Subacute care funding in the firing line

Recent enhancements to subacute care services are threatened due to the uncertain future of federal–state funding agreements

The term “subacute” was coined for use in Australia 21 years ago to describe health care where the patient’s need for care is driven predominantly by his or her functional status rather than principal diagnosis. Subacute care includes rehabilitation, palliative care, geriatric evaluation and management, and psychogeriatrics. Rehabilitation represents more than 50% of all subacute hospital care in Australia.2

The past two decades have seen slow growth in subacute care. However, the public sector was given substantial momentum in recent years through two National Partnership Agreements (NPAs) between the federal government and the state and territory governments, negotiated by the Council of Australian Governments (COAG) — the Hospital and Health Workforce Reform (HHWR) NPA and the Improving Public Hospital Services (IPHS) NPA. Both NPAs aimed to “improve efficiency and capacity in public hospitals”.3

The 5-year HHWR NPA was signed in 2008 and, of the total funding of $3042 million negotiated under this agreement, $1383 million was provided by the federal government as including provision of funding for “improving and expanding subacute care”.4

The 2009 report of the National Health and Hospitals Reform Commission (NHHRC) stated that: “Incentive funding under the National Partnership Payments could be used to drive this expansion in subacute services”.6

The NHHRC recommended investment beyond the targeted 5% increase per year under the HHWR agreement, recognising that much of this 5% increase would only account for extra demand associated with population ageing and growth. Indeed, as shown in Box 1, most states and territories have delivered much greater than 5% growth, with South Australia and Queensland reporting increases of 50% and 43%, respectively.5

The HHWR agreement made provision for a review of progress “in respect of achieving the agreed outcomes”, to occur in July 2011.7 However, apart from the annual reports of the states and territories describing the services developed under the NPA, and the reporting of activity measures, there is no evidence that any review of the NPA on a national basis has occurred. Further, although the NPA specifically describes the role of the federal government as including provision of funding support for “research into best practice models of care” and funding and providing “national coordination of the initiative [and] monitoring performance”, no provision was made for funding to continue beyond the term of the NPA, nor for a formal evaluation of outcomes at its conclusion. Consequently, the effectiveness of the developed services cannot be fully assessed because they have not been subjected to rigorous evaluation.

Although formal outcomes cannot be reported, examples of rehabilitation programs funded by the HHWR agreement are given in Box 2.

In contrast, the IPHS agreement specifies that an evaluation framework will be developed and that a review of the agreement will be completed, with a decision by COAG by December 20134 — although no details have been released to date.

These two agreements have provided public hospitals with unprecedented opportunities to develop new inpatient and ambulatory rehabilitation services and to expand existing services. These new and expanded services have dealt with previously identified deficiencies, especially the need for early rehabilitation in the acute care setting and increasing the intensity of therapy within rehabilitation settings.8-10 Public hospitals have been able to develop better rehabilitation capital infrastructure and better meet the growing need for rehabilitation, particularly among the ageing population. Between them, these two agreements represented a turning point in the development of public sector rehabilitation services across the country.

There is growing international evidence showing improved patient outcomes from the provision of more intense therapy (ie, therapy “dose”) in the rehabilitation setting, as well as showing improved efficiency.10,11 In the United States, where therapy of 3 hours per day for a minimum of 5 days per week is mandated in inpatient rehabilitation,9 length of stay for patients undergoing
1 Reported increase in subacute care services under the National Partnership Agreement on Hospital and Health Workforce Reform, by state and territory

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Services in 2007–08 (baseline)</th>
<th>Services in 2011–12</th>
<th>Increase (%) in 2011–12 compared with baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>679 048</td>
<td>813 283</td>
<td>134 235 (19.8%)</td>
</tr>
<tr>
<td>Victoria</td>
<td>786 648</td>
<td>933 930</td>
<td>147 282 (18.7%)</td>
</tr>
<tr>
<td>Queensland</td>
<td>290 368</td>
<td>414 531</td>
<td>124 163 (42.8%)</td>
</tr>
<tr>
<td>South Australia</td>
<td>197 583</td>
<td>296 604</td>
<td>99 021 (50.1%)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>511 498</td>
<td>658 781</td>
<td>147 283 (28.8%)</td>
</tr>
<tr>
<td>Tasmania</td>
<td>46 815</td>
<td>56 243</td>
<td>9 428 (20.1%)</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>62 745</td>
<td>68 038</td>
<td>5 293 (8.4%)</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>11 227</td>
<td>14 261</td>
<td>3 034 (27.0%)</td>
</tr>
<tr>
<td>All</td>
<td>2 585 932</td>
<td>3 255 671</td>
<td>669 739 (25.0%)</td>
</tr>
</tbody>
</table>

* Compiled from the individual state and territory government reports submitted to the Steering Committee for the Review of Government Service Provision (for Schedule C of the National Partnership Agreement on Hospital and Health Workforce Reform).

stroke rehabilitation is shorter, and the rate of attainment of functional gain is higher, than in Australia. More intense therapy should result in more efficient use of rehabilitation beds if length of stay can be reduced as a result. This is because the cost of providing extra therapy is relatively low compared with the high fixed costs of running an inpatient bed.

With the HHWR NPA ending on 30 June 2013, many of these new and expanded rehabilitation programs will cease. Staff are already seeking alternative employment, and programs are beginning to wind down. The fact that many health services across the country will now be closing down rehabilitation and other subacute initiatives that were funded under this NPA suggests a lack of planning by the federal, state and territory governments for what would happen after the HHWR NPA ends.

Development of subacute care must continue if Australia is to keep pressure off the acute hospital system and deal effectively with population ageing. However, in our opinion, the lack of requirements for rigorous evaluation of services developed with HHWR NPA funding, which could have provided a basis for ongoing funding if the requirements were met, is not justifiable.

Even if these programs demonstrate system-wide efficiency gains, this does not free up resources; rather, it increases capacity. As such, it would be difficult for state and territory governments to continue to fund successful programs out of existing resources, unless other programs were cut. The new ABF arrangements are not sufficient to pick up where the HHWR agreement has left off, not least because federal growth funding does not begin until 2014–15. At the system level, the sudden closure of rehabilitation and other subacute services will have flow-on effects to the acute care system, as it will increasingly have to manage patients who would otherwise have been referred to rehabilitation. The net effect is likely to be that the length of stay in acute care will increase, along with bed occupancy and waiting times.

Competing interests: Christopher Poulos is employed by the University of NSW in a position supported by funding from HammondCare, a not-for-profit provider of a range of health and aged care services, including rehabilitation services. Steven Faux, John Estell and Maria Crotty, while not direct recipients of any funding under these NPA’s, are directors of rehabilitation services that have received NPA funding through their respective state government health departments.

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