DEVELOPMENT OF A PRIVATE REHABILITATION UNIT – AN EXPERIENCE

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INTRODUCTION

Facilities available for specialised neurological and orthopaedic rehabilitation, based on the principle of a multidisciplinary approach, are very limited in South Africa. This type of specialised treatment has primarily been available at academic hospitals and those hospitals under the control of the mining industry. The resources available in these sectors have been put under enormous strain, thus limiting the quantity and quality of rehabilitation offered to the physically disabled.

Barney Hurwitz Medical Institute

In November 1991, the directors of a large group of hospitals agreed to convert an already existing hospital into a private rehabilitation institute that would cater for both in- and out-patients. A neurologist and therapists were involved in setting up the departments of physiotherapy, occupational therapy, speech therapy and social work. Nursing staff were responsible for setting up the wards for in-patients.

In February 1992, the establishment was opened, admitting post-acute neurologically impaired and poly-trauma patients for intensive rehabilitation. Within six weeks it was recognised that the staff establishment needed to be expanded. By the end of May 1992, allied medical staff complement consisted of 2.5 physiotherapists, one occupational therapist, one social worker, 0.5 speech therapist, under a rehabilitation coordinator. A clinical psychologist was available on referral.

On admission to the institute, patients were assessed by each specialty, after which the therapists would confer and contract with the patient/caregiver. This allowed the patient and therapist a specific time to reach predetermined goals, as well as preparing the home environment for discharge of the patient.

The patients day was structured so that he was involved in a full day therapy programme with therapeutic activities being carried over in the ward. The programme also included a day or weekends at home prior to discharge from the ward whereafter outpatient therapy could continue. In addition full day, half day or sessional programmes were available to out-patients.

Liaison between disciplines included weekly ward meetings involving medical, nursing and allied medical staff as well as a weekly outpatient meeting.

Problems

Financial

Although the hospital charged medical aid tariffs, a significant number of patients’ medical aids had reached the limit of benefits while the patient was still in an acute care hospital.

Representative Association of Medical Schemes (RAMS) refused to pay for services rendered by the therapists in the employing hospital.

Government gazetted codes as set out by RAMS for physiotherapy do not include a tariff for patients receiving extended periods of rehabilitation, or for assistants carrying out supervised exercise programmes.

Staff

The hospital required specialists in fields of physiotherapy, occupational therapy, speech therapy, social work and nursing, such specialists are scarce and required appropriate remuneration.

Legislation did not allow physiotherapists to be employed by any organisation/person other than the state, the mines and thus could not afford further treatment. This resulted in patients being discharged before reaching their maximal functional potential. Going home still functionally dependent to an unprepared environment puts considerable emotional and financial strain on family and caregivers.

Large institutions running on business principles cannot provide this type of service without showing a profit. Specialised therapists providing a professional service need to be suitably remunerated. Thus a balance must be found between the needs of society and the financial practicalities of running a private rehabilitation institute.

The cost of setting up a rehabilitation centre is substantial. Therefore, the benefits to the patient and community need to be critically appraised. Literature has indicated that rehabilitation in diagnostic groups is of maximal benefit predominantly due to the uniform approach to management (Flicker, 1989). This team approach should engender high moral, amongst the members and initiate research which acts as a catalyst to improve patient care and standards of treatment.

Literature indicates patients rehabilitated on stroke units/wards leave hospital sooner than those on general medical wards (Milikan, 1979). This implies that hospital costs per patient may be less on a stroke unit (Skevis et al, 1984). Results indicate a higher proportion of patients discharged from stroke units were independent compared with those from general medical units (Garraway et al 1980). Garraway found the mean length of stay in the stroke unit was 55 days in comparison to 75 days in a general medical ward. However, at one year follow-up the stroke unit benefit was no longer evident. Ongoing follow-up is more likely to be utilised by those patients who received rehabilitation in a stroke unit (eg district nurses, physiotherapists and day centres) (Garraway et al 1981).

Studies comparing formalised neuro-rehabilitation with non-formalised treatment in functional and cognitive skills have been undertaken. Results show those patients who took part in the formalised programme gained a greater functional capacity with implications for return to work and decreased cost to society (Mackay).

There is now clear evidence as to the benefit to patients and cost effectiveness of skilled and appropriately delivered neuro-rehabilitation (Brooks, 1991).
At the BHMI a tendency towards the above results was experienced. Unfortunately because of the aforementioned problems, completed results cannot be quoted.

**Suggestions:**

Prior to opening a rehabilitation centre which will provide the necessary service, all the legalistic and financial implications must be cleared. This includes permission being granted from the ruling bodies allowing therapists to be employed by hospitals. (Permission can be obtained if motivated - Editor).

Approval must be gained for a composite fee for a rehabilitation package, that will be carried out in an approved rehabilitation environment that provides all the necessary equipment. A package could be worked out depending on the amount and type of therapies required.

The allied medical staff structure should run parallel to the nursing staff with its own hierarchy, thus having a rehabilitation coordinator, senior, junior staff and assistants.

Considering the facilities currently available at the BHMI, patients admitted for rehabilitation could be separated into diagnostic groups. Each group differentiated into its own specialised units/wards allowing for optimal use of these available facilities (e.g. hydrotherapy pool and ADL centre).

**Conclusions:**

Due to these financial and personnel problems, the institute has, of necessity, adapted in order to continue providing this specific service. The institute has established gerontology and general rehabilitation wards. The therapists are no longer employed by the institute and are registered with their specific professional bodies as individual private practitioners. Liaison between team members has remained high, the cornerstone of which is the weekly team meeting during which goals of treatment, social and economic matters pertaining to the patient are discussed.

It should be noted that with the restructuring of medical aid regulations, in 1994, provision for the establishment of rehabilitation units will hopefully be made, either as separate clinics or as specific units within existing hospitals. The recognition of the need for such units and acknowledgment of the benefit to patients who are treated in these establishments must be brought to the attention of those at government level as well as the general population.

**References**


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**WORLD CONFEDERATION FOR PHYSICAL THERAPY**

**Sheena Irwin-Carruthers**

**WORLD CONGRESS**

The most exciting news at present relates to plans for the 1995 Congress and General Meeting, to be held in Washington DC from 25-30 June next year.

Various types of presentations are planned:

- Research reports or special interest reports, both of which may be given either as platform presentations or poster presentations.
- Computer programs, which must be original designs and may not be for sale commercially.
- Materials display tables, which may contain small pieces of equipment, models, graphic material, booklets or data forms. Again these must have been designed by the presenter and must not be available for sale.
- Audiovisual presentations of videotapes, motion pictures, synchronised slide-sound programmes or slides with an instructional leaflet. These must also be original designs and may not be commercially produced.

The deadline for submission of abstracts is 1 September 1994.

In addition, invited speakers will take part in an international clinical lecture series and in case conferences.

Morning round-tables (over continental breakfast) and special interest meetings are planned on a variety of subjects. There is a wide choice of pre- and post-congress CPE courses and there will also be opportunity to visit renowned health care facilities.

Social activities range from official ceremonies and receptions to jazz concerts and picnics - all very tempting!

**NOTE TO SASP MEMBERS**

If you are thinking of presenting a paper or poster at Congress, please ensure that the abstract is submitted to the National Executive Committee by 6 June 1994. This is standard operating procedure for WCPT members, so that high standards may be maintained. The NEC will not be able to consider financial assistance to members delivering papers if their abstracts have not been seen.

The "early bird" registration fee of $275, to be paid by 21 April 1995, is surprisingly reasonable for a Congress which will offer a choice of over 1,000 presentations and is expected to attract no fewer than 12,000 participants.

**POLICY PAPERS**

The Standard Task Force of WCPT has circulated a series of policy papers, requesting the comments of member organisations. NEC will be circulating these to the Branches and to appropriate Groups, Committees, portfolio holders and individuals for their comments, and it is hoped that place will have been found for their discussion during Council. The papers fall into two groups:

- **Declaration of Principle**
  - A Declaration of Principle records the Confederation's agreed stance on an issue affecting the practice of physical therapy internationally.
  - A Declaration of Principle requires a two-thirds majority vote and should become policy for all member organisations. Declaration received to date are:
    - Education
    - Autonomy
    - Standards of physical therapy practice
    - Protection of title
    - Private practice
    - Support personnel for physical therapy practice
    - Quality care
    - The rights of the Patient/client
    - Validation of practice techniques and technology
    - Personnel resources planning
    - Relationships with other health professionals
    - Relationships with medical practitioners

Declarations on Children, Torture, and Physical Therapy and Aged Care Services have already been adopted. The Code of Ethics is being re-drafted at present, having previously been circulated to member-organisations for comment.

**Position statement**

A Position Statement reflects the Confederation's preferred opinion on an issue affecting the practice of physical therapy internationally, recognising the fact that individual member organisations may be at different stages of development.

A Position Statement requires a simple majority vote and may be adopted fully by a member-organisation or may be used when debating the issue at a national level. Two have been received:

- Describing physical therapy
- Curriculum guidelines for entry level physical therapy education.

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References: