

**Submission to the Special Commission of
Inquiry into Acute Care Services
in NSW Public Hospitals**



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1. About NCOSS

The Council of Social Service of NSW (NCOSS) is an independent non-government organisation (NGO) and is the peak body for the non-government human services sector in NSW.

NCOSS has as its vision a society where there is social and economic equity, based on cooperation, participation, sustainability and respect. NCOSS works with its members on behalf of disadvantaged people and communities towards achieving social justice in New South Wales.

It was established in 1935 and is part of a national network of Councils of Social Service, which operate in each State and Territory and at Commonwealth level.

NCOSS membership is composed of community organisations and interested individuals. Affiliate members include local government councils, business organisations and Government agencies. Through current membership forums, NCOSS represents more than 7,000 community organisations and over 100,000 consumers and individuals.

Member organisations are diverse; including unfunded self-help groups, children's services, youth services, emergency relief agencies, chronic illness and community care organisations, family support agencies, housing and homeless services, mental health, alcohol and other drug organisations, local indigenous community organisations, church groups, peak organisations and a range of population-specific consumer advocacy agencies.

1.1. NCOSS' approach to health advocacy and policy

NCOSS convenes a number of forums and Policy Advice Groups to inform our work so that it reflects the expertise and views of the sector. One such forum is the Health Policy Advice Group (HPAG). The NCOSS HPAG is a forum of peak consumer and community non-government organisations that advise NCOSS on health policy issues, particularly access and equity issues for low-income and disadvantaged groups. The NCOSS Health Policy Advice Group provided information to NCOSS which has been used in this submission.

NCOSS believes that health policy and systems need to be based on principles that recognise health as a human right, the social determinants of health, and the importance of strengthening the role of the community and consumers in the development and delivery of health services.

The World Health Organisation Constitution states that:

"The enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without the distinction of race, religion, political belief, economic or social condition."¹

¹ World Health Organisation Constitution, available at: http://www.who.int/entity/governance/eb/who_constitution_en.pdf (last accessed 19 March 2008)

More specifically, the United Nations have explained that seeing health as a human right can be understood as:

“The right to... an effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or a political system.”²

Simultaneously, a social determinants of health approach recognises that the cultural, social and economic environment in which people live shapes their health, and that inequalities in these areas lead to inequalities in health. Recognising the social determinants of health as a principle in the development and delivery of health and other human services builds on the recognition of health as a human right, and facilitates a process of integrated service delivery.

NCOSS also believes that across health policy and service delivery the community generally, and consumers of health services more specifically, should be involved in all aspects of health care design, from individual to systemic levels. Consumer engagement is essential to the development and delivery of accessible, effective, appropriate and patient-centered health services that lead to positive health outcomes.

These principles form the foundation of the work NCOSS undertakes in relation to advocacy and policy in Health.

² UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of mental and physical health, 2006

2. Introduction

NCOSS believes that acute care services in NSW Public hospitals are an essential part of our health system. This submission outlines some of the issues raised with NCOSS in relation to the delivery of acute services in NSW public hospitals. In providing this submission NCOSS recognises that there are a range of organisations who have direct experience and knowledge in this area, and who are subsequently able to provide more detailed comment, such as on particular challenges facing different parts of the health workforce, and the challenges currently experienced by acute care staff.

In responding to the establishment of the Special Commission of Inquiry, NCOSS has argued that acute care services are not the only part of our health system requiring attention, and that it is somewhat misleading to separate the challenges and difficulties being faced in the delivery of acute services in NSW public hospitals from the operation of the broader health system, but particularly from the delivery of primary health services. Despite the NSW Government developing a 10 year State Plan³ that sets a longer term framework for the state and which includes an overall government commitment towards early intervention and prevention, we continue to see the Government focus on the crisis end of the spectrum, often at the expense of prevention and early intervention.

NCOSS has repeatedly stated that if the Government is serious about decreasing the strain on our public hospital system it needs to invest in health prevention and early intervention services. To focus purely on acute care is counterproductive to the long-term sustainability and quality of the NSW health care system for the entire community.

NCOSS was therefore encouraged when during the first public hearing of the Special Commission of Inquiry, 14 February 2008, the Commissioner indicated that:

“On one view, if one can reduce by 15 per cent or 20 per cent the number of patients arriving at the accident and emergency department doors of public hospitals in New South Wales, the staffing questions are of a different order and magnitude.

I certainly think that my terms are wide enough to look at the interface before one gets to the door... but I recognise that I need to look at the earlier step than the front door of the emergency department.”⁴

It is predominantly within this context that NCOSS provides this submission.

³ NSW Government Premier's Department 2006, *State Plan, a new direction for NSW*, Sydney: NSW Government

⁴ Transcript of first public sitting of the Special Commission of Inquiry into acute care services in NSW Public Hospitals, p.26, lines 20-31. Available at: http://www.lawlink.nsw.gov.au/lawlink/Special_Projects/ll_splprojects.nsf/pages/acsi_index (last accessed 19 March 2008)

3. Investment in Primary health services

3.1. The relationships between primary health and acute care

Total Government expenditure on public health in NSW as a proportion of total recurrent Government health expenditure has declined from 2.43 in 1999-00 to 2.37% in 2005-06, placing NSW below the national average of 2.66%⁵. The small and declining investment in public health in NSW contributes to a health system that focuses on 'sickness' rather than 'wellness' – that is, a system that focuses on treating the sick rather than, and perhaps at the expense of, keeping people healthy.

NCOSS believes that some of the pressure currently exerted on acute care services is the result of a lack of investment in public health services, in particular health promotion and early intervention and prevention services. There is a range of research available which supports this position.

Potentially avoidable deaths are those that through health and related activities and interventions could have been prevented, such as through health promotion, disease screening and management, or intervention. In NSW, almost a quarter of all deaths, and 67.4% of deaths that occur before the age of 75, are potentially avoidable⁶. The majority of these deaths could have been avoided through prevention-based health interventions⁷. Health inequities are clearly manifested in potentially avoidable deaths, with higher rates of potentially avoidable deaths amongst people with low socioeconomic status compared to those with high socioeconomic status (in 2004 this was 188.4 to 122.7 per 100 000 people, a difference of approximately 66 people)

Nationally 32% of the burden of disease, a combined measurement of mortality and morbidity, is the result of fourteen preventable health risks. The largest of these are tobacco (7.8%), high blood pressure (7.6%), high body mass (7.5%) and physical inactivity (6.6%). Again, a greater burden of disease was evident in populations in areas with a lower socioeconomic status than those with higher socioeconomic status.⁸ Burden per head of population was also higher in remote compared to metro areas.⁹

Of more immediate consequence for acute services in hospitals, avoidable hospitalisations arising from ambulatory care sensitive (ACS) conditions are those that are considered potentially avoidable through prevention and early intervention in diagnosis and disease management – activities often undertaken in a primary health setting¹⁰. NSW figures for

⁵ Australian Institute of Health and Welfare 2008, *National public health expenditure report 2005–06*, Canberra: AIHW. Available at <http://www.aihw.gov.au/publications/hwe/npher05-06/npher05-06.pdf> (accessed 19 March 2008)

⁶ NSW Health 2006, *The health of the people of New South Wales: Report of the chief health officer*, Sydney: NSW Department of Health p.85

⁷ *ibid*

⁸ Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD, 2007. *The burden of disease and injury in Australia 2003*, Canberra: AIHW: p. 108 Available at: <http://www.aihw.gov.au/publications/hwe/bodaiia03/bodaiia03.pdf> (accessed 19 March 2008)

⁹ *ibid* p.111

¹⁰ Page A, Ambrose S, Glover J, Hetzel D. 2007, *Atlas of Avoidable Hospitalisations in Australia: ambulatory care-sensitive conditions*, Adelaide: University of Adelaide. Available at: http://www.publichealth.gov.au/pdf/atlas/avoid_hosp_aust_2007/avoid_hosp_full.pdf (last accessed 19 March 2008)

2002/03 to 2004/05 indicate that there are 141, 806 hospital separations for ACS conditions in NSW each year. The majority of these conditions are Chronic Obstructive Pulmonary Disease, diabetes complications, asthma and congestive heart failure.¹¹ Once again there is a marked difference in avoidable hospital admissions as a result of ACS conditions based on socioeconomic status, with national figures indicating that rates in lower socioeconomic areas are more than 60% above those in higher socioeconomic areas.¹²

It is clear that a large number of deaths, hospitalisations and the overall burden of disease is avoidable, and that primary health services have an essential role to play in the delivery of prevention services along with the delivery of early diagnosis, treatment and management services. Were this occurring, there is potential for significant positive repercussions for levels of demand on acute care services in public hospitals.

However, given the levels of preventable deaths, illness and hospital admissions that are occurring, it is clear that funding for primary health services in NSW is inadequate, and that the negative effects of this are being felt across the health system.

NCOSS believes that there needs to be a significant investment in primary health services in NSW, contributing to a long-term reorientation towards a prevention-based health system. Whilst acute care services will always be an essential component of the health system, NCOSS believes that many of the changes required to improve the functioning of acute care services will result from an investment in primary health services, and not simply from an internal analysis or band aid funding for acute care.

3.2. Cost-savings through investment in primary health

The cost-effectiveness of investing in prevention has been illustrated in a report developed for the NSW Health AIDS/Infections diseases branch, *The Impact of HIV/AIDS in NSW – mortality, morbidity and economic impact*¹³. Economic analysis undertaken in the report found that:

- For every \$1 spent on prevention \$13 is saved in clinical care costs
- A total of \$18 027m (2005/06 prices) in clinical care costs that would otherwise be borne by the NSW Government would be saved over the lifetime of the HIV cases avoided by prevention initiatives funded under the program.
- 394, 000 life years were expected to be gained for people prevented from contracting HIV
- Quality Adjusted Life Years (QALYs) of people who would otherwise have been infected with HIV were expected to be 863,000

Furthermore, there is evidence that programs that provide an integrated approach to health needs are cost-effective. The Housing and Accommodation Support Initiative

¹¹ NSW Health 2006 *op cit*, p.94

¹² Page et al 2007 *op cit*

¹³ Health Outcomes International Pty Ltd 2007, *The impact of HIV/AIDS in NSW: Mortality, morbidity and economic impact, Final Report*, NSW Health AIDS/Infectious Diseases Branch, p.2-3

(HASI) is one example. HASI is operated through a partnerships between NSW Health, the Department of Housing and non-government organisations. Its aim is to “assist people with mental health problems and disorders requiring accommodation support to participate in the community, maintain successful tenancies, improve their quality of life and most importantly to assist in their recovery from mental illness.”¹⁴ Amongst other positive outcomes, The Stage 1 Evaluation Report of the Housing and Accommodation Support Initiative (HASI) found:

- A reduction in hospitalisation rates, frequency and duration for 84% of participants.
- An 81% reduction in time spent in hospital and emergency departments, coming to an average of 70 days per person per year.¹⁵

The evaluation also illustrates that, at an average cost of \$57, 530 per person per year, a broad range of outcomes were achieved, including: stabilised tenancies, decreased hospital admissions and days spent in hospital per admission, improved mental health, improved life skills, increased social, economic and educational participation, decreased imprisonment rates.¹⁶

NCOSS believes that this range of outcomes illustrates the cost-efficiency of programs that provide an integrated continuum of care between primary/community settings and acute settings. These benefits are evident not only for the health system and the individual, but across the human service and justice systems.

In developing the report and recommendations of the Special Commission of Inquiry, NCOSS encourages the Commission to view the health system as a whole, and not focus on the separateness of its component parts at the expense of developing multifaceted recommendations.

¹⁴ NSW Department of housing website: <http://www.housing.nsw.gov.au/About+Us/Partnerships/HASI+-+Housing+and+Accommodation+Support+Initiative.htm> (last accessed 19 March 2008)

¹⁵ Muir et al 2007, *Housing and Accommodation Support Initiative: Stage 1 evaluation report*, Sydney: NSW Department of Health. P. vii Available at: http://www.health.nsw.gov.au/pubs/2007/pdf/hasi_evaluation.pdf (last accessed 19 March 2008)

¹⁶ *Ibid* p.33

4. The delivery of acute care services

In addition to what NCOSS sees as the systemic issues affecting the delivery of acute care services as a consequence of a lack of adequate investment in primary health services, a range of organisations have raised with NCOSS issues more directly associated with the delivery of acute care services.

This information is not intended to be comprehensive analysis of problems within the hospital system in relation to acute care services. NCOSS is aware that there are many other organisations, both professional organisations, unions and consumer organisations, which are better placed to provide detailed comment on issues directly associated with delivering acute care services. NCOSS intention is to add to the information presented by these groups, and provide an outline of a range of issues raised by NGOs in relation to some of the systemic issues they identify in relation to acute care.

4.1. Communication and planning

A number of issues have been raised with NCOSS in relation to communication and planning within acute care services.

4.1.1. Information and records

A common issue raised by patients and consumer groups is frustration with being required to repeatedly provide the same information to different clinical and administrative staff. Whilst it is acknowledged that it is necessary for some information to be communicated in multiple settings or for the purposes of assessments, patients, families and carers express a sense that they are required to detail the same information repeatedly due to a lack of systemic information or records systems, or a failure to utilise them where they may exist. In some cases this can cause unnecessary additional distress in situations that are often already stressful.

NCOSS welcomes the commission's investigation into communication, record keeping and note-taking, and recommends that in making recommendations about these practices the Commission emphasise the need for these systems to balance a minimal amount of distress to patients and their families and carers with the need for safe and appropriate clinical and administrative practice.

NCOSS is currently on the NSW Health Electronic Health Record Steering Committee. NCOSS has raised a number of concerns about the Electronic Health Record¹⁷. NCOSS is not opposed to the introduction of an Electronic Health Record and can see that there will be major benefits, however we do not support their introduction at the expense of people's privacy and health.

4.1.2. Improved coordination between acute services

Another issue raised with NCOSS relates to the need for improved coordination between some sections of hospitals, particularly where integrated treatment may be required. For example, concerns have been raised about the relationships between psychiatric units and other areas such as oncology, or between Accident and Emergency and oral health or

¹⁷ Available at: <http://www.ncoss.org.au/bookshelf/health/health.html>

dental services. NCOSS is not in a position to comment on the extent to which this is a systemic problem, or to provide clear direction on how this can be resolved, however, the extent to which instances of the lack of integrated care between acute services in hospitals are cited lead us to recommend that this issue be further investigated by the Commission.

4.1.3. People with cognitive or communication difficulties

People with cognitive or communication difficulties are a group that NCOSS encourages the commission to consider specifically in the development of recommendations on communication in acute care settings. As a fundamental principle, NCOSS recommends that the first engagement should be with the person who is receiving treatment or care, and that this person should maintain the maximum amount of involvement in decision-making about the care and treatment they receive. This is particularly important when treating a person with cognitive or communication difficulties, as NCOSS is informed that some hospital staff can assume a person is a carer, and can focus on communicating with that person rather than with the person receiving care or treatment (where this is possible). This becomes problematic as sometimes the person deemed responsible by staff may not be the appropriate person, or the individual may not have a carer, or they may not want their carer involved. Clearer systemic direction needs to be given to the need to take the time to communicate with the person receiving care or treatment, and to identify and seek appropriate consent to communicate with their carers, family or friends. Similarly, if the person requests an advocate, this should be built in to systemic procedures.

4.1.4. Open Disclosure

In reviewing communications within acute care settings, NCOSS encourages the Commission to investigate methods for and encourage the implementation of open disclosure. Open disclosure allows for transparency between clinical staff and patients, carers and/or families where there are adverse events in the provision or treatment or care. The National Open Disclosure Standard¹⁸ indicates that open disclosure includes: an expression of regret, a factual explanation of what occurred and the consequences of this and steps being taken to manage this and prevent its reoccurrence. Whilst some hospitals and health care facilities have shown a commitment to open disclosure, NCOSS believes that this approach needs to be implemented on a systemic basis, including monitoring to ensure compliance.

4.1.5. Discharge Planning

Whilst there have arguably been some improvements in discharge planning from acute care services in hospitals over the last decade, NCOSS continues to receive information that points to gaps in the implementation of comprehensive discharge planning processes, implemented on a consistent levels across health services. Particular issues raised include: comprehensive and consistent assessment of people requiring a discharge plan; a lack of clarity about people responsible for coordinating discharge; the need to improve responses to people who are homeless (how are services going to be delivered?); and the

¹⁸ Australian Commission on Safety and Quality in Health Care, *National Open Disclosure Standard*, Available at: [http://www.health.gov.au/internet/safety/publishing.nsf/Content/C3D94BA657FEE027CA2573E00000B3FA/\\$File/opendiscclfact.pdf](http://www.health.gov.au/internet/safety/publishing.nsf/Content/C3D94BA657FEE027CA2573E00000B3FA/$File/opendiscclfact.pdf) (last accessed 19 March 2008)

delivery of appropriate services in rural and regional areas, where service infrastructure may be low.

4.1.6. Mixed-gender facilities

Finally, concerns have also been raised with NCOSS about bed allocation processes, particularly in relation to mixed-gender facilities, including rooms. Whilst it is acknowledged that both the physical infrastructure of some hospitals and demand mean that it will be difficult to ensure bed allocation is appropriate for the individual in all cases, NCOSS believes that where possible, bed allocation should be driven by consideration of the comfort and preference of individuals in relation to mixed-gender shared facilities and infrastructure. Many patients experience heightened levels of discomfort, stress and feelings of vulnerability when admitted to hospital, a situations that can be exacerbated through a mixed-gender approach. It is not clear to NCOSS the extent to which these matters are currently being considered at a systemic level, or are guided by policy.

NCOSS believes that Improvement in these areas will contribute to better patient experiences and an improvement in safety and quality.

4.2. Workforce Issues

NCOSS acknowledges workforce shortages are both evident and predicted to increase across the health system. As previously noted, there are many organisations and individuals able to provide detailed comment on this issue.

However, we would like to draw to the attention of the committee the Productivity Commission's *Review of Government Services 2008*¹⁹. This report allows for some analysis of how the NSW Health Workforce looks like in relation to the health workforces of other States and Territories. This report indicates that:

- In 2005-06 there were on average 11.4 FTE staff per 1000 population in NSW public hospitals (including psychiatric), above the national average of 10.8.
- NSW has a below average rate of FTE nurses per 100 000 population, at 1 099 compared to a national average of 1138, and only higher than Queensland and Western Australia (998 and 1069 respectively)
- 2005 figures indicate that 57.7% of the nursing workforce in NSW (including midwives) is between the ages of 40-59.

In reviewing workforce challenges facing the health system, NCOSS encourages the Commission to consider these challenges on a system-wide basis that includes a consideration of the primary health and NGO workforces. NCOSS believes that an integrated health system is required in order to provide a continuum of care, and that a comprehensive consideration of the health workforce is therefore warranted.

NCOSS also encourages the Commission to pay particular attention to the Aboriginal health workforce. NCOSS believes that the recruitment, employment, retention and professional development of Aboriginal staff is an essential component of the effective delivery of health services, particularly Aboriginal specific health services. There are,

¹⁹ Productivity Commission 2008, *Report on Government Services*, Available at: <http://www.pc.gov.au/gsp/reports/rogs/2008> (last accessed 19 March 2008)

however, significant workforce shortages of health professionals, particularly Aboriginal workers. This has been recognised through both the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework²⁰ and the NSW Health Aboriginal Workforce Development Strategic Plan, 2003-2007²¹. NCOSS encourages the Commission to follow-up on the implementation and information available on the evaluation of these documents, as well as planning for ongoing Aboriginal health workforce initiatives, in completing their report. In particular, NCOSS is concerned that Aboriginal health workforce initiatives be developed in close conjunction with relevant aboriginal community-controlled health services, as well as the non-government health sector.

4.3. Out of hospital programs

When Australian hospital statistics from 1995/96²² are compared to those from 2005/06²³ it is evident that in NSW public hospitals:

- The number of separations increased from 1,247,301 to 1,420,463.
- Same-day separations increased from 465,414 to 618,501 (37.3% of all separations to 43.5% of all separations)
- The number of patients days decreased from 6,513,857 to 5,976,834.
- The average length of stay decreased from 5.2 days to 4.2 days.
- When same-day separations are excluded, the average length of stay has decreased from 7.7 days to 6.7 days.

Across this period there has been a general shift, characterised by an overall increase in separations coupled with a decline in patients days. This data indicates that whilst the number of occasions of service for public hospitals has increased, people are staying for shorter periods of time. This shift has been associated with an attempt to extend hospital resources and reduce pressure on inpatient services by providing alternatives to hospitalisation. Other benefits associated with shorter hospital stays include a decrease in the risk of 'hospital acquired' infections and meeting the preference of many consumers and patients to be treated in the community and/or their homes.

However, consumers and their advocates have expressed concern about the shift towards earlier discharge. Problems identified have included²⁴:

- increased care demands which underfunded community services, particularly 'community care' services cannot meet

²⁰ Australia Health Ministers' Advisory Council, 2002, *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*, available at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/DA4283E5D5C265BDCA25722E007B377B/\\$File/wrkstrgy1.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/DA4283E5D5C265BDCA25722E007B377B/$File/wrkstrgy1.pdf) (last accessed 19 March 2008)

²¹ NSW Health, 2003, *Aboriginal Workforce Development Strategic Plan*, available at: http://www.health.nsw.gov.au/pubs/a/pdf/ab_work_strat.pdf (last accessed 19 March 2008)

²² Australian Institute of Health and Welfare (AIHW) 1997. *Australian hospital statistics 1995-96*, AIHW, Available at: <http://www.aihw.gov.au/publications/index.cfm/title/22> (last accessed 19 March 2008)

²³ Australian Institute of Health and Welfare 2007, *Australian hospital statistics 2005-06*, Canberra: AIHW available at: <http://www.aihw.gov.au/publications/index.cfm/title/10455> (last accessed 19 March 2008)

²⁴ Community Health Collaboration briefing paper 1, *Earlier discharge: Delivering health care in the home or is it?* (The community health collaboration was a project of NSW Community Health Association and NCOSS)

- Increased responsibility on families, carers and friends to provide care
- Confusion about who is responsible for parts of the care process, both within and beyond the health system
- Additional costs for consumers, such as increased transport to attend outpatient services, payment for personal care services, and purchasing medications in the community setting
- Complex nature of the 'home' environment does not lend itself to measurement so little is known about some 'home' environments from a medical perspective. Thus decisions to discharge in some cases are not properly assessed even where policies exist to prevent inappropriate discharge.

Partly in response to the identification of some of these issues, a number of “out of hospital programs” have been implemented. At the front end, Healthy at home (formerly the sub acute fast track elderly (SAFTE) care program) targets older people living in the community who are at risk of presenting to an Emergency Department. The intention of the program is to provide a rapid and integrated response to older people to prevent them from needing to enter the hospital system, or to minimise the length of stay if they do. At the back end, ComPacks provide 6-weeks of case-management for people being discharged from hospital who require two or more community services to live independently.

Over the last decade NCOSS has raised concerns about this shift, arguing that earlier discharge is reliant on a continuum of care from the community to the acute care facility and back to the community. Despite the emergence of programs such as Healthy at Home and ComPacks, this continuum is not consistently or comprehensively available. Some programs target a particular group (people over 65) and are only available in some locations. Additionally, it needs to be recognised that not all people will have the same needs or experiences, and that earlier discharge will impact on different groups in the community in different ways. Some groups that need specific consideration include people from ethnically diverse backgrounds, including newly arrived communities and people with little English, people with disability and people who fall outside of the Home and Community Care (HACC) target groups of frail aged and people with disability. NCOSS has also been informed that more comprehensive involvement of health care professionals is needed where support workers in these programs identify an escalation or deterioration of a condition or functioning.

NCOSS encourages the commission to consider the implications of how shifts in the pattern of service delivery in acute care services in public hospitals - both those that can be identified as current or recent systemic shifts and any that the Commission may recommend – will need to be met with comprehensive complimentary measures from other government human service systems and non-government groups in order to ensure high quality, safe and integrated care for patients, consumers and their carers.

NCOSS is also aware that the NSW Audit Office is currently undertaking a performance audit of Out of Hospital programs, in developing their report we encourage the Commission to consider information available from the Audit Office on this review.

4.4. Responding to sexual assault

Acute services in public hospitals play an essential role in responding to sexual assault. A number of issues have been raised with NCOSS about responses to sexual assault through the acute care system in public hospitals. These factors, whilst mostly evident at a local level, are structural in that the problems are evident and issues are repeated across NSW.

4.4.1. Access

There are a number of factors that affect access to sexual assault responses. In the first instance this includes knowing that it is the local major hospital that will assist. In some cases, hospitals need to work more closely with local communities and service providers to ensure that there is clarity about what hospitals in a region are responsible for in relation to responses to sexual assault, and in particular in clarifying which is the local major hospital.

Accessing the local major hospital can also require travelling significant distances. Police will provide transport but this is not always an appropriate option, as people may not be comfortable contacting police, they also may not have decided to report the assault. Once at the hospital, the person will also need return transport. Sexual Assault services can generally arrange transport (taxi's etc.), but this is not broadly advertised or known, which therefore affects accessibility.

There have also been reports that in some cases administrative staff may act as gatekeepers, refusing treatment to people who do not have a Medicare card. As a person who has been sexually assaulted is a victim of a crime, it is not necessary for them to have a Medicare card in order to receive treatment.

4.4.2. Training

In the first instance, triage nurses are not always trained to respond appropriately to sexual assault, and may not see sexual assault as appropriate to the emergency department. Following on from this, many hospitals do not have Doctors and/or Nurses who have appropriate forensic training. For example, sexual assault victims from North West NSW must travel to Dubbo for forensic responses. In some cases where Doctors are inadequately trained in forensic procedures, evidence is subsequently not admissible as proper procedures have not been followed.

4.4.3. Infrastructure:

There is often a lack of privacy, including in the triage areas of some hospitals. This can often exacerbate the distress experienced by the victim in seeking medical assistance as the result of sexual assault.

4.4.4. Coordination

In many situations a counsellor takes on a coordination role to ensure that police and hospital staff are responding appropriately to the victim. This takes them away from their

role in supporting the victim. This sort of coordination role should be undertaken by an alternative designated person within the hospital system. There is also a need for improved integration with services and support for the victim following on from immediate medical responses, including follow up to ensure access to counseling and pathology results and referral.

4.5. Dementia

In 2005, about 220,000 Australians (about 1% of the population) had dementia. More than a third lived in NSW. Access Economics estimates that in 2050 there will be 730,000 people in Australian with dementia, with about 227,000 people (31%) living in NSW.²⁵

A diagnosis of dementia has been shown to increase a patient's length of hospital stay and hospital resource utilisation. In a recent research study entitled, *Relationships between dementia and length of stay of general medical patients admitted to acute care*, an admission diagnosis of dementia was significantly related to increase length of stay and an increase usage of hospital resources²⁶.

The research also found that patients with dementia waited longer to be referred to an aged care assessment team within the acute care setting and were in hospital longer after the assessment had taken place than those older patients without dementia. These findings, as well as other studies in this area, support the need for early comprehensive assessment of older people in acute care settings.

Whilst some of these issues are taken up in *The NSW Dementia Action Plan 2007- 2009*, organisations such as Alzheimer's Australia (NSW)²⁷ have pointed to the need to develop additional priorities and strategies that better target and reflect the needs of people with dementia and their families and carers. For instance, they have pointed to the need to the need to involve and maintain the relationship of carers, where available, in hospital admission procedures to assist with assessment and individual needs.

4.6. Oral health

Last year the Australian Institute of Health and Welfare reported that dental conditions were the greatest contributor to avoidable hospitalisations for acute conditions in Australia in 2001/02²⁸. In that period more than 43,600 people were hospitalised because of a dental condition placing them in the top five conditions with the highest admission rates (7.9%).

As a result of poor funding, the public dental system has been describes as one that predominantly provides emergency, acute or episodic treatment, with little long term care or prevention. Evidence presented to the Legislative Council Standing Committee on Social Issues *Inquiry into Dental Services in NSW* in 2005 suggested that the present

²⁵ Access Economics 2003, *The Dementia Epidemic: Economic Impact and Positive Solution for Australia*, available at: <http://www.alzheimers.org.au/upload/EpidemicFullReportMarch2003.pdf> (last accessed 19 March 2008)

²⁶ King, B et al 2006, 'Relationships between dementia and length of stay of general medical patients admitted to acute care', *Australasian Journal on Ageing*, Volume 25, Number 1, March 2006 , pp. 20-23(4)

²⁷ Go to: <http://www.alzheimers.org.au/content.cfm?categoryid=21>

²⁸ Page et al 2007 *op cit*

system actually exacerbates existing problems. For example, a submission to that inquiry from Sydney South West Area Health Service stated that:

“Because there are insufficient resources to meet even the demand for emergency care there is very little general care provided in public oral care clinics and, therefore, public patients find themselves in a cycle of deteriorating oral health and repeated extractions.”²⁹

NCOSS has also been informed that there can be a lack of awareness amongst emergency department staff about how to treat people presenting with oral injuries. As a result, the NCOSS submission to the *Inquiry into dental services in NSW* argued for better coordination between emergency departments and dental services, suggesting consideration be given to placing a dental unit within public hospitals. This could be available 24 hours a day, 7 days a week and staffed with a dentist on call.

4.7. Asylum Seekers and Refugees

The NSW Refugee Health Services has estimated that approximately a third of asylum seekers living in the community do not have access to Medicare services³⁰.

The Royal Australasian College of General Practitioners has argued that whilst many refugees are in good health, some may arrive with or develop a range of health care needs. In addition to common health issues experienced by the broader Australian community, they have identified the following common health problems amongst refugees: psychological disorders, direct physical consequences of torture, under-recognised or undermanaged chronic illness, poor oral health, infectious disease and delayed growth or development amongst children.³¹

NCOSS has been informed that there is not a consistent approach to providing asylum seekers and refugees who may not have access to or possess a current Medicare card with free public hospital services. We strongly encourage the Commission to investigate this issue further in their report.

²⁹ Sydney South West Area Health Service submission to the Legislative Council Standing Committee on Social Issues 'Inquiry into Dental Services in NSW', June 2005, p.2.

³⁰ NSW Refugee Health Service, *Medicare Information relating to Refugees and Asylum Seekers*, available at: <http://www.swsahs.nsw.gov.au/areaser/refugeehs/files/Medicare%20Dec%2003.doc> (last accessed 19 March 2008)

³¹ Royal Australasian College of General Practitioners, *Health Care for Refugees and Asylum Seekers*, <http://www.racgp.org.au/refugeehealth>, (last accessed 19 March 2008)

5. Conclusion

NCOSS would like to emphasize that it is clear that a large number of deaths, hospitalisations and the overall burden of disease is avoidable, and that primary health services have an essential role to play in the delivery of prevention services along with the delivery of early diagnosis, treatment and management services. Were this occurring, there is potential for significant positive repercussions for levels of demand on acute care services in public hospitals.

NCOSS has also outlined a range of areas where systemic improvements in the delivery of acute care services are required. We encourage the Commission to consider these issues in developing their report.

NCOSS thanks the Commissioner for the opportunity to respond to the Special Commission of Inquiry.