16 February 2013

Dear Sir or Madam,

RE; Senate Inquiry on the Implementation of the National Health Reform Agreement.

I am writing to you to make a submission to the Senate's inquiry on the Implementation of the National Health Reform Agreement. I am writing to request that the National Partnership Agreement and in particular the grants made by the Federal Government to the States to increase capacity in the subacute sector (rehabilitation, palliative care and psychogeriatrics) become part of the remit of the senate committee's inquiry.

I am an Associate Professor of Rehabilitation Medicine at University of NSW and St Vincent's Hospital and the Director of that Hospitals Department of Rehabilitation Medicine. My department has been fortunate enough to have been distributed $1.2 million dollars per year for 4 years from the HPOA grants, the first injection of funds to our sector for over 20years. In the 4 years we have generated $4.3 million dollars of saving per year, we have treated over 70% more patients, cut our outpatient waiting times in half and have been able to deliver best practice rehabilitation medicine treating the right patient at the right time in the right setting.

Our achievements have focused among others on a group of patients usually disenfranchised from adequate subacute and community based services, namely the young and middle aged disabled. This group have been offered a suite of services never before available to them. This in turn has improved their independence, decreased their rates of institutionalisation and kept them out of acute hospitals where many fall prey to the negative impact of prolonged bed rest (clots in the legs, pneumonia, and hospital born infections).

Colleagues at the adjoining distict health service have been told by the state government to fund these services from their existing (pre HPOA funded) budgets and while those hospital administrators they have relied on the figures available to them (1 of the programs have as yet only generated 8 months of data)– they will only fund 1 or 2 of the services which in the end will not allow them to maintain their gains in capacity, efficiency or quality of service – it is akin to funding surgery for hernias but not the anaesthetics or pharmacy for the surgery because the link between the surgery component and improved patient outcomes are clear for

all to see, but not funding the other services is however short sighted and is sure to make the project fail.

In order to explain let me outline some of the developments in NSW.

The injection of over $167 million dollars to the state health budget in 2008 was used in a variety of ways. Perhaps most significantly the NSW Ministry of Health was able to audit rehabilitation services that had not received any new money for over 20 years and discovered significant gaps in service provision. This lead to a redesign project of Rehabilitation Services in NSW (Price Waterhouse were involved) which identified a 4 pillar approach to providing evidence based rehabilitation. This included the use of in reach rehab team (mobile or acute rehabilitation teams), which commenced rehabilitation in the acute hospital in a parallel care model with acute physicians and surgeons, thus mitigating the risks of prolonged bed rest such as DVT, hypostatic pneumonia and urinary tract infection. (An example may be that a multi trauma victim who had rehabilitation commenced in the orthopaedic ward on day 3 post injury rather than waiting till the acute episode was complete and an available inpatient rehab bed was found. This can delay rehab by an average of between 3-6 weeks (Parker et al)). The second pillar was to have a rehabilitation inpatient unit with sufficient staff to offer a high intensity of therapy which has been shown to be associated with improved length of stay, improved independence and a decreased institutionalisation rate (Kwakkell et al, Foley et al). At one hospital in our group a "time and motion" study was completed prior to the funding, and it showed patients spend longer each day in the bathroom that in therapy with their own therapist. In stroke rehabilitation we are far behind the US and New Zealand who are currently offering over 3 hours of therapy per day for stroke survivors (Teasell et al, McNaughton et al PSROP study). The third pillar is an active outpatient therapy program with sufficient staff to be run in a multidisciplinary manner according to Australian guidelines (AFRM guidelines), this was been shown to improve inpatient length of stay, support carers and to offer those living in the community ongoing rehabilitation to consolidate, gains achieved in the inpatient setting. The final pillar is a community based rehabilitation program (Rehab in the Home) which have been shown to improve independence (Crotty et al) and allows disabled patients too young to access geriatric home based services (TACP guidelines) a chance to rehabilitate within their own homes (see appendix A – patient report), supported by their own families and not reliant on daily transport (often lacking in rural areas) to access outpatient rehabilitation therapies.

In our area health service and the adjacent one these four services were able to operate over the previous 2 years with data collected to indicate their cost effectiveness and impact on capacity of the services. Figures released to NSW Health showed that the South East Sydney Health District and St Vincent's Hospital have been able to dramatically improve their length of stay by over 10 days per patient episode at one hospital and separations increase by over 70% in another. The in-reach teams (mobile/acute rehabilitation teams) showed a cost saving of over $2.27 million in one hospital and over $1.6 million in another, based on prevented admissions to inpatient rehabilitation (patient able to be independent at home at the end of their acute hospital stay, thereby avoiding admission to rehab). The rehab in the home program which has been only operating for 8 months has saved over $650,000 in prevented

admissions while the outpatient service has doubled their occasions of service and decreased their waiting time by over 50%.

Local administrators at South East Sydney keen to avoid the directives from state health ministers to fund these program from their existing budgets have had to make decisions about which projects or pillars of the model to fund. Predictably they look at cost effectiveness figures only. These can only be expressed in saved inpatient admissions or decreased lengths of inpatient stay, as prevented readmissions to emergency, earlier access to outpatient services, better efficiency of waiting times are difficult metrics to convert to dollars and nigh impossible to track in a heterogeneous population with individual hospital data systems that often do not integrate well.

While their motives may be laudable, they miss the point. Because achievements in decreased length of stay and saved admissions are attributed not to one service model or another but to the integrated system of all four services. The flexibility of the four service contexts allows clinicians to treat "the right patient, in the right setting at the right time". For example a man with metastatic prostate disease causing paraplegia was treated by the in reach team who noted small improvements in motor function, he was transferred to residential care due to incontinence but continued in rehabilitation outpatients where he improved to a point of being able to transfer from bed to chair with minimal assistance. It was then he was readmitted to inpatient rehab for intensive rehabilitation over a short period (2 weeks), before being discharged home with rehab in the home. At the end of his community based admission he was independent in his own home, continent and free of pain. His Ministry of health statistics will show a 2 week inpatient admission for reconditioning. It is clear this achievement has not occurred simply because of improved intensity of rehabilitation in the inpatient setting but nevertheless administrators will congratulate their decision to only fund increased service in inpatient rehabilitation.

What has been described above has demonstrated what could be achieved if the money was used to deliver evidence based rehabilitation, sadly this has not been the case in other Australian health districts; some have simply plugged their existing budget deficits and have not passed any money on to rehab units or only very little or very late (Western Sydney), others have simply not started services (Western Australia), some have used the funding for much need infrastructure which has not lead to direct patient care.

The money was supposed to be used to increase the capacity in the subacute sector so as to assist in the management of the disabled population and improve access to acute hospitals and emergency departments. In our hospital we have created 17.9 virtual extra beds through our cost savings and increase in capacity, we have used the money to employ over 15 more staff and we have overreached all set targets. However, our funding will be cut, our teams devastated and the achievements made will disintegrate because of the very minimal review, reassessment or a formal evaluation process. The writing has been on the wall for four years but I am unaware of any discussion between State and Federal Health Ministers regarding ongoing funding, no clinicians have been invited to be part of the governance of any review

process and perhaps what is more worrying is the variety of ways that the states used the money, some with little regard to the goals and objectives of the grants.

If given the opportunity to present to the committee I would strongly recommend that the National Partnership Agreement subacute grants be part of the senate's committee of inquiry into health reform and I would be able to provide documents with detailed costings, results and outcomes.

Thank you for considering my submission.

A/Prof Steven Faux

Director of Rehabilitation and Pain Medicine

St Vincent's Hospital Sydney