accept these costs as a contribution to the NDIS by NSW Health.

Recommendation 8: That NSW Health develop funding streams for rehabilitation flying squads to assess the medical conditions or changes in care need in their home or in NDIS accommodation of people living with disabilities. The aim would be to commence treatment in place and to prevent hospital admission.

Recommendation 9: That emergency departments have allocated subacute funding officers to identify and commence paperwork on those eligible for funded subacute services within 24-48 hours of injury/illness. These officers could also identify those on the NDIS and action rapid and early rehabilitation consultation to ensure efficient passage through the hospital system and the utilisation of carers, available through the NDIS, to assist NSW Health staff.

Recommendation 10: That NSW introduce decision making tools to accelerate time from admission to rehabilitation consultation allowing for earlier rehabilitation.

Recommendation 11: That NSW Health advocates to the Federal Department of Health to enhance capabilities of the Australian Rehabilitation Outcomes Centre (AROC) to form linked data sets with acute state registries including cancer, stroke, joint replacement, trauma etc.

Recommendation 12: That the NSW government support and fund AROC in the development of a health economic index that represents the cost savings of care in the community associated with improved rehabilitation outcome scores achieved in NSW Health's hospital based rehabilitation departments.

Recommendation 13: A greater emphasis of NSW Health in developing training schemes with TAFE for allied health assistants.

Recommendation 14: To commence training positions for CNCs in rehabilitation to develop positions as nurse practitioners.

Recommendation 15: That the NSW government support and fund the development of rehabilitation in the home services in NSW hospitals with a focus improved patient's outcomes and improved cost effectiveness.

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Who are we, what do we do and the available infrastructure for NSW Health?

The Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ) is the peak body representing qualified rehabilitation physicians and registered trainees in Australia and New Zealand and is affiliated with the International Society of Physical and Rehabilitation Medicine and World Health Organisation (WHO)[1]. A major role for the Society is to serve as a medium for advocacy on behalf of rehabilitation physicians in Australia and New Zealand to improve health, function and quality of life of people living with disabilities, with a dedicated and clear focus that is independent and unconstrained by competing interests[2]. Rehabilitation physicians (Addendum 1) manage patients of all ages (including children and the elderly) with medical, musculoskeletal, neurological and deconditioning sequelae of illness or injury. They work in teams of colleagues including allied health professionals, healthcare assistants and nurses, in a defined framework of goal achievement and consumer involvement[3]. Rehabilitation physicians treat people in all settings inpatients, outpatient, in the home and virtually. Every state of Australia has established departments of rehabilitation medicine in metropolitan and large regional hospitals. Each department has similar models of service, which include outpatient rehabilitation and telerehabilitation as well as inpatient rehabilitation on specific rehabilitation wards.

Of NSW's 9000 hospital beds over 1280 are subacute 70% of which are dedicated to rehabilitation. In NSW a clear model of care has been established since 2015 (updated in 2019)[4] that includes inpatient, inreach (the rehabilitation treatment of patients while they receive acute care), outpatient clinics, community rehabilitation in the home and tele rehabilitation, models of care. Variations of these models have been adopted in all states of Australia.

This includes hub and spoke models of service delivery for people living in rural settings who receive treatment from both their local rural hospital with support or from their larger regional centre or networked city hospital. Each department has an integrated team structure and communication with specialist referrers and general practitioners. This communication is integral to many internal processes including discharge planning and community follow up.

We will now turn to the Terms of Reference

A. How the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future

High quality, timely and equitable health care is dependent on the appropriate and efficient use of resources that should lead to improved access for hospital services including clinics and inpatient services.

Access to inpatient beds in NSW is dependent on both hospital admission prevention and timely discharge or egress from the hospital system. Subacute beds and services, specifically those offered through rehabilitation departments are integral to discharging patients from hospital through timely rehabilitation service delivery and transferring patients who are medically stable to a rehabilitation or subacute bed for further inpatient treatment (at a lower bed day cost ($1024/day) compared to acute bed day ($1728/day) costs representing over 40% reduction in bed day costs).[5]

When the rehabilitation service is efficient, there is enhanced patient flow from one service to another, which allows for the efficient use of the acute bed base, and treats people suffering with temporary and permanent disabilities in a variety of settings from inpatient to outpatient to in-home services and virtual services.

These rehabilitation services form a suite of services available through rehabilitation medicine departments for patients who develop temporary or permanent disability through injury or illness or congenitally (i.e inability to walk, inability to make decisions, selfcare or speak). It represents improved quality of care as people living with disabilities can be treated at the right time with the right treatment in the right setting.

However, spending on subacute care has not increased since 2013 and there had been very little injection of funding for capital expenditure in rehabilitation services in NSW for over 20 years. Facilities are aging, often not fit for purpose and some have facilities that are not always accessible for people with disabilities. [6]

In 2009 – 2013 the Gillard-Rudd government increased funding to the subacute sector by over $1 billion (nationally)[7], through the COAG structure. The Hospitals and Health Workforce Reform (HHWR) NPA and the Public Hospital Services (IPHS) NPA was signed in 2008. In it's 2009 report it stated "There is … an urgent need for substantial investment in,

and expansion of, sub-acute services — the 'missing link' in care — including a major capital boost to build the facilities required."

In NSW the COAG funding administered by NSW Health included support and boosting of rehabilitation services. Evidence from this experiment showed that for every $1 spent on rehabilitation services $4.84 was saved in hospital efficiencies and in one hospital's case 17 virtual beds were created by turning over existing beds faster, more efficiently and with better patient outcomes.[8] This has previously been reported in international literature. The federal government was due to review the progress of the of this increase in subacute funding in respect to achieving agreed outcomes[9] in 2011 and did not.

In 2014/15 NSW Health increased funding to CEO's of LHDs to allow for some of the subacute services to continue[10] however, the additional funding was variably used with only some inner city hospitals being able to access partial enhancements.[11]

When subacute funding is sent to LHDs from NSW Health with advice on it's uses, there is a variety of outcomes with a minority of CEO's passing on the entire amounts allocated for use by subacute services.[12]

At a senior administrative level, it is very difficult for subacute services to be seen as equivalent contributors to efficiency in hospitals. Emergency services and other front door services are seen as a priority in hospitals, at board level and during question time in parliament. As such, subacute resources are often redirected to acute care service which is what was seen following the COAG initiatives and when there are pressing needs to fund other acute services, or budgetary imperatives to curtail or cut activity or services. This often results to unintentional perverse incentives and leads to worsening bed block, rather than improving access to acute services.

Recommendation 1: That dedicated funding be allocated to subacute services for the creating of a suite of rehabilitation services (including in reach services, enhanced inpatient and outpatient capacity and services and a rehabilitation in the home bed base) in order to improve efficiencies and capacity of acute services in NSW public hospitals.

Recommendation 2: That funding to LHDs for subacute services be quarantined for those purposes to ensure an efficient, safe and optimal egress from acute services.

Recommendation 3: That a review take place on the need for capital funding of rehabilitation facilities in state hospitals so that they are fit for purpose.

B. How governance structures can support efficient implementation of state-wide reform programs and a balance of system and local level needs and priorities.

LHD boards are constituted by board members as indicated in clause 26 of the 1997 Health services Act[13]. While there are specifications for members to have experience in clinical and other health services, there is no specification of any member to have experience in subacute services. Despite subacute services representing 10 – 15% of the bed base of each LHD, and as such there are few boards who have representation from those familiar with subacute services such as rehabilitation. At a federal level there are no officials that have overview of subacute services despite subacute services being clearly defined in 2013 by the Australian Institute of Health and Welfare (AIHW)[14]

The federal government's Department of Health have not clearly defined a responsible department/directorate or office to direct inquires or any matters pertaining to subacute/rehabilitation matters. All representations regarding any administrative or funding decision, not matter how minor, must be directed to the minister or their delegate. The COAG funding experiments in subacute care of 2009 – 2013 delivered by the –Gillard-Rudd Government were not followed up despite evidence of efficiencies.

Further, there are several interactions between public hospitals and disability services including the NDIS, services available through the private sector and Disability support pension approvals that effect safe care and efficient public hospital processes such as discharge planning, community integration and access to private services. Despite the ongoing risk of service gaps, duplication of services or inefficient use of scant state based resources, there are no moves or discussion regarding an office or directorate for rehabilitation services within the Federal department of health.

In 2022 the RMSANZ, AMA and Australian Association of Private Psychiatrists signed a deed with the private health insurer NIB/Honeysuckle health in the Competition Tribunal. This deed[15] related to a move by NIB/HH to financially incentivize surgeons by imposing clinical targets to discharge people home following joint replacement surgery with rehabilitation in the home rather than the utilisation of funded private day hospital and inpatient services for joint replacement rehabilitation. During this deliberation, it became clear that people with private health insurance who may be treated in either public or private hospitals, had access to a rehabilitation in the home service through a hospital substitution scheme referred to in the Private Health Insurance Act. However, the legislation was inexact and vague about the clinical governance of the patient while receiving rehabilitation in the home and the remuneration of attending specialist rehabilitation physicians or general practitioners for home visits or telehealth during that period. Without clarification of these aspects of private insurance funded rehab in the home – all rehab in the home programs run from public hospitals for privately insured patients (in public hospitals) will not be able to access remuneration through the patient's private health insurer.

This means that patients with private health entitlements treated in public hospitals have no access to privately funded hospital substitution programs despite being able to activate their private health insurance while in public hospitals. As such any rehab in the home program run for a privately insured patient in a public hospital will have to be financed by the state government despite upto 30% having entitlements under the private health insurance act.

Modelling of rehab in the home from public hospital for public patients with deconditioning[16] show a saving of over 28% of all costs including infrastructure costs. However, in the same article the only models of care that can be safely delivered is totally publically funded rehab in the home programs. Funding for general practitioner care during hospital substitution programs has legal concerns relating to the vagueness of the clinical governance of the patient. As such the only model that is clear relating to clinical governance and remuneration is a totally state funded program.

Recommendation 4: That one member of every LHD board have experience and be familiar with rehabilitation services in the subacute care either as a hospital worker or a consumer.

Recommendation 5: That the NSW government advocate for a subacute care -rehabilitation directorate in the Federal Government's Department of Health to work with NDIS, improving rehabilitation or restorative care in aged care, and to ensure that there is governance and support of the delivery of subacute services including rehabilitation with a focus on the smooth integration of community services such as the NDIS with the hospital system.

Recommendation 6 : That the NSW government advocate for the federal government to review the hospital substitution programs for privately insured patients in public hospitals so that medical governance and remuneration of treating doctors are set out and clarified in law.

C. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all.

Currently NSW Health finances the accommodation and maintenance/nursing services for inpatients who have permanent or temporary disabilities awaiting accommodation, services, and care from the NDIS[17].
Estimates shows that up to 10-15% of hospital rehab beds in NSW are occupied by people waiting for NDIS services [18] who have an extension to their length of stay by at least 22-36 days.[19] There is an estimate opportunity cost of tens of millions of dollars per year in NSW, related to these accommodation/nursing costs. Further these beds are also closed for use

by people requiring rehabilitation and who have to wait in acute hospital beds for their rehabilitation leading to downstream access block and highly inefficient patient care and further incurring high costs.

In the aged care sector public hospitals run flying squads of geriatricians to review patients in their home or in their aged care facilities in order to treat them in place and prevent their admission to public hospitals and associated personal costs. No such equivalent is available for NDIS patients being cared for in their homes or in NDIS accommodation (SLA).

Recommendation 7: That NSW Health move to recoup the costs of patient on maintenance care type while awaiting NDIS accommodation and services by negotiating the retrieval of these costs from the Federal Government or have the Federal government accept these costs as a contribution to the NDIS by NSW Health.

Recommendation 8: That NSW Health develop funding streams for rehab flying squads to assess people's medical conditions or changes in care need in their home or in NDIS accommodation through rehabilitation flying squads. The aim would be to commence treatment in place and to prevent hospital admission.

D. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency.

Patients injured in motor vehicle accidents or at work who require rehabilitation after their initial injury or illness are slow to be identified in the state's public hospital system. There are variable structures to identify them. Issues to do with emergency treatments and privacy this will often lead to delayed identification of alternate funding streams for the patient's subacute rehabilitation care. If these streams are not identified early, then costs for rehabilitation in public rehabilitation hospitals will be borne by NSW Health as opposed to third party insurance, workers compensation insurance or public liability insurance.

Recommendation 9: That emergency departments have allocated subacute funding officers to identify and commence paperwork on those eligible for funded subacute services within 24-48 hours of injury/illness. These officers could also identify those on the NDIS and action rapid and early rehabilitation consultation to ensure efficient passage through the hospital system and the utilization of carers available through the NDIS to assist NSW Health staff.

E. Quality delivery - Opportunities to improve NSW Health procurement process and practice, to enhance support for operational decision-making, service planning and

delivery of quality and timely health care, including consideration of supply chain disruption.

Early rehabilitation has been shown to be cost saving, improve outcomes and to improve efficiency in care management[20] Currently an early rehabilitation referral process called "Pres" has been shown to identify people within 5 days of admission to an acute hospital who are likely to require a rehab consultation and/or early rehab which improved outcomes and efficiency and time spent in hospital.[21] These automated processes can assist decision making and improve egress and discharge from hospitals but are only suitable in hospitals where early in reach rehabilitation is available.

At the University of Wollongong, over the last 20 years the Australian Rehabilitation Outcomes Centre (AROC)[22] collects outcomes in rehabilitation episodes of care in NSW (and Australia) and is funded by contributions from each public hospital in NSW. Its processes are also used through the NSW Health synaptix system to identify activity in rehab. Data linkage with acute data sets would allow for long term and functional outcomes to be assessed as a measure of quality for both the subacute and acute sector by linking patient's data for those who require rehab after their acute episode of care. Further in terms of delivery of quality and timely health care the Australian Rehabilitation Outcomes Centre (AROC) needs to have its facility to link to other registries and data sets enhanced.

Australasian Rehabilitation Outcomes Centre (AROC) has recently been linked to trauma and stroke registries which has led to discoveries that have enhances services and efficiencies in NSW health these include a more aggressive approach to treating the elderly with brain injury[23] which had led to improved independence and a decrease in institutionalisation rates. In stroke, while advances in treatments in the acute sector have saved lives and improved disability scores in the acute phase of stroke, they have not been associated with improvements in stroke rehabilitation outcomes, indicating that early rehabilitation continues to be a significant contributor to improved stroke outcomes.[24]

Further AROC has assisted the UK NHS in develop economic value to rehabilitation outcomes in neurological rehabilitation, spinal cord injury and brain injury[25] but has yet to develop similar outcomes measures despite costing for long term care now available through the NDIS. This data would isolate cost savings for the federal department of health's NDIS brought about but quality of care in rehabilitation in the NSW hospital system.

Recommendation 10: That NSW introduce decision making tools to accelerate time from admission to rehabilitation consultation allowing for earlier rehabilitation.

Recommendation 11: That NSW Health advocates to the Federal Department of health to enhance capabilities of the AROC to form linked data sets with acute registries including cancer, stroke, joint replacement, trauma etc.

Recommendation 12: That the NSW government support and fund AROC in the development of a health economic index that represents the cost savings of care in the community associated with improved rehabilitation outcome scores achieved in NSW Health's hospital based rehabilitation departments.

F. The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services, including:

The enhancement of training and availability of allied health assistants within the hospital system would allow allied health members of rehabilitation teams to treat larger numbers of patients, more efficiently. Allied health professionals would be able to prescribe specific exercises for individuals to undertake outside of formal therapy times monitored and encouraged by utilising allied health assistants. Allied health assistants can also provide support for allied health professionals such as assisting in housing and pension applications with social workers or undertaking speech and language drills for speech pathologists, as well as assisting carers to practice safe transfer skills for when patient go home

Rehabilitation trained clinical nurse consultants could be encouraged to train as nurse practitioners and have access to Medicare claiming. As nurse practitioners in rehabilitation they may be able to run surveillance and review clinics to assist in identifying patients who required further rehabilitation to avoid a hospital admission. As nurse practioners they may be able to take on a larger role in carer training and monitoring carer strain which can assist in earlier and safer discharge. Currently there are less than 5 such trained nurses in NSW all of who had to finance their own masters courses, to complete their qualification.

Overall there is a lack of a specialized post graduate education program of study for all Registered Nurses interested in Rehabilitation. Developments in this area of the nursing workforce would create an upsurge of interest in rehabilitation as a clinical career pathway. Nurse Practitioners, would be able to augment services by working in hospital, out of hospital or in the virtual space.

Recommendation 13: A greater emphasis of NSW Health in developing training schemes with TAFE for allied health assistants.

Recommendation 14: to commence training positions for CNCs in rehabilitation to develop positions as nurse practitioners.

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H How barriers to workforce expansion can be addressed to increase the supply, accessibility and affordability of specialist clinical services in healthcare workers in New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation;

Rehabilitation in the home models have been developed in NSW and their cost effectiveness have been shown to save costs by over 28% for people with rehabilitation needs after prolonged hospital stay[26]. They are intrinsically different from Hospital in the home programs in that those services are staffed by nurses mostly focus on admission prevention or early discharge of acute care cases. Rehabilitation in the Home programs are staffed by doctors nurses and allied health staff and deal with more complex patient needs. They allow people with disabilities of all ages to be discharged from hospital earlier and like the TACP programs (which are available exclusively for geriatric patients) provide rehabilitation in the home in order to prevent readmission and decrease insitutionalisation.

Recommendation 15: That the NSW government support and fund the development of rehabilitation in the home services in NSW hospitals with a focus on cost effectiveness and cost savings.

Conclusion

The NSW government's health financing inquiry provides an opportunity for many sectors of the community to contribute improving the sustainability of the health system in NSW. It is however, clear to the RMANZ that the contribution of the subacute sector to efficiencies and cost effectiveness of health in NSW has been underestimated and less well understood. No state based health service can assess its health financing systems without consideration of the federally funded aspects of care particularly for people living with disabilities. These include access to general practice, the functioning of the NDIS, access to disability service pensions and/or Aged care services. The RMSANZ is eager to assist the NSW government in harnessing the advantages, efficiencies and cost saving offered by a well organised and resourced public hospital rehabilitation service.

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Addendum 1

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The WHO defines rehabilitation as - set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment…… Anybody may need rehabilitation at some point in their lives, following an injury, surgery, disease or illness, or because their functioning has declined with age.

The RMSANZ published a position statement in Sept 2022 on the role of rehabilitation medicine physicians in the management of COVID 19 patients.

As such, they are integrally involved in the management of patients suffering from prolonged symptoms, loss of independence and cognitive impairment following infectious diseases, medical illness and surgery.

They work in teams of colleagues including allied health professionals, healthcare assistants and nurses, in a defined framework of goal achievement and consumer involvement. Rehabilitation physicians are specialist physicians who are fellows of the Australasian Faculty of Rehabilitation Medicine, itself a Faculty of the Royal Australasian College of Physicians. Rehabilitation medicine has been recognised as a non-age-related specialty by the medical board of Australia since 1974. Its training program is under the auspices of the Australasian Faculty of Rehabilitation Medicine and the Royal Australasian College of Physicians. The post graduate speciality training for qualified doctors involves all forms of rehabilitation in all settings, takes 4 years to complete and has an extensive qualification process.

There are over 500 such departments nationwide (AROC) and with allied health, healthcare assistants and nurses working in an established framework of regular case conferences, goal setting and admission and discharge criteria.

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Addendum 2

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The Royal Australasian College of Physicians

BRIEF TO MINISTER FOR HEALTH – SUBACUTE FUNDING

Purpose

This note responds to your request for a briefing on the impact of the cessation of the subacute funding provided under the National Partnership Agreement (NPA) on Hospital and Health Workforce Reform.

Recommendation

It is recommended that the Minister:

Note that, in hospitals that had NPA funded programs, the impact of the cessation of this funding for rehabilitation will result in

- blocking of up to 10 transfers per week from the emergency department to acute wards
- poorer outcomes for the young and middle aged disabled patients, and
- decreased access to acute hospitals of up to 500 people per year per hospital.

Renew New South Wales' commitment to subacute funding currently provided for under the National Partnership Agreement on Hospital and Health Workforce Reform.

Background

On 8 May 2013, the Health Minister met with Fellows of the Royal Australasian College of Physicians' Australasian Faculty of Rehabilitation Medicine (AFRM). At that meeting, you requested a briefing on ways in which the NPA funding has in those health services which implemented new rehabilitation programs:

- Enabled integration of subacute and acute health services through the innovative mobile rehabilitation teams, which have been developed in some of the NSW Hospitals that received funding.
- Enabled these teams to treat patients in the acute hospital in a parallel care model while they receive medical or surgical care. They have been effective in preventing up to 57 per cent of patient's seen from requiring admission to a rehabilitation unit.
- The St Vincent's Hospital rehabilitation program enabled integration of subacute and community services through the Rehabilitation in the Home teams which are the first such models in NSW for young and middle aged disabled patients, preventing unemployment, social dislocation and depression.
- Enabled rehabilitation teams and their services to be integrated within each NSW hospital so that patients receive the right treatment, at the right time, in the right place which in the South East Sydney and Illawarra Health Service has saved up to $4.80 for every $1 spent (Appendix A).

1. Models of Care

- The rehabilitation programs funded in NSW under the NPA on Hospital and Health Workforce Reform have been shown through formal evaluation to have resulted in improved efficiency across the state from 20 to 70 per cent, increased capacity with up to 500 more patients treated per year per hospital and significant cost savings.

- Young and middle aged disabled patients have for the first time in NSW history received home based care and report higher satisfaction, earlier return to independent living and work and greater support and care in the community (Appendix B).
- For example, in the St Vincneent health Network , a suite of four integrated services were developed: inpatient rehabilitation, outpatient rehabilitation, mobile rehabilitation teams in the acute hospital and Rehabilitation in the Home teams in the community. These services were integrated in all funded hospitals that were able to develop them, ensuring that patients flowed seamlessly from one service to another obtaining the right treatment, at the right time in the right place.
- Further, these teams lay down the processes of maximising independence, minimising the need for care in the home and returning the newly disabled to work. This will pave the way for processes central to the NDIS's efficiency, funding and outcomes. If there are no rehabilitation processes to assist the young and middle aged disabled to return to work, the costs of the NDIS may be difficult to contain.

2. Patient Stories

- Christine is a 45 year old shop owner who had a stroke affecting speech, walking and arm use. Prior to the NPA funded Rehabilitation in the Home services she would have spent over 55 days in rehabilitation and then needed long term care in her home. With the funding she was discharged after 21 days to the Rehabilitation in the Home program and within seven days she was making her kids' lunches as part of her rehabilitation program. Her husband was also able to return to his work. By day 55 she had returned to work fulltime and started outpatient rehabilitation for persisting arm weakness.
- Paul had a devastating stroke four years ago and was house bound at the age of 39. His wife went to work and he simply moved about the house in a state of depression and fell over on average two to three times per month due to weakness from the stroke. He began the Rehabilitation in the Home Program on the request of the outpatient rehabilitation service, which noticed his deterioration. Within six weeks his mood had lifted, he was able to catch buses, he applied to return to work as a DJ, and his wife said she finally had her husband back.
- Tom was in his twenties when he had a brain tumour diagnosed. This was operated on leaving him with an inability to move one side of his body or care for himself. Five days after his operation he commenced rehabilitation while still on the neurosurgical ward with the mobile rehabilitation team. Within two weeks he was able to mobilise and care for himself with his partner assisting him. He went home with the Rehabilitation in the Home team. After eight weeks of rehabilitation in his flat, he was able to walk with a stick, climb stairs and re-enrolled in university. His partner received support and counselling and Tom continues in the rehabilitation outpatient service. Before the existence of these services Tom would have spent up to six months as an inpatient in the rehabilitation unit with an average age of 56.
- Carla is 49 and has a chronic kidney disease. During the final part of a prolonged 10 week acute hospital admission she received treatment by the mobile rehabilitation team and was discharged directly home as she became able to get to dialysis independently. She continued in outpatient rehabilitation and made impressive gains, from being largely wheelchair bound, to being able to walk for a few hundred metres unaided along the beach and return to gardening, which were her passions.
- Please also see attached a testimonial from a 47 year old stroke patient who participated in the Rehabilitation in the Home program (Appendix B).

A/Prof Steven Faux
Executive Member of the NSW Branch of the Australian Faculty of Rehabilitation Medicine, Royal Australian College of Physicians

Prof Stephen Leeder

Chair, New South Wales Committee of The Royal Australasian College of Physicians

13 May 2013

Attachments
Appendix A: COAG reports St Vincent's and SESHD
Appendix B: Patient testimonial