



Appendices

8 Appendices

Appendix A Terms of Reference

Terms of Reference for a Review of the Program of Appliances for Disabled People (PADP)

August 2005

Key tasks

Examine current arrangements for the delivery of the Program of Appliances for Disabled People, (PADP) including current and future budgetary requirements up to 2015, and make recommendations on improvements which increase cost-efficiency, and achieve more equitable distribution of equipment and appliances to eligible residents of NSW.

Element 1. Management and Administration

- 1 Identify the full range of publicly funded programs providing equipment to people with a long-term disability in NSW.
- 2 Determine the cost effectiveness of different lodgement systems including a fully centralised PADP lodgement system, a partly decentralised system with a single Lodgement Centre in each Area Health Service, and other relevant models of equipment service provision across Australia and internationally.
- 3 Advise on costs and benefits of consolidation of State Government equipment schemes administered by the Department of Ageing Disability and Home Care (DADHC) and the NSW Health Department.
- 4 Examine the current process of assessing applications (including the use AHS Advisory Committees, and current work on the Priority Assessment Tool and Prescriber Guidelines), and determine the potential cost savings and improvement in quality through alternate models.

Element 2. Target Population and demand issues

In view of the overarching PADP policy statement that it is a program for people who are financially disadvantaged:

- 1 Review the equity of the current threshold levels for each of the four (4) financial eligibility bands including review of the high cost threshold (\$800) for access for Bands 3 and 4 clients.
- 2 Review the equity of the use of the health care card for automatic entry to Band 1.
- 3 Investigate capping the value of PADP's contribution towards:
 - (a) Equipment packages

- (b) Individual items of equipment where the cost of the prescribed item significantly exceeds the average cost for such items
 - (c) Consumable items such as continence pads and nutrition aids
 - (d) Examine the impact on access and equity.
- 4 Make recommendations for a hierarchy of prioritisation for clients with high clinical priority across the four financial eligibility bands.
 - 5 Review the universal access for children given the significant financial burden and lack of choice for low income parents.

Element 3. Budget Requirements

- 1 Determine the efficacy of budget banding for:
 - (a) Low through high cost packages
 - (b) Single use products such as continence pads
 - (c) Equipment supplied on a one-off basis such as mobility or personal care equipment.
- 2 Review the current system of co-payments including grandfathering of clients under previous arrangements and the amount of the co-payment in order to ensure its cost effectiveness and equity.
- 3 Determine current and future budget requirements for PADP in consideration of:
 - (a) Other equipment programs
 - (b) The current equipment list
 - (c) Enhanced technology
 - (d) Expansion of state-wide purchasing contracts to include all standard equipment and services
 - (e) Changing expectations in relation to people being cared for at home
 - (f) Eligibility criteria
 - (g) Cost efficiencies of proactive early intervention strategies
 - (h) The population projections for children and adults living in NSW with moderate to severe disabilities.

Appendix B Recommendations and implementation of recommendations from the 1998 PADP review

Recommendation	Detail of recommendation	Implementation of the recommendation
<p>1. Need for a whole of Government approach</p>	<ul style="list-style-type: none"> • NSW should adopt a whole of government approach to the provision of equipment and aids for people with disabilities living in the community. • This can be achieved by: <ol style="list-style-type: none"> a) NSW Health and the Ageing and Disability Department, as joint sponsors of the NSW Disability Policy Framework, developing a Strategic Plan for the provision of aids and equipment incorporating goals and performance indicators in relation to policy, planning, financing, user charges, procurement and administrative systems b) establishing effective data and information systems within NSW Health and with related agencies to monitor demand for PADP c) undertaking research to accurately assess the equipment needs of specific client groups, the costs of equipment packages and their benefits in terms of reduced requirements for personal care d) improving some aspects of the administration of PADP to get better value for money and improve service to consumers e) negotiating inclusion of aids and equipment in bilateral Commonwealth/State agreements for aged care and disability. 	<ul style="list-style-type: none"> • PADPIS was implemented and will continue to be developed. • The PADPIS provides an information database for individual applicants. It is also a financial management system, adjusting the recorded current budget to reflect committed expenditure at the time an order is placed, and adjusting the budget to reflect actual expenditure when an invoice is received and processed.
<p>2. State PADP Advisory Committee</p>	<ul style="list-style-type: none"> • A State Advisory Committee should be established to advise NSW Health and the Ageing and Disability Department on: <ol style="list-style-type: none"> a) State-wide policy, planning and performance for PADP. b) Desirable outcomes such as increased client independence and reduced reliance on specialist disability support services. c) Initiatives that will improve the targeting, community care service linkages and performance of the Program. • The role of the State Advisory Committee would be to: <ol style="list-style-type: none"> a) Assist NSW Health and the Ageing and Disability Department to develop and monitor implementation of the PADP Strategic Plan. 	<ul style="list-style-type: none"> • A State Advisory Committee was established for PADP, and was first convened in February 1999. • The aim of the Committee is to assist in the ongoing review and development of PADP drawing on recommendations of the study. • The roles and responsibilities of the Committee are as outlined in the recommendations. • The Committee is chaired by the Deputy Director-General, Policy (or delegate) and meets on a quarterly basis.

Recommendation	Detail of recommendation	Implementation of the recommendation
	<ul style="list-style-type: none"> b) Review information on demand, waiting-time and participation in the Program by key target groups and advise on trends. c) Review and periodically update State-wide policies in relation to eligibility, user charges and co-payment. d) Review aids and equipment supplied under PADP and propose new items that have demonstrated potential to improve independence and outcomes and reduce reliance on specialist disability services. e) Advise on procurement and purchasing systems and strategies. f) Monitor consumer and stakeholder feedback on the operations of the Program. g) Propose and review the findings of research on PADP and the role of aids and equipment in minimising the impact of disability. 	
<p>3. State Advisory Committee membership</p>	<ul style="list-style-type: none"> • The State Advisory Committee should include representation of key stakeholder groups including: <ul style="list-style-type: none"> a) NSW Health and the Ageing and Disability Department. b) Key service providers including the Department of Community Services and HomeCare NSW. c) Peak groups, such as ACROD (National Industry Association for Disability Services), the Council on Disability and the Council on the Ageing. d) AHSs in metropolitan and rural NSW. e) A PADP Coordinator. f) Representatives from peak clinical groups responsible for prescribing equipment and aids. g) A representative from a specialist group such as the Independent Living Centre or Technical Aids for the Disabled. 	<ul style="list-style-type: none"> • The Committee includes broad representation from government and NGO's, along with peak clinical groups involved in the provision of services to and the care of people with disabilities in NSW. • The Committee comprises representatives from the following groups: Australian Quadriplegic Association; Disability Council of NSW; Northcott Society; Ageing and Disability Department; Spastic Centre of NSW; Paraplegic and Quadriplegic Association of NSW; Australian Association of Occupational Therapists; Home Care Service of NSW; DeafBlind Association; ACROD NSW; Continenence Foundation of Australia in NSW Inc; Council on the Ageing; Department of Community Services; Muscular Dystrophy Association; Physical Disability Council of NSW; People with Disabilities (NSW) Inc; Australian Physiotherapy Association of NSW; The Multiple Sclerosis Society of NSW; Post Polio Network (NSW) Inc; Thoracic Society of Australia & NZ, (NSW); Chief Executive Officer of an AHS; Policy Analyst, NSW Health Department; and two PADP Coordinators (1 metropolitan, 1 rural).

Recommendation	Detail of recommendation	Implementation of the recommendation
4. State Technical Reference Groups	<ul style="list-style-type: none"> • The State Advisory Committee should have the resources to establish technical reference groups to advise government on issues such as equipment procurement and materials management systems, new product assessment and clinical guidelines, and equitable equipment packages for disabled people with complex needs. 	<ul style="list-style-type: none"> • No technical reference groups were established to date
5. PADP management	<ul style="list-style-type: none"> • NSW Health: <ol style="list-style-type: none"> a) NSW Health should continue to administer the PADP Scheme and undertake planning and performance monitoring for the PADP Strategic Plan in collaboration with the Ageing and Disability Department. b) State-wide performance indicators should be developed and reported annually Relevant indicators may include number of applicants, number of clients assisted, waiting time by client group and the proportion of available funds spent of high cost items, high volume low cost items and oxygen. • Health Services: <ol style="list-style-type: none"> a) All AHSs should establish Area PADP Advisory Committees responsible to the Area Chief Executive Officer for planning, funds management, prioritisation of applicants on the basis of need, and implementation of system improvements. b) All Area PADP Advisory Committees should include consumer representatives. c) Funding requirements by equipment type should be assessed annually in consultation with the principal local service providers such as HomeCare branches, the Department of Community Services Area office and non government organisations providing personal care services for the PADP target groups. d) AHSs, in conjunction with the Ageing and Disability Department and local agencies should establish registers of high need high cost clients to forecast needs and assist budget planning. e) All AHSs should implement consistent systems to provide information to clients and referrers on waiting time, eligibility and user charges. f) Mechanisms for complaints and appeal processes should be standard across NSW. g) PADP performance indicators should be reported as part of the AHS Performance Agreement with the Director-General of Health. 	<ul style="list-style-type: none"> • NSW Health continues to have responsibility fro the program. • State-wide performance indicators are in development. • AHSs were required to establish a PADP Advisory Committee to oversee the functioning of PADP. • Each Committee is a multidisciplinary group involved in the provision of health care services in the AHS and must include representatives of people with disabilities who are PADP customers. • The Committee's are responsible to the AHS Chief Executive Officer for planning, funds management, prioritisation of applicants on the basis of need and implementation of system improvements.

Recommendation	Detail of recommendation	Implementation of the recommendation
6. Definition of disability for PADP eligibility	<ul style="list-style-type: none"> The Disability Services Act 1993 definition of disability should continue to be the basis for defining the first level of eligibility for assistance under the PADP Scheme. 	<ul style="list-style-type: none"> The Disability Services Act 1993 definition of disability has continued to be the basis for defining the first level of eligibility for assistance under the PADP Scheme.
7. Residents in NGO group homes	<ul style="list-style-type: none"> Resident of NGO managed group homes should continue to be eligible for assistance through the PADP Scheme. The number of residents with equipment and aids requirements should be monitored by the Department of Ageing and Disability as part of their service agreements with funded agencies and relevant information provided to assist State-wide planning on PADP resource allocation. 	<ul style="list-style-type: none"> Residents of NGO managed group homes continue to be eligible for assistance through PADP. Since December 2005, residents of DADHC operated group homes do not have access to PADP.
8. Department of Community Services community group home residents	<ul style="list-style-type: none"> The Department of Community Services should undertake an independent audit of the PADP equipment budget, current and future resident needs and projected costs for departmentally managed group homes to establish baseline demand, current levels of expenditure and future funding requirements. The Ageing and Disability Department should review the findings of this audit and commence negotiations with Health and the Department of Community Services to establish a common PADP funding pool. 	<ul style="list-style-type: none"> No independent audit undertaken to date.
9. Residents of Commonwealth funded nursing homes and hostels	<ul style="list-style-type: none"> The PADP Scheme should not provide aids and appliances to residents of Commonwealth funded Nursing Homes and Hostels given current Commonwealth/State roles and responsibilities in aged care. NSW should review the current status of customised equipment provision under the Commonwealth Aged Care Reforms and negotiate the necessary amendment to the regulations. The arrangements for young disabled people residing in Commonwealth funded Nursing Homes and Hostels require review to determine the number of people with high cost equipment needs and the cost/benefit to the State of current residential care arrangements compared to other care alternatives. Subject to the finding of this review and negotiations with the Commonwealth, ongoing access for this group to customised equipment under the PADP Scheme may be warranted. 	<ul style="list-style-type: none"> Residential Aged Care Facilities are responsible for meeting certain equipment needs for their clients. Residents of these facilities may only be supplied with aids and appliances through PADP where the required item is not included in Schedule 1 of the Quality of Care Principles 1997 under the Aged Care Act 1997.

Recommendation	Detail of recommendation	Implementation of the recommendation
10. Eligibility based on need	<ul style="list-style-type: none"> • NSW should continue to use the income test for entitlement to the following Social Security payments and associated concession cards to determine core eligibility for PADP: <ul style="list-style-type: none"> a) Pensioner Concession Card b) Health Care Card c) Health Benefit Card d) Pharmaceutical Benefits Card e) Child Disability Allowance. • AHS Chief Executive Officers should retain some discretion to determine eligibility based on need in borderline cases. 	<ul style="list-style-type: none"> • PADP has continued to use the income test for entitlement to the described Social Security payments and associated concession cards to determine core eligibility for PADP.
11. PADP budget management and State funding pool for high cost equipment	<ul style="list-style-type: none"> • Current approaches to budget management for the PADP Scheme contribute to waiting times for high cost items. The PADP Budget should be segmented into separate components and funds identified and cash flowed appropriately for: <ul style="list-style-type: none"> a) high volume, low cost equipment, aids and appliances b) oxygen c) high cost items such as complex mobility aids. • Funds for high cost items should be pooled at State level to improve purchasing power, reduce waiting times and enable consistent criteria for prioritisation of need and user charges to be applied. Pooling should be introduced by January 1, 1999. A review of the effectiveness of the State Pool should be undertaken in 2001. • AHSs should remain responsible for the assessment and prioritisation of clients requesting high cost equipment, aids and appliances and for making recommendations for the allocation of funds from the State Pool. • Funds for oxygen and low cost items should continue to be administered by AHSs. 	<ul style="list-style-type: none"> • The PADP Budget is not segmented. However, oxygen was removed from PADP in 2000 but continues to be administered by the AHSs under a separate budget. • Pooling of funds for high cost items at State level was attempted, but was abandoned after some years. • AHSs remain responsible for the assessment and prioritisation of clients requesting high cost equipment, aids and appliances. • Funds for oxygen and low cost items continue to be administered by AHSs

Recommendation	Detail of recommendation	Implementation of the recommendation
12. Size of the State pool	<ul style="list-style-type: none"> • The initial budget for the State Pool should be approximately \$3.5 million. • The State Pool should be established using: <ul style="list-style-type: none"> a) the 1997/98 enhancement funds for PADP and any further budget supplementation provided. b) negotiated shares for each Area c) equipment funds for spinal injuries totalling \$0.5m held by Northern Sydney Area Health Service and South Eastern Sydney AHS. 	<ul style="list-style-type: none"> • The high cost pool is no longer used.
13. User charges and co-payments	<ul style="list-style-type: none"> • Provision for user charges and reasonable levels of co-payment should continue to apply to PADP in line with other government managed community care programs. • A standard set of policies on user charges and co-payments should be developed for all major products supplied under PADP. 	<ul style="list-style-type: none"> • All individual PADP recipients are charged a single \$100 co-payment each financial year (except those in Band 4, who are charged 20% of the retail cost of the basic item to meet their needs).
14. Procurement and purchasing	<ul style="list-style-type: none"> • The NSW Health Peak Purchasing Council should be requested to undertake a review of purchasing and procurement options for all products supplied under PADP and to develop appropriate strategies to reduce costs through Area or state-wide contracts. • Once the PADP Information System is in place and producing accurate data on equipment requirements, NSW Health should review options for restructuring procurement arrangements under the Program. This would include the feasibility of moving to leasing or outsourcing for aspects of equipment supply. • Equipment recycling should be adopted as a standard practice to reduce costs for those items of equipment where no loss in functionality or quality would occur. Referrers and consumers should be informed that they may receive refurbished equipment under PADP. • NSW Health should initiate discussions with the Department of Veterans Affairs (DVA) to arrange more favourable terms for the acquisition of surplus Rehabilitation Appliances Program equipment for distribution through PADP. 	<ul style="list-style-type: none"> • Outsourcing aspects of equipment supply was not introduced.
15. Better information on PADP	<ul style="list-style-type: none"> • NSW Health is finalising the development of a state information system for PADP. AHSs should ensure that the Information System is in operation from September 1, 1998 by providing computer hardware and technical support for all PADP Lodgement Centres. • NSW Health should set aside funds for the development of Version 2 of the software by July 1999 to incorporate relevant measures of disability. It is recommended that Functional Impairment Codes be used as the basis for the disability classification with the addition of appropriate codes for respiratory disorders, diabetes and incontinence. 	<ul style="list-style-type: none"> • The PADPIS was developed and implemented across the AHSs. • The development of an improved system is in the pipeline.

Recommendation	Detail of recommendation	Implementation of the recommendation
	<ul style="list-style-type: none"> NSW Health should implement a minimum data set for quarterly reporting on PADP by AHSs from September 1998 to enable AHSs, NSW Health and the proposed PADP State Advisory Committee to monitor demand, cost and waiting time for the Program. 	
<p>16. Information for consumers and referrers</p>	<ul style="list-style-type: none"> A comprehensive Consumer Guide to the NSW PADP should be produced in plain English and community languages for distribution to clients and carers, disability and aged care organisations and community care service providers. A Guide for Referrers and Prescribers should also be produced with additional information for prescribers on clinical indicators for aids and equipment and their role in assisting consumers to select the equipment and aids most appropriate for their needs. 	<ul style="list-style-type: none"> The consumer guide includes standard information on eligibility for PADP, the range of equipment available, the lodgement of applications, mutual responsibilities and expectations, and steps for complaints and appeals.
<p>17. Investing in research and evaluation</p>	<ul style="list-style-type: none"> Funds should be earmarked in all relevant community care programs to provide grants to appropriate bodies and organisations to undertake research and evaluation into the role, benefits, costs and outcomes of equipment provision for people with disabilities. 	<ul style="list-style-type: none">
<p>18. Future investment in PADP</p>	<ul style="list-style-type: none"> NSW should work towards investment of \$284 per capita in PADP by 2001 to meet demand and ensure the Program can continue to support community care policies for people with permanent long term disabilities. Budget supplementation should be phased and linked to successful implementation of strategies to improve value for money and better targeting of resources and to the availability of accurate full year data on demand by type of equipment and cost. Budget supplementation of \$6.7 million over three years is required, taking the PADP budget in 2001 to \$18.5 million. The recommended phasing is: <ol style="list-style-type: none"> \$2.5 million recurrent in 1998/99 \$2.2 million recurrent in 1999/2000 \$2.0 million recurrent in 2000/2001. NSW should explore opportunities to secure a bilateral funding agreement with the Commonwealth to expand provision of equipment and aids in all relevant community care programs. 	<ul style="list-style-type: none"> The PADP budget has been supplemented for several years since 2000.

Appendix C Scheme Comparison

	Equipment Program				
	New South Wales	Victoria	Western Australia	Queensland	New Zealand
Program name	Program of Appliances for Disabled People (PADP)	Victorian Aids and Equipment Program (A&EP)	Community Aids and Equipment Program (CAEP)	Medical Aids Subsidy Scheme (MASS)	Enable New Zealand and Accessable
Description of the program	Eligibility program	Subsidy program	Eligibility program	Subsidy program.	Eligibility program
Application process	<p>The application process involves:</p> <ul style="list-style-type: none"> From obtained from lodgement centre. Prescription required from appropriate health professional. Lodgement centre staff determine means test eligibility. 'Equipment list' defines aids and equipment categories. Lodgement centre processes application and orders equipment. 	<p>The application process involves:</p> <ul style="list-style-type: none"> Referral to service provider. Service provider establishes if applicant is within the target population, if yes forwards an application form, responsibility of client to collect all documentation required. GP certifies diagnosis of disability Application returned to service provider for consideration. 	<p>The application process involves:</p> <ul style="list-style-type: none"> Applicant obtains a referral from doctor or therapist (known as the referrer). Referrer sends application to a specifier for an assessment of the applicant's specific needs. After assessment, specifier will recommend the correct item of equipment, and ensure the funding approval is forthcoming from the service provider. 	<p>The application process involves:</p> <ul style="list-style-type: none"> Designated MASS prescribers for each category of aids/equipments (in consultation with applicant) submits an application to MASS for consideration for subsidy funding assistance 	<p>The application process involves:</p> <ul style="list-style-type: none"> Specialised assessor's asses the needs, goals and appropriate equipment of an individual. Able to approve equipment up to the value of \$500. Greater than \$500 approval is required from Enable Funding, greater than \$20,000 approval required from the Health Funding Authority
Managing authority	NSW Health and Area Health Services	Department of Human Services	Disability Services Commission	Queensland Health	Health Funding Authority

	Equipment Program				
	New South Wales	Victoria	Western Australia	Queensland	New Zealand
Information available for the client	Information brochure ¹⁸ and policy ¹⁹ available on NSW Health's website.	Website ²⁰ includes brochure, application form & program guidelines.	Website ²¹ includes a brochure detailing application process, eligibility and equipment available.	Website ²² detailed information, includes application form, eligibility, procedures, application process and publications.	Website ²³ informing clients to arrange a needs assessment and provides two telephone numbers to locate an assessor.
Prescriber for aides and equipment requirements	On the basis of expertise, prescribers are allocated to equipment categories to provide a prescription.	Specialist assessors provide assessments in the relevant categories. Costs incurred are paid by applicant.	Select health professions determine the requirement for aids or equipment.	Conducts initial needs assessment and is responsible for application. Each group of aids has a selected prescriber(s).	Specialist assessors established in accredited areas assess the eligibility/equipment options.
Equipment covered by the program	Equipment categories defined in policy guidelines	<i>See equipment scheme table below.</i> The program does not provide the following: <ul style="list-style-type: none"> • Aides or equipment specifically for use at work or in educational settings. • Funding for aides and equipment that are standard household or 	<i>See equipment scheme table below.</i>	<i>See equipment scheme table below.</i>	Self propelling wheelchairs, aids to communicate expression of core needs, individualised walking sticks ad frames, individualised complex seating support systems, shower commodes.

¹⁸ <http://www.health.nsw.gov.au/health-public-affairs/factsheets/pdf/padp.pdf>

¹⁹ http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_563.pdf

²⁰ http://hnb.dhs.vic.gov.au/ds/disabilitysite.nsf/sectionthree/aids_equipment?opendocument#Related

²¹ http://www.dsc.wa.gov.au/2/234/67/Community_Aids_.pm

²² <http://www.health.qld.gov.au/mass/default.asp>

²³ <http://www.weka.net.nz/weka/weka.nsf/wpgsectionindex/Living+with+a+Disability--Equipment>

	Equipment Program				
	New South Wales	Victoria	Western Australia	Queensland	New Zealand
		personal items (e.g. washing machines, beds, clothing etc) and generally regarded as a community norm for the person or their family to purchase <ul style="list-style-type: none"> • Funding for items associated with medical treatment or surgical interventions • Funding for the provision of short-term aides and equipment. 			
Eligibility - assessment	Includes DVA clients.	Must be a permanent resident of Victoria and hold a Medicare card, have a permanent or long term disability and/or frail aged, and require aids and equipment from the aids' available list on a permanent or long-term basis.	Must have a disability of a permanent or indefinite nature, are not currently hospital patients, are holders of one of a number of specified concession cards, are in a residential situation that is structured to encourage independent living and live in the community for the majority of the time, are resident in a private home to be eligible for home modifications, and have not received a compensation settlement.	Must be a permanent resident of Queensland, be shown as currently eligible for benefits, have a permanent and stabilised condition or disability which restricts activities in the home environment, meet the clinical guidelines applicable to each section of the MASS State-wide Prescriber Procedures Manual for the requested aids and equipment, provide clinical justification by the prescribing health professional as to why the aids and equipment are needed, and be able to appropriately store and maintain the aids and	Reside in NZ, assessed by a specialist assessor as required, and the equipment/aid is required for improved quality of life.

	Equipment Program				
	New South Wales	Victoria	Western Australia	Queensland	New Zealand
				equipment. Specific eligibility criteria apply to specific categories of aids and equipment.	
Eligibility - means testing	<p>Band 1: All people aged 16 and over holding a pensioner card or Health Care Card.</p> <p>Band 2: Taxable income \$26,759 (single) or \$45,490 (couple/family).</p> <p>Band 3: Taxable income for singles ranges from \$26,760 to \$39,941 and for families \$45,491 to \$67,899.</p> <p>Band 4: Taxable income above \$39,941 (singles) and \$67,899 (families), and they are only eligible to apply for high cost items (i.e. greater than \$800).</p> <p>The policy states that the Bands are to be reviewed annually.</p>	Not known.	If not a holder of one of the above cards, can apply for consideration on the grounds of financial hardship.	Not known.	Not known.

	Equipment Program				
	New South Wales	Victoria	Western Australia	Queensland	New Zealand
Individuals who are not eligible for the program	Those who are ineligible include: outpatients, clients with far advanced progressive disease, community nursing assistance, health funds and compensable clients, residents of department of community services facilities for people with developmental disabilities and residents in hostels and nursing homes.	Those who are ineligible include: those in supported accommodation equipment access scheme, DVA gold card holders, Government funded residential care facilities and Victorian Work cover authority. A patient of a public or private hospital can claim cost of aid equipment through a private health insurance policy, within 30 days following post discharge from a public hospital where aid or equipment is related to the hospital admission.	Those who are ineligible include: hospital patients who have been discharged without the equipment, are residents of the commonwealth government funded aged care accommodation, or are eligible for equipment under other programs e.g. DVA, CRS Australia.	Those who are ineligible include: WorkCover, DVA, residential aged care facility recipients with a residential classification of 1-8 for oxygen and 1-4 for other aids and equipment. Or those who are one of the following: hospital inpatients, public hospital medical grade footwear, palliative care eligible persons, ostomy association persons, compensations claims, children under the age of 5 for incontinence pads and nappies.	Those who are ineligible include those who have a disability resulting from trauma, accident or injury.
Waiting lists	Variable, dependant on Area Health Service.	Not accessible.	Not accessible.	No waiting list ²⁴ .	Not accessible.
Children	Children under the age of 16 are eligible regardless of parental/carer income.	Children are mentioned on the web site, but in no specific capacity.	Not mentioned in guidelines.	Different eligibility applies for children aged less than 16 for some aids/ equipment depending on the child's age.	Not mentioned in guidelines.

²⁴ <http://www.health.qld.gov.au/mass/publications/newsletters/massactionsept2005.pdf>

	Equipment Program				
	New South Wales	Victoria	Western Australia	Queensland	New Zealand
Co-payment	<p>People requesting an item less than \$100 in a financial year with financial hardship are asked to make a co-payment</p> <p>A single co-payment of \$100 for everyone including people who require multiple items, except for those in Band 4.</p> <p>20% of retail value for those people in band 4.</p> <p>If a person wishes to upgrade, they are required to meet the additional cost.</p>	<p>If the item exceeds the subsidy cost, the service provider advises the supplier and client that a separate invoice covering the difference must be issued to the client.</p>	<p>Joint funding conditions include:</p> <ul style="list-style-type: none"> • Equipment which is recyclable remains the property of the service provider. • If the applicant has contributed to greater than 50% of the item, items are consumable, or have undertaken home modifications, and then the applicant owns the item. • Maintenance remains responsibility of service provider. • If the family/applicant has made a significant contribution to the initial purchase of an item, they will not be required to contribute to the replacement or updating of basic and essential features if item is still on imprest list. 	<p>Co-payment conditions include:</p> <ul style="list-style-type: none"> • Co-payment must be between applicant and MASS, not third party arrangements. • MASS retains ownership of the loan aid and assumes responsibility for repairs/maintenance. • A statutory declaration needs to be signed to indicate commitment to the co-payment responsibility. • Applicant will make their co-payment direct to the supplier. 	<p>An individual may purchase a more expensive item, however they are required to pay the additional costs.</p> <p>Regardless of the contribution made, the equipment remains the property of the health funding authority.</p>

	Equipment Program				
	New South Wales	Victoria	Western Australia	Queensland	New Zealand
Local or centralised processing	Area health services are responsible for PADP, with the NSW Health responsible for the monitoring and evaluation of the Area Health Services.	Department of Human Services manages the budget and allocations to regional Victorian A&EP service providers. Service providers: manage program and determine priorities of applications	Disability Services Commission is responsible not the Health Department of WA. The commission operates as a source of funds to number of service providers receive funding from central pool for these services.	MASS runs through the Queensland Health Department.	Health Funding Authority contracts out to either enable NZ or <i>accessible</i> as the service providers. The Health Funding Authority is still in charge of eligibility criteria for equipment purchased.
Priority assessment	Bands 1-3 have priority over Band 4. Each Area Health Service and local PADP Advisory Committee should establish budgets and broad aid categories where appropriate, that address priority of need for each category, timeframes for the provision of items, and the creation of priority list in order of date of application for clients requesting low urgency items.	Priority ratings include: 1. No waiting category <ul style="list-style-type: none"> • Clients who meet the clinical eligibility criteria of the oxygen program. • Wheelchair repairs. • Ongoing supply of continence aids. • Availability or re-issue aids and equipment. 2. High urgency category <ul style="list-style-type: none"> • Aids & Equipment critical to the safety of client or injury prevention in daily living activities. • Non availability will lead to a deterioration of the client's health or functioning. 	The appropriate service provider is expected to provide all items on the standard list of aids/equipment.	Category 1: <ul style="list-style-type: none"> • Oxygen. • Ongoing continence supplies. • Enabling a QLD public hospital discharge to occur. • At risk of imminent hospitalisation because of safety or medical need. • Repairs or maintenance to existing mass aids and equipment. • Modifications and or accessories to mass aid for a mass client who is at risk. • Replacement of a mass aid that is unsafe for use. Category 2:	Not known.

	Equipment Program				
	New South Wales	Victoria	Western Australia	Queensland	New Zealand
		<ul style="list-style-type: none"> • Non availability will lead to excess demands on carers in caring for person. <p>3. Low urgency category</p> <ul style="list-style-type: none"> • Length of waiting period. • Clinical factors as indicated by prescribing therapist. 		<ul style="list-style-type: none"> • All other categories. 	

Equipment scheme table

Equipment category	Equipment Scheme		
	Victoria	Western Australia	Queensland
Walking Aids	<ul style="list-style-type: none"> • Frames • Gutter crutches • Specialised walking aids • Standing frames • <i>Not included: sticks, crutches</i> 	<ul style="list-style-type: none"> • Crutches • Walking stick/frame • Standing frame 	<ul style="list-style-type: none"> • Not mentioned
Wheelchairs	<ul style="list-style-type: none"> • Manual (basic and light weight) • Electric • Scooters • Customising 	<ul style="list-style-type: none"> • Manual/powerd • Powered scooter • Stroller/buggy for postural seating • Wheelchair push mitt 	<ul style="list-style-type: none"> • Manual/power drive and accessories • Foam/pressure reduction cushions • Wheeled walking aids • Infant/child mobility aid
Orthosis	<ul style="list-style-type: none"> • Orthosis • Callipers • Corsets(surgical) • Braces • Cervical collar • Shoes (specialised) • Custom moulded orthosis/built-up 	<ul style="list-style-type: none"> • Orthosis (including spinal/upper limb + modifications-minor/major) • Shoes (specialised, modified or custom made) 	<ul style="list-style-type: none"> • Lower limb and spinal orthosis • Shoes (prefabricated, customised, custom made)
Continance aids/Pressure garments	<ul style="list-style-type: none"> • Anal plugs • Catheters • Connectors • Drainage bags/bottles • Intra-vaginal bladder support • Washable continuance pads/pants • Tubes • Waterproof covers for mattress • Environmental control units • Lymphedema compression garments • Mammary prosthesis • <i>Not available: disposable continance pants/nappies</i> 	<ul style="list-style-type: none"> • Pressure management garments • Mammary prosthesis 	<ul style="list-style-type: none"> • Reusable pants • Disposable nappies/pads • Stretch pants • Reusable bed pads • Disposable catheters • Indwelling catheters • Latex sheaths • Night drainage bags • Leg bags • Catheter valves

Equipment category	Equipment Scheme		
	Victoria	Western Australia	Queensland
Oxygen	<ul style="list-style-type: none"> • Concentrators • Oxygen gas 	<ul style="list-style-type: none"> • Ventilator • Continuous airway pressure appliance • Respiratory appliance mask complete or parts • Humidifier 	<ul style="list-style-type: none"> • Not mentioned
Personal Use items	<ul style="list-style-type: none"> • Bath seats • Bed sticks, rails, cots • Beds/mattresses-specialised • Blocks to raise head of chair/bed • Child car seat • Commodes/shower • Transporters • Electronic lounge chair • Hoists (ceiling, eclectic) • Hydraulic adjustable height change table • Over toilet rails, raised seats • Portable ramps • Pressure care equipment • Safety helmets • Seating (specialised) • Self help poles • Shower chairs/stools • Transfer equipment • Trolley-kitchen 	<ul style="list-style-type: none"> • Bath seats • Bed rail • Pressure management mattress • Bed backrest • Bed end/bed raise • Commode • Hoists (manual/electric) • Height adjustable table • Toilet frame, step, support • Helmet • Shower hose/chair/stool • Kitchen-trolley • Bath support • Shower chair/commode cushion • Alternative positional seating • Mechanised standing equipment • Night time positioning equipment • Optical prosthesis • Postural support • Specialised chair/stool • Leg rest • Cushion • Transfer board 	<ul style="list-style-type: none"> • Bath boards • Pressure reduction mattresses • Non-mobile commodes • Electric mobile floor hoists/slings • Mobile over toilet • Mobile shower chairs • Bathroom transfer benches
Wigs	<ul style="list-style-type: none"> • Basic synthetic wigs • Human hair only <16 	<ul style="list-style-type: none"> • Wig 	<ul style="list-style-type: none"> • Not mentioned

Equipment category	Equipment Scheme		
	Victoria	Western Australia	Queensland
Communication aids and equipment	<ul style="list-style-type: none"> • Electronic voice aids/electrolarynz • Voice prosthesis • Electronic communication device scheme 	<ul style="list-style-type: none"> • Communication board • Communication card • Tangible symbols • Communication/cant book • Eye pointing frame • Box scanner • Memory/message box without voice input • Single switch for voice output device • Computer interface/access • Alternative keyboards • Mounting systems • Replacement battery • Communication output device with or without voice • Electrolarynz replacement • Voice amplifier • Cochlear implant speech processor 	<ul style="list-style-type: none"> • Electro larynges • Electronic communication devices
Home modifications	<ul style="list-style-type: none"> • Modifications to kitchen/bathroom/toilet/ • Laundry • Toilet attachment/thermostats • Door fitting • Door widening • Hand basins for w/c access • Hand held showers and switch cocks • Hand rails and grips • Painting repairs • Non-slip paint for ramps • Power outlets/switches • Shelving for w/c access • Safety flooring • Shower screen • Taps (where tap turner cannot be used) • Ramps/step modifications 	<ul style="list-style-type: none"> • Needs additional application 	<ul style="list-style-type: none"> • Not mentioned

Appendix D Discussion Paper

Purpose of this paper

PricewaterhouseCoopers has been appointed by the NSW Department of Health to undertake a review of the NSW Program of Aids for Disabled Persons (PADP).

This paper has been prepared to aid in the round of discussions being undertaken by PricewaterhouseCoopers during November and December 2005.

These discussions are intended to provide the opportunity for consumers, their families and carers, equipment suppliers, advocacy groups and consumer organisations and health and disability care workers to comment on the operation of, and on the policies and procedures that govern the current program.

In addition to comments provided at the consultations written comments may be forwarded to:

Ms Rebecca Jessop
PricewaterhouseCoopers
GPO BOX 2650
Sydney 1171

Or emailed to

rebecca.jessop@au.pwc.com

Or Faxed to

(02) 8286 5962

Rebecca can be contacted on (02) 8266 5962

Why have this review

This review is examining three major elements of the Program:

- Management and administration
- Target population and demand
- Budgetary requirements and financial management.

Each of these elements is considered in some detail in Section 5 of this discussion paper, but in particular there are a number of key issues that will need to be addressed in this review. These are:

- Consistency of practice between lodgement centres within and across Area Health Services
- Efficiency of operation of lodgement centres in processing applications
- Potential for duplication and confusion between different schemes
- The wide variety in cost of equipment and packages
- Projected increase in demand at a higher rate than overall population growth, due to correlation between age and disability and improved survival rates for people with a disability, and shift the towards community care
- The impact of low-cost single-use items on the budget and the need to balance the supply of high cost and low cost items
- Potential for ambiguity in the eligibility criteria and some adverse consequence in the current eligibility criteria
- Inequity and inconsistencies in equipment distribution and the difficulty in balancing clinical need with financial need
- A range of issues in relation to the financial model of the project including patient co-payment, budget banding and state-wide procurement.

Background to PADP

PADP provides equipment, aids and appliances to eligible residents with life-long or long-term disabilities in order to help them live and participate in their communities. PADP aims to assist those individuals who are financially disadvantaged and have a disability of a permanent or indefinite nature. Access to PADP is means tested for adults, while access for children (less than 16 years old) is universal.

The program was established in 1982 and is administered by NSW Health through the Area Health Services. PADP budgets are allocated by NSW Health using a specifically developed 'Resource Distribution Formula'.

The current Policy for PADP commenced on 1 January 2001. This policy sets out a framework for Area Health Services administering the program, and includes guidelines to assist them to provide appliances and equipment.

As outlined in the PADP policy, the objectives of the program are to ensure:

- 1 improved access to appropriate equipment and appliances based on a person's needs
- 2 improved quality of life for people with disabilities

- 3 improved capacity to participate in family and community activities and the prevention of premature and inappropriate entry in to institutional care
- 4 continuity of care
- 5 effective management of existing resources
- 6 timely and efficient service
- 7 improved customer service.

Budget, target population and demand

Annual Budget

There has been a substantial growth in the annual budget for PADP over the past five years. In 2001/02 the available PADP budget was \$10.4 million. This had increased to \$21.8 million by 2004/2005. Budget increases of \$0.5 million in both 2005/06 and 2006/07 are planned.

How the budget is spent

The most commonly supplied equipment items provided through the PADP include:

- showering and toileting aids
- wheelchairs
- seating support systems
- patient lifters
- continence aids
- communication devices
- environmental control units
- breast prostheses.

The data in the tables below has been provided by the Department of Health from the PADP IS database and represents the data supplied by Centres for 2003/2004. Not all Centres provided data to the Department during that year, and it is believed there are some gaps in the data, particularly in relation to the supply of incontinence products. These gaps have arisen due to some characteristics of the PADP IS software. Accordingly these tables are provided for guidance and should not be relied on as a true representation of cost or distribution – for example the \$9.8m in 2003/04 total expenditure presented in Table 1 does not reconcile with the total budget for this year.

Table 41 shows the break-up of expenditure on new equipment across types of equipment and age groups for 2003/04. This is the most recently available data for a full year.

Table 41 indicates that mobility aids were the leading expense for those aged 0-15, 16-44 and 45-69 years, which accounts for approximately 50% of all expenditure. Incontinence aids were the leading expense item category for individuals aged 70 and over.

Table 41 NSW PADP 2003/04 percentage of total expenditure for newly purchased equipment by age-group for 2003/2004

Equipment Group	0-15	16-44	45-69	70+	Total
Incontinence	22.8%	13.0%	9.1%	41.7%	20.4%
Mobility	48.8%	54.4%	53.7%	31.5%	48.1%
Others	4.6%	5.2%	10.4%	10.6%	7.5%
Maintenance	1.8%	6.7%	7.9%	2.4%	4.9%
Beds and Seating	7.6%	10.3%	11.1%	7.0%	9.1%
Self Care	4.0%	7.7%	4.9%	3.7%	5.2%
Nutritional	8.2%	1.9%	0.9%	0.9%	3.1%
Prostheses	0.2%	0.2%	0.8%	1.0%	0.5%
Communication	2.0%	0.5%	1.2%	1.3%	1.2%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%

Figure 8 and Figure 9 outline the percentage of the total expenditure for mobility aids and incontinence aids by age group for 2003/2004.

Figure 8 NSW PADP 2003/04 percentage of total expenditure for mobility aids by age group

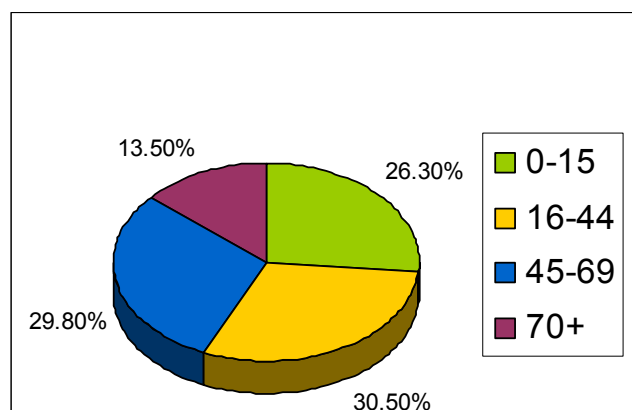
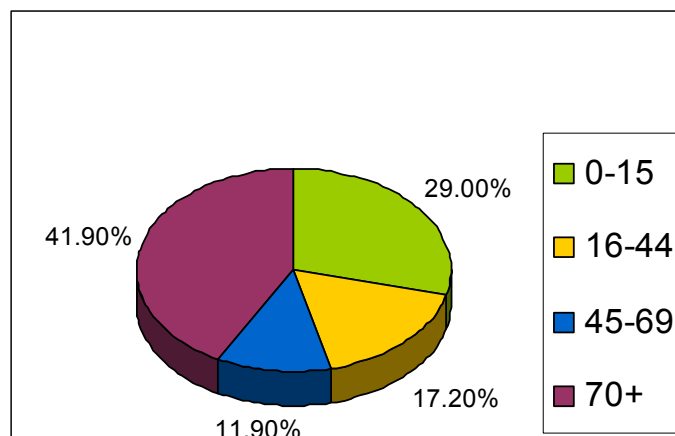


Figure 9 NSW PADP 2003/04 percentage of total expenditure for incontinence aids by age group



Unit cost of items

Individuals aged between 0-15 years accounted for the highest percentage of expenditure and the highest percentage of demand in nutritional aids and accounted for the highest percentage of expenditure in communication devices.

Clients in the 16-44 age group had the highest percentage of expenditure on self care and mobility devices.

Individuals aged 45-69 years had the highest percentage of expense and highest percentage of demand in beds and seating and maintenance. This client age range also accounted for the largest expense in prosthesis and others and the largest demand in mobility and communication devices.

Groups over 70 accounted for the highest percentage of expenditure and demand for incontinence equipment. This age bracket also had the highest percentage of demand in self care, prosthesis and other equipment.

Waiting lists

Each lodgement centre maintains waiting lists. The waiting lists are submitted to NSW Health on a six monthly basis.

The most recent collection of waiting list data submitted to the NSW Health was in May 2005. However the details of that data are no longer useful to this discussion paper for the following reasons:

- As special arrangements have been made to reduce waiting lists and so the previous data is now inaccurate.

Lodgement centres will next submit waiting list data at the end of November 2005.

Key issues for the program

Access

This section covers the arrangements for people to gain access to the program, including information, lodgement centres, application and prescription.

Current policy

Dissemination of information about PADP

NSW Health provides information on the PADP on its web site at <http://www.health.nsw.gov.au/health-public-affairs/factsheets/pdf/padp.pdf>. The most recent policy statement on PADP dated 2000 is also available from NSW Health.

Some peak groups such as Carers NSW also provide information on PADP on their website.

Lodgement Centres

Access to PADP for most persons seeking aids or equipment is through their local lodgement centre.

There are 27 PADP Lodgement Centres (Centres) in NSW all administered by a public health facility.

The number of Area Health Services was reduced from seventeen to eight on 1 January 2005. As a result of the amalgamation of Area Health Services, there are now a number of Centres in each Area Health Service.

Making applications

Applications are made to the local Centre, which process the applications.

Each Centre is allocated a budget to pay for the services requested by the applications from local eligible persons. The allocation of funds to each Centre is allocated based on a formula that takes account of the relative aged distribution and level of disability in the local catchment area.

Prescriptions

Equipment and aids have to be prescribed and this prescription has to support the application. The categories of authorised prescribers are specified in NSW Health's policy.

Table 42 summarises these issues and raises some options for discussion.

Table 42 Access Issues, Facts and Options

Issues	Facts	Possible options
Information	Information for potential consumers on PADP is available from health, disability and rehabilitation professionals. PADP is not advertised, yet more people than the budget can support appear to make application to it each year.	<p>Should PADP be advertised although it has a limited and fixed budget?</p> <p>Is there any evidence that persons who may be eligible are missing out through lack of information about the program?</p> <p>Is there a need for more information to be available to persons who may be eligible or would this be a waste of the limited funds available?</p>
Administration	A variety of different models are used for the administration of the Lodgement Centres across NSW. Some Centres are administered as part of the local rehabilitation, aged and community care services. While in other locations they are administered as part of the general finance and administration services of the Area Health Service. The roles, skills and experience of the coordinators vary from Centre to Centre.	<p>Are there advantages to locating the PADP service with the health professionals who are likely to be making the assessments for eligibility and monitoring the progress of the consumer?</p> <p>Should the administration of the service remain separate and distinct from the professional making the assessment decisions and monitoring the progress the person supplied with the aids and equipment?</p>
Number of Centres	The number and location of the Centres is historically based and has not been reviewed since the administrative changes to Area Health Services on 1 January 2005.	<p>Is there the right number of Centres in the right locations?</p> <p>Is it more cost effective to have the Centres located close to the supply of equipment pools at local hospitals and working closely with the local service providers, or should they be centralised to save administrative costs.</p>
Cost of Centres	In most cases, the cost of the coordinator is paid for by the PADP budget. Local policy determines if any other administrative costs are charged to the PADP budget.	Should the cost of administrative arrangements remain as a local decision?
Application forms	Each service produces its own application form and has its own method of assessment. All Centres are required to comply with the NSW state policy. To access the service, consumers are required to complete an application form from the local	<p>Should there be a single state-wide application form to guarantee that there is equity in this element of the program?</p> <p>Is there any advantage in have an application form that can be downloaded from an Internet</p>

Issues	Facts	Possible options
	Lodgement Centre.	website?
Prescribing	<p>There are many instances where the prescriber is a professional who has an established relationship with the consumer that may influence their prescription in order to get the 'best' for their client or patient.</p> <p>The skills and experience of the prescribers varies considerably, particularly for some items of equipment that need to be customised.</p> <p>In some instances of specialised equipment, prescribers will seek the advice of equipment manufacturers and suppliers.</p>	<p>Should prescribers for specialised equipment have special training and experience?</p> <p>If yes, who would pay for this training or would this place an additional and unacceptable burden on the PADP budget to pay for such training?</p> <p>Should the prescription of some items (particularly high cost items), be the responsibility of prescribers who are independent of the person treating the individual Would this result in poor decisions, additional cost and further delays?</p>

Eligibility

Current policy

The current policy describes the target population in part 4.

The target population for PADP is those individuals living in the community who:

- have a disability of permanent or indefinite nature (eg. a disability likely to last more than 12 month regardless of the cause of the disability) as defined under the Disability Services Act 1993;
- are a permanent resident of the Area Health Service;
- are resident in a group home operated by a non-government organisation on behalf of the Ageing and Disability Department, Department of Community Services or NSW Health;
- have not received compensation or damages in respect of the disability for which the aid has been prescribed;
- have been discharged from hospital for at least one month and are not eligible for the provision of equipment under a loan arrangement or on a permanent basis by a hospital or health service for the condition for which the equipment is required; and
- are not eligible to receive the requested appliance under any other program.

Eligibility Criteria

Following is an excerpt from Part 2 of the current policy statement.

All children under the age of 16 years within the target population are eligible for PADP regardless of parental or carer income, including children in foster care.

All people aged 16 years and above within the target population are eligible for PADP in accordance with the following financial criteria:

- Band 1: All people aged 16 years and above holding a Centrelink pension or a Health Care Card are eligible for PADP.
- Band 2: All people aged 16 years and above whose taxable income in the preceding financial year was less than or equal to \$26,759 (single) or \$45,490 (couple or family) are eligible. These figures include an allowance for an estimated \$5,000 per annum to cover the cost of a disability. A further \$1,500 per dependent person is to be added to the single and family income figures for applicants with dependents.
- Band 3: All people aged 16 years and above whose taxable income in the preceding financial year was \$1 above the upper level in Band 2 and less than or equal to \$39,941 (single) and \$67,899 (couple or family) are eligible for high cost items only under PADP. These figures include an allowance for an estimated \$5,000 per annum to cover the cost of a disability. A further \$1,500 per dependent person is to be added to the single and family income figures for applicants with dependents.

- Band 4: All people aged 16 years and above whose taxable income in the preceding financial year was above \$39,941 (single) and \$67,899 (couple or family) adjusted for dependents are eligible to apply for high cost items only.

Applicants in Bands 1-3 have priority over applicants within Band 4 except with approval of local Advisory Committees.

The income bands for people aged 16 years and over are based on the mean income of residents in the 10 postcode areas with the lowest incomes in NSW (Band 2) and the mean income for all NSW residents (Band 3) as recorded by the Australian Tax Office for the 1997/98 financial year.

Current performance and Issues

Centres that cover populations in wealthier communities report a concern with the access by children of relatively wealthy families to the program, while other persons of considerably lower wealth and income remain on the waiting list.

There is some ambiguity around the supply of aids and equipment to persons who are receiving care under the Commonwealth’s Aged Care Program through the Community Aged Care Packages (CACP) and Extended Aged Care At Home (EACH) program. These categories are not specifically dealt with in the current policy.

In some Centres, persons who are in Band 3 or 4 are discouraged from leaving their name on the waiting list, as they are unlikely to be granted supply of equipment through the local Advisory committee due to the preference given to persons in Bands 1 and 2.

Comparisons have been made between incontinence products and oxygen. In 2001 oxygen was removed from the PADP budget on the basis that it was a high percentage of the cost of the program and an argument was made that it should not be part of a disability supply program as it was disease related. An ‘once off’ adjustment was made to the PADP budget and provided to the Area Health Services. Oxygen has continued to be administered through the PADP program but is not paid for from the PADP budget. There is a suggestion that incontinence products should similarly be removed from the PADP budget. However, there is a significant difference as continence problems are not disease specific.

Table 43 summarises these issues and raises some options for discussion.

Table 43 Eligibility Issues, Facts and Options

Issues	Facts	Possible options
Children’s access	Universal access for children under the age of 16, regardless of parental financial situation.	Should the eligibility testing for children less than 16 years of age be based on the income of their family? Should children be prioritised based upon the income of their family, that is, children from low income families receive assistance first.

Issues	Facts	Possible options
High cost items	As all applications for equipment and/or aids costing more than \$800 have to go through the local advisory committee, decisions are delayed until the committee meets.	Should the cost limit of applications for which the local advisory committee Advisory Committee must assess be raised to \$2000 to reduce delays?
Health Care Card holders	There are reports that not all persons holding a Health Care Card, which gives them access to PADP, are in a low-income category.	Should the eligibility for Band 1 be restricted to those who meet the income test only, and exclude persons who have a Health Care Card but do not meet the income test?
Banding system	Persons on the waiting list in Bands 3 and 4 may never reach the top of the list.	Should the eligibility for PADP cut-out at Band 2 (the average income in the 10 postcodes in NSW with the lowest incomes)?
Incontinence products	Consumables, such as incontinence products, are a high cost to the program. Clients may need the product over a long period of time.	Should some consumables (e.g. continence products), be quarantined as a separate budget and taken out of the PADP (similar to how oxygen is managed)? Would removing continence products from PADP disadvantage persons whose problems are disability rather than disease related?

Management and administration

Current policy and performance

\$100 co-payment

Since 2000, all persons eligible for PADP are requested to pay a \$100 co-payment each year. Persons who were receiving supplies at the time the co-payment was introduced are not required to make the annual \$100 payment.

The \$100 co-payment is not income related, is not related to the cost of the equipment and has not been indexed since it was introduced.

One Lodgement Centre has determined that about 280 persons on their program are exempt from the \$100 co-payment due to the grandparenting clause. This amounts to a loss of income of \$28,000 a year.

If this arrangement were removed the Centre could supply either:

- nearly 30 beds, or
- 2 ½ electric chairs, or
- 15-20 manual chairs, or
- 30 shower commodes, or
- 12 electric hoists.

Local Advisory Committees

- The current policy requires each lodgement centre to have a Local Advisory Committee to make decisions and recommendations regarding high cost items (over \$800). The current policy states that:
- *'Each PADP Advisory Committee is a multidisciplinary group involved in the provision of health care services in the Health Service and must include representatives of people with disabilities who are PADP consumers. The position should be advertised in the local press and applicants interviewed to ensure appropriate and effective representation of people with disabilities or their advocates and guardians. Any payment of consumers for their participation on a local PADP Advisory Committee should be in accordance with the current Premier's Memorandum on remuneration of board and committee members.'* (Section 19.2).
- Some issues have arisen with the decision-making capacity of consumer representative on Advisory Committees. In a number of cases, it has been reported that they have difficulty in making objective rationing decisions. There are also privacy issues in small communities where persons with disabilities may be well known in the community.

Table 44 summarises these issues and raises some options for discussion.

Table 44 Management and administration Issues, Facts and Options

Issues	Facts	Possible options
Maintenance and repairs	<p>Lack of management/ monitoring around the maintenance, repair and replacement of equipment could be causing the program to lose equipment or to pay for repairs of equipment that should be condemned.</p> <p>There is currently no central database on available equipment that is no longer needed in a particular Area Health Service.</p>	<p>How much effort should go into the development and maintenance of a continuous and effective equipment list, which would be achievable for at least 50% of stock – with codes and basic prices?</p> <p>Should the effort go into the establishment and maintenance of a state-wide database listing available stock in Area Health Services and the establishment of a system for the exchange?</p>
Grand parenting policy on \$100 co-payment	<p>A significant number of consumers are exempt from the \$100 annual co-payment.</p>	<p>Should the \$100 grandparenting clause be phased out?</p>
Implementation of \$100 co-payment	<p>The implementation of the \$100 co-payment varies by AHS</p>	<p>Should the policy be \$100 for all items e.g. including replacements?</p>
Government contract	<p>Use of private v government contracts (e.g. buying in bulk and saving costs)</p>	<p>Can greater use be made of government contracts?</p>

Attachment A – Consumer Guide

PADP

consumer guide

Program of Appliances for Disabled People

What is PADP?

The Program of Appliances for Disabled People (PADP) is a NSW Government program for people with disabilities.

The role of PADP is to assist eligible residents of NSW who have a permanent or long-term disability to live and participate in their community by providing appropriate equipment, aids and appliances.

Adults and children are eligible to apply.

PADP is administered locally from Lodgement Centres.

- ▶ are unable to obtain equipment, aids or appliances from any other government program
- ▶ have not received compensation or damages in respect of the disability
- ▶ have been discharged from hospital for at least one month and are not eligible for the provision of equipment under a loan arrangement or on a permanent basis by a hospital or health service for the condition for which the equipment is required.

How can I contact my local PADP Lodgement Centre?

Your local PADP Lodgement Centre operates during normal business hours (Monday to Friday). **For contact details see the back of this brochure.**

Am I eligible?

You are eligible if you:

- ▶ have a long-term or permanent disability and need equipment to live and participate in the community
- ▶ live permanently in NSW

What types of items are available?

PADP provides a wide range of equipment, aids and appliances.

Children and young people under 16 years of age and people on low incomes are eligible for the full range of equipment provided by PADP.

People on higher incomes may qualify for

PADP equipment, aids and appliances which cost in excess of \$800.

Your prescriber or your Lodgement Centre can advise you whether the item you need is available

What happens when my

How do I apply?

All applications for assistance should be made on a PADP application form available from your PADP Lodgement Centre.

The application must be accompanied by a prescription from a specialist medical

practitioner or another authorised prescriber.

Your application must also include either a copy of your latest Australian Tax Office Notice of Assessment or details of your Centrelink pension or Health Care Card.

You should send your completed application form to your local PADP Lodgement Centre.

How much will it cost?

People who receive assistance through PADP are required to make a payment of \$100 towards the cost of the items they have received. You can only be asked to make one payment of \$100 in any given financial year.

Some higher income earners are required to make a payment of 20 percent of the cost of the item.

Your PADP Coordinator will be able to advise you what payment will apply given your particular circumstances. If you would like an item that is more expensive than the one prescribed, you will need to meet the additional cost.

How will my application be assessed?

Your application will be assessed by your PADP Coordinator in the first instance, and may be considered by the local PADP Advisory Committee. Equipment is available based on priority according to need and your financial situation.

application is successful?

The PADP Coordinator will let you know when your equipment can be picked up or delivered and what payment is required.

What can I do if my application is unsuccessful?

If your application is unsuccessful or you wish to comment about any matter, your options include:

- ▶ discussing the matter with the PADP Coordinator or the manager
- ▶ lodging a complaint with the Complaints Officer of the Area Health Service
- ▶ contacting the **Health Care Complaints**

Commission on Tel. **(02) 9219 7444** or **1800 043 159** (outside Sydney metropolitan area).

Where can I find a copy of the PADP policy?

A full copy of the PADP policy is available at your PADP Lodgement Centre or on the NSW HealthWeb at

www.health.nsw.gov.au/fcsd/rmc/cib/circulars/2000/

Look under – **Circular 2000/103**

What if my equipment needs repairs or maintenance?

If the equipment requires repairs or maintenance to be carried out, you need to contact your PADP Lodgement Centre. The Lodgement Centre will arrange for the repairs to be made. Only in emergency situations will the cost of repairs be reimbursed without prior approval by your

Where can I hire items for short periods?

Your PADP Coordinator can advise you about equipment loan pools operated by your local hospital and other organisations.

Who owns PADP items?

Appliances issued through PADP remain the property of the Area Health Service.

What if I am a veteran or war widow(er)?

The Department of Veterans' Affairs (DVA) supplies eligible veterans and war widow(er)s with aids and appliances under the Rehabilitation Appliance Program (RAP).

What can I expect and what are my responsibilities?

You can expect:

- ▶ to receive a clear explanation of your assessed equipment needs and the terms and conditions of its provision
- ▶ to receive considerate, respectful and quality service without discrimination
- ▶ to receive equipment in good working order that meets your prescribed needs
- ▶ to be taught how to use and maintain the equipment to promote independence and safety
- ▶ privacy and confidentiality

Lodgement Centre.

- ▶ accepting that the equipment may be recycled rather than new
- ▶ using the equipment safely
- ▶ advising the Lodgement Centre if you change address, if you no longer meet the eligibility criteria or need the item, or
- ▶ if the item requires repairs
- ▶ accepting the outcomes if you refuse the item
- ▶ taking proper care of the item and contributing to the cost of repairs if the item is wilfully damaged or neglected
- ▶ returning the item to the PADP Lodgement Centre in a clean state when no longer required
- ▶ reimbursing PADP for the cost of equipment or repairs if compensation is received.

Your Local PADP Lodgement Centre

Your Local Lodgement Centre can be found at:

- ▶ www.health.nsw.gov.au/fcsd/rmc/cib/circulars/2000/circulars/2000/ Circular 2000/103 is the PADP Policy.
- ▶ Your local public hospital can also give you the phone number of your local Lodgement Centre.

For further copies contact

Better Health Centre
Publications Warehouse
Locked Mail Bag 5003

- ▶ to be able to comment or complain and have your comments or concerns addressed.

You are responsible for:

- ▶ knowing the terms and conditions of PADP assistance

Gladesville, NSW 2111

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A full copy of this pamphlet can be down-loaded from the NSW

HealthWeb/Net site:

www.health.nsw.gov.au

Appendix E Case Studies

These case studies have been developed for the purpose of aiding in the discussion of the current policy, management arrangements and procedures of the program.

Sun Valley Lodgement Centre

A 30 year old woman with terminal cancer, originating in her thyroid gland, has made an application for a range of equipment and modifications to enable her to live independently. She has recently lost the use of all limbs due to a secondary lesion in her thoracic spinal column. Her sole source of income is from her disability pension and she has no immediate family.

Following a period in the local hospital she is determined to go home. Assessments by the local therapists have indicated a range of specialist equipment and home modifications that have little potential use for future clients. The estimated cost of the equipment is estimated at \$40,000.

The application is supported by her prescriber, her medical specialist and other treating health professionals. They have based their assessment on the improvement to the quality of life this equipment is expected to give her, taking into consideration her age and determination to live independently.

Her prognosis is unclear but it is unlikely she will live past the next eighteen months.

The Lodgement Centre currently has a waiting list for equipment valued at approximately \$45,000. Those on the waiting list include persons assessed in Band 2 and Band 3 as well as some persons with a Health Care Card waiting for incontinence products. The local Committee has established a limit of expenditure on incontinence products regardless of the income assessment of the applicant because of the demands for high cost items.

As a member of the Advisory Committee you are asked to make a determination on her application.

Happy Valley Lodgement Centre

Mr J is in his early 40's and has congenital spina bifida which severely limits his mobility. In his younger years he was able to walk slowly with the aid of callipers and crutches however, in recent years he has accumulated additional weight and has ceased making the effort to walk. He is largely confined to his bed and has only recently commenced receiving some personal care from a HACC service provider. His ageing parents are his primary carers but their age and his weight increase have made it difficult for them to cope. He has no assets and is a disability pensioner. His parents are both aged pensioners.

The PADP coordinator recently received an application for an electric bed and pressure mattress. One of his treating therapists had arranged for a supplier to provide a similar bed on a trial basis. The PADP coordinator has an identical bed in stock that was purchased for a previous client, that has been returned and is still in good condition.

The prescriber has indicated that the trial of the electric bed has been successful in reducing pressure sores and skin tears. The Advisory Committee has agreed to the supply of the equipment.

On contacting the family, the Coordinator was informed that the family were not prepared to accept the second hand bed and wanted to keep the new bed. They requested that PADP pay for the new bed. An invoice for \$12,500 has been received.

The lodgement centre has a waiting list for high cost items that includes an electric wheelchair for a child under 10 years of age, a number of people in Bands 2 and 3 who need incontinence products and a short list of people waiting for prosthetic devices.

There are sufficient funds left in the annual budget to pay for the item this year if it is determined to be the highest priority by the Advisory Committee.

As a member of the Advisory Committee you are asked to make a determination on the appropriate course of action. What recommendations to the policy would you make if any in relation to avoiding this situation in the future?

Pretty Valley lodgement Centre

A general practitioner writes a prescription for a woman in her 60's to have orthotic footwear made. She is a self funded retiree, in no financial stress but has a Health Care Card due to her limited mobility.

The woman has a problem walking as a result of trauma early in her life. As she is ageing she is finding greater difficulty in walking. Although very mobile and unlikely to lose mobility altogether she tires easily and at times her legs become painful. As her condition deteriorates her doctor thought she would be assisted with a calliper fitted to her shoe. He believes that an orthotic shoe would assist her quality of life, reduce her discomfort and aide her in walking.

As this is an individually made item, the PADP coordinator had no idea of the cost and immediately referred her to the orthotist. The quote was over the \$800 limit and was referred to the Advisory Committee. Considering this to be a one-off expenditure, the Committee approved the item.

The shoe and the calliper were made and proved to be considerably more expensive than originally quoted. There was not further consultation with the PADP coordinator until the invoice arrived. It was the belief of the Advisory Committee that if the true cost of the item was known prior to approval, they would have sought another quote or rejected the application.

Upon returning to the doctor, he immediately wrote out a prescription for the right leg and submitted it to the coordinator claiming that the second was now needed to avoid further complications with the use of one orthotic device.

As a member of the Advisory Committee you are asked to make a determination on her application for the second shoe. What recommendations to the policy would you make if any in relation to avoiding this situation in the future?

Appendix F Consultation write-up

Management and administration

<i>Management and administration</i>	
Issues	Comments from consultations and feedback
Administration	<ul style="list-style-type: none"> The overarching request for the administration of PADP is for greater clarity, consistency and transparency in how the program operates and the decision making process. <p>Central administration</p> <ul style="list-style-type: none"> Create a central centre to allow for consistency in administration state-wide as there is lack of consistency in the way the program is currently implemented across the State. This would ensure that all applications are assessed equitably and there would be a reduction in client complaints due to greater transparency of the system. Encourage an investigation into whether PADP would result in a fairer and more accessible service, if the program was administered and processed centrally, but delivered locally. With functions related to the delivery of aides and equipment and repairs and maintenance remaining at a local level. The process would also allow for clear criteria in priority assessment to be established and result in disbanding of the local advisory committee. Further, through a centrally administered system, opportunities would exist for streamlining and accelerating access to the program, e.g. using the internet for online applications. Having decentralised lodgement centres makes access to PADP more accessible for health professionals and clients, particularly in rural areas and in large AHSs. A centralised process would mean that the communication/information exchange system would need to be very sophisticated in order to ensure that the client is managed at the local level. This local management adds to the clients' satisfaction of the process. A determination is needed of what functions are best served on a local level and what efficiencies and improvements can be made through centralised functions. For example, functions better served at a central level include governance factors, general inquiries and information dissemination, monitoring and analysis of the waiting list, application procedures, decision making processes and criteria, equipment purchasing and service arrangements and data collection and analysis. However, functions that may potentially be better served at a local level include the distribution of non-specialised low cost items and logging of equipment for redistribution. With the amalgamation of area health services, the cost of delivering goods from an equipment pools has risen. People in rural areas have come to accept that there is a central point in their AHS; however they would not be happy with Sydney as a central location. Good transport systems will be needed if a centralised system is implemented in order to achieve economies of scale. Those delivering the equipment will need to be able to set it up in clients' homes and ensure it works properly. It is doubtful that PADP could be entirely centralised due to the AHS structure, which gives virtual autonomy to individual AHSs. <p>Structure</p> <ul style="list-style-type: none"> PADP should be an administrative that includes the decision making process for allocation of equipment. Hence, if it were co-located with health service providers, a conflict of interest may arise. PADP could be co-located with rehabilitation and aged care services as there was more support for this option than an administrative process. One reason given for this suggestion is the experience of staff in the daily prioritising of applications based on clinical need. If PADP was to be located within a specialist environment accessibility to be program would be decreased. <p>Performance standards</p>

Management and administration	
Issues	Comments from consultations and feedback
	<ul style="list-style-type: none"> • PADP needs the creation of performance standards to measure the effectiveness of PADP in meeting its objectives. • If reporting of performance standards is introduced, staff need the infrastructure to support this i.e. if data needs to be collected; an efficient information system is needed. • Benchmarks can be onerous, however they do keep people honest and will aid with reporting if reporting against these benchmarks. • It would be relatively simple to add some reporting of PADP to the annual report. • There should be more opportunities for regular feedback from clients and clinicians about PADP. • Introduce independent financial and process audits of lodgement centres and the PADP program. <p>Naming of the program</p> <ul style="list-style-type: none"> • The title of the program as it is currently is the Program of Appliances for Disabled People. The people involved are not disabled, they have a disability. Hence, the name should be changed to the Program of Appliances for People with a Disability. <p>Equipment for the ageing</p> <ul style="list-style-type: none"> • While funds remain limited, the Government needs to provide an alternate source of funds for equipment for people whose need results from the ageing process. Without this, the availability of funds for children, young people and adults with a disability will be impacted upon. <p>Staffing issues</p> <ul style="list-style-type: none"> • Train administrators in working with people who have disabilities so they are sensitive to the differing needs of this population group. This needs to be incorporated into training for PADP roles and standardised across the state. • There is current concern that the number of people available to administer and deliver PADP in rural areas has greatly decreased. This also includes OT's who are not equipped with the correct knowledge of how to individualise assessments. • The administration staff should be from a health background. • If the coordinator was from a clinical background, more decisions regarding high cost items could be made without the need to forward these applications to the Advisory Committee. However, this would be a lot of responsibility for one person. • In some areas, PADP staff are very difficult to get a hold of (both email and telephone), there needs to be an efficient way of ensuring contact with staff.
Bathurst PADP lodgement centre	<p>Concerns about the lodgement centre</p> <ul style="list-style-type: none"> • This lodgement centre is an example of where service delivery has not been separated from the PADP lodgement centre. As all children who require seating must go through this clinic in order to receive PADP funding. A number concerns have been raised regarding this procedure: <ul style="list-style-type: none"> – Families do not have a choice from a number of options for seating. – There is overlap between therapists involved in the prescription process. – The clinic only looks at seating issues and does not take into consideration to context of the child's life, e.g. schooling or transportation. – The clinic is limits the number of home or school visits. – The quality of equipment being prescribed is questionable, with a report that the centre uses recycled equipment that is not appropriate for use. – The clinic is unwilling to accept prescriptions from therapists at The Spastic Centre.

Management and administration	
Issues	Comments from consultations and feedback
PADP Policy	<p>Clarity of PADP policy</p> <ul style="list-style-type: none"> • There is a lack of clarity in the policy around the provision of equipment to clients in nursing homes and the provision of medical equipment. • The policy itself is ambiguous and unclear, e.g. individuals have a manual wheelchair and now want an electronic one, the policy states that PADP can provide two wheelchairs to the one client. • The principles of PADP need to be underpinned by a strong/rigid policy that encourages transparency, even at the NSW Health level. • Clarification is needed regarding the eligibility of palliative care patients and communicated to all PADP centres to ensure interpretation of eligibility for palliative care patients is consistent.
The demand for PADP services	<p>The need for an accurate indication of demand for PADP services</p> <ul style="list-style-type: none"> • Being aware of who is eligible and planning for their long term needs are essential to ensuring that PADP can operate within a budget while meeting the needs of people with a disability. • A notification system should be established so that NSW Health is aware of as many of those eligible or likely to be eligible for equipment under PADP as early as possible. • There have been suggestions that therapists avoid applying for PADP aides and equipment due to a history of long waiting times. Hence, the true demand for PADP services may not be accurately reflected by current waiting lists. • The inconsistencies that exist across the PADP program, are disguising the true level of demand for aides and equipment. • It will be difficult to project the need for PADP as you cannot assume that people are going to be living in the same place with the same level of functioning for the remainder of their lives. • Waiting list data should continue to be collected on a regular basis, along with the number of applications not submitted due to consumers being advised that their lodgement centre had funding limitations. • Reliable information collected through robust information collection and collation systems is the foundation of good management. The failure of NSW Health to keep track of supply and demand imbalances in PADP indicates where the focus of reform should be i.e. basic business management practices and procedures.
Duplication with other programs	<p>Duplication with Aides for Individuals in DADHC Accommodation Services (AIDAS)</p> <ul style="list-style-type: none"> • AIDAS is a program established by DADHC that provides aides and equipment to people living in DADHC operated accommodation. • AIDAS and PADP provide exactly the same support; therefore the two programs could be amalgamated so that individuals with a disability in NSW have the same access to support.
Advisory committees	<p>Advisory Committee membership</p> <ul style="list-style-type: none"> • Health professionals need to be on the Advisory Committee. • It is difficult to find a 'neutral' consumer representative for the Advisory Committee as most representatives inevitable become lobbyists for a certain group. Additionally, within local areas it is hard to locate a consumer representative who does not know the local people and their situations. • The Advisory Committee needs to have a consumer representative to ensure consumer needs are voiced and contributes to the transparency and openness of the process. • In rural areas, it is hard to get clinicians in for specific issues that arise in the committee. <p>Procedures for the Advisory Committee</p> <ul style="list-style-type: none"> • Local Advisory Committees need to operate with consistent criteria and be adequately trained to assess information in an objective manner. • Provide an annual calendar to alert clinicians when advisory committees are scheduled and the clients

Management and administration	
Issues	Comments from consultations and feedback
	<p>that will be discussed, to allow the clients clinician to attend in order to advocate for their client.</p> <ul style="list-style-type: none"> • Clients need to be informed of who is on the Advisory Committee, including the consumer representatives. • Have an induction guidance and training for new members appointed to the Advisory Committee. • It is not necessary that the committees meet in person; it is possible for the committee members to link up via teleconference or video conference. • The Terms of Reference for the committee need to capture impartiality and transparency, ensure that consumer representatives declare any conflict of interest and ensure all applications are de-identified. • Consumer representatives should not be making decisions about the prioritisation of a client; this should only be done by a clinician. • The aim of the committee should be to prioritise waiting lists and high cost items, they therefore need prioritisation criteria and Terms of Reference. • The Advisory Committee used to report to the Board, however since the amalgamation of the AHS' there is no longer a Board leaving the reporting structure unclear at the moment. • The State Advisory Committee should look at policy and protocol development to ensure there is transparency within the community. <p>State-wide advisory committee</p> <ul style="list-style-type: none"> • It is the role of the committee to assist in the ongoing review and development of PADP. • A board should be established to direct the program with representation from within NSW Health at CEO or deputy CEO level.
Budgeting	<p>Changes to the distribution of funds</p> <ul style="list-style-type: none"> • Keep a proportion of the budget for crisis, extraordinary situations, repairs and maintenance, continence products and communication devices. • The reliance on enhancement allocations (non-recurrent) each year and the lack of certainty regarding the amount and timing of the allocation limits the ability of local PADP committee's to effectively budget for the service. • Portion the annual PADP budget to each equipment area to ease prioritisation decisions and to ensure the increase in demand for certain equipment areas does not take funding that is allocated for other equipment areas. Each equipment area could also be contracted out to different organisations. • Allocate a set amount of money, per year for families with a child that has high equipment needs associated with their disability. The amount could be based upon the overall needs of the child, the family's support and caring needs and the families combined income. • The PADP budget should remain quarantined. • The provision of breast prostheses should be quarantined out of the PADP budget (e.g. Victorian State-wide Breast Prostheses Subsidy Program), as clients who have tried unsuccessfully to access replacement prostheses via PADP find the eligibility criteria is too stringent, breast prostheses are at the bottom of the priority list or the budget has been consumed. <p>Salaries/administrators</p> <ul style="list-style-type: none"> • Using health professionals as administrators of the program has the potential to make the program more expensive to administer. • An equitable percentage of the budget should be identified to fund staff and administrative costs across all AHSs. • Use a separate budget to pay for the salaries of those who administer PADP. • The cost of salaries should be built into the budget, with staffing needs determined by the demand for PADP in that area. Alternatively, deduct coordinators salary from the PADP budget. • There should be an upper limit on the proportion of the PADP budget that can be used for

Management and administration	
Issues	Comments from consultations and feedback
	<p>administration.</p> <ul style="list-style-type: none"> • Consumers would like to see accountability and transparency in where the allocated money for PADP is spent. • There needs to be a standard salary across the state for coordinators. <p>Increase of budget</p> <ul style="list-style-type: none"> • Equipment costs are increasing but the budget is remaining the same. The budget needs to be increased to a workable level. • There are inefficiencies in relation to forecasting demand and managing approvals across the financial year. • The budget needs to be able to keep clients well and mobile. However the funding is not sufficient enough to do this at the moment. • A capped budget for this essential service is inappropriate. <p>Resource Distribution Formula</p> <ul style="list-style-type: none"> • The resource distribution formula needs to more adequately address rurality. • The current funding model is not consistent with the PADP policy. • The resource distribution formula needs to be reviewed to ensure equitable distribution of funds. <p>Specialist set-up funds</p> <ul style="list-style-type: none"> • Following the initial set-up of a client using a specialist set-up fund there is no budget that allows for the replacement of equipment later on. • Clients need to be in one of the specialised spinal units in order to receive the start-up funds. • Brain injury clients need access to a special set-up fund. <p>Allocation of budget to specialist non-government organisations</p> <ul style="list-style-type: none"> • Specialist non-government organisations should be added to the existing state-wide PADP services so that they are provided with a PADP budget directly. This arrangement would remove some of the burden of assessing applications from AHSs and would mean that the applicant would only need to be assessed once in order for the appropriate equipment to be provided. This allocation method has successfully been implemented in Victoria.
Grand-parenting policy on \$100 co-payment	<p>Removal of the grand-parenting clause</p> <ul style="list-style-type: none"> • It is unfair, as everybody should have to pay annually to access the services that PADP provides. • The extra income could be re-invested into PADP to provide more equipment and aides to clients. For example, with 250 people who are on the grand-parenting clause currently, would provide \$25,000 in extra funds which could purchase two electric wheelchairs or 16 manual wheelchairs. • The grand-parenting policy should not be phased out as people with a disability are amongst the poorest in society. There needs to be the ability for the program to respond to situations where individuals are incapable of meeting this co-payment.
Implementation of \$100 co-payment	<p>Clarity of PADP policy on the \$100 co-payment</p> <ul style="list-style-type: none"> • Lack of clarity and consistency in approach around the state to the implementation of the policy on the \$100 co-payment. • The co-payment as it stands is inequitable as there are people who can't afford to pay it and clients receiving high cost items and paying the same amount as those receiving low cost items. • An option should be available for clients to contribute more to an item, as some cultural groups like to contribute in order to have a sense of ownership. • Increase co-payments for items that are high cost. • The policy needs to be clear about what the co-payment is actually for e.g. administration costs,

<i>Management and administration</i>	
Issues	Comments from consultations and feedback
	<p>equipment or to access PADP.</p> <p>Authority to implement policy</p> <ul style="list-style-type: none"> • There is a need for PADP administrators to have the authority to refuse supply of equipment when the \$100 co-payment has not been received. <p>Removal of co-payment</p> <ul style="list-style-type: none"> • Co-payment should be removed as the net increase the payment provides would be marginal and the cost of collecting the \$100 could be used to improve other facets of PADP. • PADP should not expect parents or carers to provide a co-payment, as the expenses already incurred through having a child with a disability are substantial. <p>Suggested changes to the \$100 co-payment</p> <ul style="list-style-type: none"> • A percentage of the total cost of the item should be used instead of the \$100 co-payment. • A system implemented for the exemption or reduction of the co-payment when significant financial hardship is demonstrated. • An administration fee of \$30-\$50 could be charged instead of the \$100 co-payment. True co-payment should be implemented where the client can contribute to the cost of an item should be an option. However, there is an ownership issue with offering the option of true co-payment. • Implementation of a sliding scale contribution could be implemented; however this may introduce issues regarding ownership of the equipment. • It would be advantageous to change the name of the \$100 co-payment to a yearly contribution towards the maintenance of equipment. • The co-payment should be means tested. • The co-payment should be included for replacement items as well. • If the co-payment is to be retained, it should only be applied to those clients with higher incomes who apply for high cost items. • An annual indexation of the co-payment should occur.

Access, eligibility and the target population

<i>Access, eligibility and the target population</i>	
Issues	Comments from consultations and feedback
Information	<p><i>Consistency of information</i></p> <ul style="list-style-type: none"> • An increase in transparency and consistency is needed between funding programs for aides and equipment. <p><i>Increase information disseminated to clinicians</i></p> <ul style="list-style-type: none"> • There is a need for general practitioners (GP's) and therapists to be more informed on the limitations of the PADP program. • Information to GPs needs to be improved as this is the first point of contact with the health services for many clients. <p><i>Advertising PADP to the general public</i></p> <ul style="list-style-type: none"> • Currently, program information is hard to locate and the policy is difficult to understand for both clients and health workers. A search of NSW Health's website does not provide clear and direct links to relevant documents such as the program overview, eligibility and approval criteria, application forms etc. • It is important to spend some money to ensure misunderstandings about PADP are eliminated i.e. there is a need to be more honest with the public about what PADP is about. • Provide pamphlets/information in GP's offices, Member of Parliament's offices, kindergartens/pre-schools, ethno-specific based organisations, along with public and private hospitals. • By advertising about PADP there will be improved comprehension of the need for PADP's services. • It is unethical not to inform the general public about the program. • Advertising PADP will also allow families to be more informed about the options available to them when sourcing equipment for children or family members. • Information needs to highlight all potential equipment and aides that can be supplied by PADP, e.g. PADP is traditionally known for mobility and continence products hence there is a lack of awareness that PADP also supplied communication devices. • The information needs to simple e.g. describing that a service exists and for more information clients need to speak to a health professional. Information needs to be translated, culturally, socio-economically sensitive and be provided in accessible formats, e.g. 'Easy English' or pictorial formats. • It needs to be identified who would be the target group of the advertising, given the program cannot currently cater for all known clients. Instead of advertising PADP, the program should be providing better access for the known group of clients. • Create an easy to find and accessible website with a section included for frequently asked questions. In addition, posters and brochures etc should also be used. • There is no need to advertise PADP; funds could be used to improve communication between PADP and prescribing therapists. • The priority for the spending of program funding must be given to providing appliances to low-income people with a disability. • A continence consumer guide should be written as an appendix to the main consumer guide as continence differs from other PADP equipment as it requires recurring orders. The guide requires a clear statement regarding monthly/annual limits and equipment lists for continence aides and appliances as clients often expect (and often health professionals) that PADP will supply the quantity that they use. • Information needs to be updated on a regular basis to ensure that contact number and lodgement centres listed are accurate.

Access, eligibility and the target population	
Issues	Comments from consultations and feedback
Number of centres	<ul style="list-style-type: none"> Localising PADP allows for a link to be established with the community, especially for OT's and Community Nurses. With too many sites there are a smaller number of resources available. There needs to be a balance between lodgement centres and sites from which to pick up equipment. The number of centres is not an issue, it is the lack of consistency across the centres that is the main issue. One centralised PADP service for the amalgamated AHS could operate effectively and efficiently. This change could enhance budget availability for the provision of equipment to clients. However, it would require a review of staffing arrangements to provide the larger service.
Eligibility of those receiving aged care/ accommodation support	<ul style="list-style-type: none"> The administration of the program needs to ensure that people are not accessing PADP if they are eligible or have assistance under the Commonwealth's Aged Care Program and the Extended Aged Care at Home program. NSW Health needs to discuss with the Commonwealth whose responsibility it is to provide continence aides to those individuals with aged related continence problems. There are currently issues regarding who the provision of equipment in supported accommodation should come from. Currently, people in nursing homes are eligible for PADP for customised equipment, however they rarely receive funding for it. Priority must be given to equipment for young people in nursing homes to ensure access for a highly disadvantaged group.
Eligibility of those receiving compensation	<ul style="list-style-type: none"> The criteria for clients who have received compensation needs to be reviewed, as their application will continue while other clients who are in genuine financial hardship continue to wait to be funded.
Application forms	<ul style="list-style-type: none"> There was great support for the implementation of a state-wide application form. Currently, the different application forms and processes across the State make it difficult for those health professionals who work across NSW. <p>Features to be included in the application form</p> <ul style="list-style-type: none"> There should be one form that is very specific on what information is required in order to place an application to PADP. The application form should serve the single purpose of facilitating an individual to become a client of the program and not acting as a prescription form. The application form requires a check list of the specific information required for the application process. Explicit information should be provided on the form regarding what clients can and cannot expect to be funded by PADP. On the application form a section in the instructions needs to inform potential clients that they are not to expect brand new equipment if there is second hand equipment available that meets their needs. If supporting material is required on the application form, instructions need to be simple yet explicit on how to write supporting documents. The application form needs to transferable between different regions. Localised differences in an application form can enhance equity rather than detract from it. Need to consider the impact of altering the application forms on all groups of people who access the program. <p>Downloadable application form</p> <ul style="list-style-type: none"> The application form needs to be in a format that is accessible to people who use screen readers. A downloadable form allows clinicians who are not part of the public health service to access the program. It is a cheaper, quicker and more practical alternative, and would particularly be of great benefit to people in rural areas.

Access, eligibility and the target population	
Issues	Comments from consultations and feedback
	<ul style="list-style-type: none"> • Ultimately, the more formats in which the application form is available the more equitable the program. • To ensure equity for those individuals who cannot access the internet hard copies should be available. • A copy of the application form should be placed on the intranet for health professionals. • There needs to a single point of entry for the application forms. <p>Application process</p> <ul style="list-style-type: none"> • Clients should be able to apply directly to PADP to determine their eligibility to enter the program. Then PADP could refer clients to the local prescribing health professional. • Information should be provided regarding the progress of an application as there are often delays or inconsistency in communication. Written confirmation should be provided when: an application is received; after the application has been prioritised; and when funded.
Assessment and prescribing	<p>Specialists prescribing equipment</p> <ul style="list-style-type: none"> • Only specialists should be allowed to prescribe equipment as there is currently a significant amount of money wasted on incorrect equipment. • Having specialists prescribing equipment restricts access to the program by having only certain individuals with the ability to prescribe equipment, instead use existing resources such as The Spastic Centre/Independent Living Centre or integrate training into job/education. • The use of 'experts' has sometimes meant that family knowledge of what is best for the client was disregarded and therefore equipment was prescribed that was not used. • Strict guidelines should be sufficient to prevent the need for all prescribers to undergo training. • A list of skilled prescribers should be made available to eligible PADP clients. • Create an accreditation system through training, with the prescriber then able to prescribe high cost items. The individual or organisation employing the therapist would be responsible for cost of training. • A belief exists that GP's are not qualified to prescribe equipment for PADP. • The use of specialist prescribers in regional and remote areas may be unpractical considering the availability of health professionals in these areas. • PADP appointed prescribers would add another tier to the system, delaying the process for clients and adding to the administrative costs of the system. <p>Assessment/prescribing process</p> <ul style="list-style-type: none"> • Utilise centres that specialise in the provision of certain equipment to assist with making assessments on specialist aides and equipment e.g. The Spastic Centre. • As a result of the long waiting lists and the diversion of funds through area health services, individuals often need to be assessed twice – once when the application is made and again when the application is approved, this process needs to be streamlined. • There currently is no consistent or reliable system for flagging those clients who require reassessment prior to the issuing of equipment to ensure equipment is still appropriate after a long delay between prescription and equipment approval. • Local decision makers often lack the medical knowledge to reject an inappropriate prescription. • In rural areas it is not always possible to get multiple quotes. • To adequately prescribe, a clinician needs at least six or more contacts with the clients. In rural areas that rely on travelling consultants, this is not possible. • A second opinion should be prescribed for items over a nominated amount. • In order to replace an item, a full assessment by the relevant clinician is required even though the physical status of the client has not changed. • There is a need to have a consistent approach to applying, reporting and quotation requirements across all lodgement centres, e.g. some lodgement centres are requiring three quotes whereas others are only

Access, eligibility and the target population	
Issues	Comments from consultations and feedback
	<p>requiring one. There have also been suggestions procedures are different between lodgement centres in the one area health service.</p> <ul style="list-style-type: none"> • Significant time must be invested in order to understand the client’s needs. Managers of prescribers should sign-off on the request and where possible ensure that their prescription is appropriate. • The relationship of a clinician with the PADP committee may currently have some influence on the decision making process e.g. some clinicians may have a certain standing within the committee and their decisions are more valid than other clinicians. <p>Training/support services for prescribers</p> <ul style="list-style-type: none"> • Training needs to be provided to prescribers in order to assist with a range of tasks e.g. maintaining an objective viewpoint when prescribing equipment and how to integrate families into the prescription process. Health Professional Managers should ensure that their staff have access to relevant education and training. • Consider the possibility of offering phone advice for prescribers when they are ordering expensive or extraordinary equipment. • There is a need for assessors to be trained in prescribing for regional clients as their needs may be different to those clients who live in city areas. • When prescribing a high cost item, a joint consultation should occur between the therapist and a specialist therapist or group, e.g. when therapists are prescribing high cost wheelchairs, prescriptions should take place in a seating clinic where the client’s therapist can consult with the specialist. • The Independent Living Centre runs competency based training programs on equipment prescription skills. As there are no specific competencies for prescribing equipment, industry competencies need to be developed. If the client receives the correct equipment, they are more likely to use the item and make the efficacious effects last longer. • Currently, there is an inability of podiatrists in publicly funded food care services to prescribe services for PADP. By allowing podiatrists in publicly funded clinics to prescribe it negates the need for a client to attend a PADP clinic. <p>Suppliers</p> <ul style="list-style-type: none"> • There is an issue with suppliers not knowing the functions of their own equipment. • Prescribers should not seek advice from manufactures as the prescription needs to be an independent decision. <p>Prescription forms</p> <ul style="list-style-type: none"> • Prescribers require order forms that allow for specifications to be explicitly explained. • Clinicians would like to see explicit instruction given by PADP on how to correctly fill out a prescription form to save the prescription form from bouncing. • Create aide specific guidelines, e.g. specific guidelines on prescribing continence aides. <p>Potential conflicts of interest to arise with prescribing</p> <ul style="list-style-type: none"> • To prevent a conflict of interest the prescriber needs to be separate from any decision making or administrative roles within PADP. However, there is a role for independent specialists to assist with the decision making process. • A need exists for NSW Health to audit prescriptions to ensure a conflict of interest does not exist e.g. prescribing from the same manufacturer.
Waiting Lists	<p>Management of waiting lists</p> <ul style="list-style-type: none"> • Waiting lists should be looked at every three months. • It is difficult to predict the length of waiting lists as they vary dramatically, which makes it difficult for therapists to plan for equipment approval. • The length of time a client is on the waiting list should be factored into where a client is placed on the

Access, eligibility and the target population	
Issues	Comments from consultations and feedback
	<p>list. This also needs to be weighed up against the hidden costs associated with the client not having this equipment i.e. therapist/hospitalisation costs.</p> <ul style="list-style-type: none"> • There needs to be a limit on the maximum time a client can be on the waiting list as it is unfair to clients to simply inform them they are on a waiting list and never be given a timeframe of when they may receive their aides and equipment. • There should be performance benchmarks created for children who are on waiting lists. As there have been several reports suggesting by the time children receive equipment, they have outgrown the prescribed item or have lost skills required to operate the prescribed item and have to re-learn this skill. • The actual need and demand for PADP has never been accurately reflected, as many people don't continue with their application when it is indicated that they may have to wait a long time or many never get the equipment. • The issue of clients moving around the state and where they fit on the waiting list needs to be resolved. • The PADP information that is available suggests that as long as a person is eligible they will receive the equipment, waiting lists are not mentioned and there is no suggestion that equipment will not be received in a timely fashion. <p>Alternative arrangements to waiting lists</p> <ul style="list-style-type: none"> • There should no need for waiting lists, if the budget is accurately estimated and the program was run more efficiently. • Clients on the waiting list should have the opportunity to purchase equipment from the supplier at cost price. • Keeping people on a waiting list is depressing and more costly to the health system in the long term as the person's health and function status could deteriorate.
Prioritisation	<p>Clinical priority</p> <ul style="list-style-type: none"> • One option suggested when assessing clients for aides and equipment is to give priority to those clients who require mobility aides and equipment. <p>Allocation decisions</p> <ul style="list-style-type: none"> • Current guidelines in regards to prioritisation are inadequate. • Palliative care patients should be able to access PADP aides and equipment without discrimination simply because they have a palliative diagnosis. • A lack of priority is given to clients who require essential equipment for speech generation or sleep positioning purposes. • Allocation equipment for children in a piecemeal process defeats the purpose of the equipment. Children often need a system of equipment, and by providing all items required, the child's health, will benefit and therefore in the long term the over health budget. • A lack of prioritisation for high risk patients in the provision of footwear. Guidelines should be written to prioritise these patients and patients requiring orthosis.
Children's access	<p>Means testing and universal access</p> <ul style="list-style-type: none"> • There needs to be means testing for children's access and prioritisation should be based upon need. • If there is means testing, the income level should be set at a high rate. • Incontinence products should be means tested. • Larger items should have a stepped co-contribution scheme according to parental income. • A large issue for PADP administrators is the PADP policy does not support administrators when they are aware that families can afford the equipment/aides. • Universal access is fair because parents have a large number of costs when raising a child with a disability and as children are still growing and developing they are more likely than adults to suffer

Access, eligibility and the target population	
Issues	Comments from consultations and feedback
	<p>adverse consequences from using inappropriate equipment.</p> <ul style="list-style-type: none"> • The universal eligibility of children should be maintained with priority given to children from households that do not fall into a high income category when additional factors are considered. These factors could include, but are not limited to: the number of income earners in a family, caring responsibilities, where the family resides and the high turnover of equipment for children. • The number of high incomes parents would be so few that the administrative effort used to income test parents, would be more costly than the money saved by the process. • Before any decision is made regarding changing universal access for children, data should be collected to ascertain if there was an increase in application due to the introduction of universal access. • Universal access for children is neither fair nor equitable. • Children should be allowed the equipment they require in order to decrease the costs to the health system in the long run. • To ensure equitable access for children, priority should be based upon a range of factors including the number of dependents the parents' income is supporting, the amount of money already spent by the family on essential disability-related expenses and whether any other dependents have a disability. <p>Prescribing for children</p> <ul style="list-style-type: none"> • A concern with prescribers especially when dealing with children is their impartiality disappears and applications come in to PADP with extra 'bells and whistles' that are not essential to the clients needs.
Health Care Card holders	<p>Consideration given to the inclusion of the Health Care Card (HCC)</p> <ul style="list-style-type: none"> • Inclusion of the HCC in the PADP policy has increased applications to the program. • A need exists to increase the restrictions surroundings the HCC eligibility in the PADP policy e.g. restrict Band 1 to those who meet the income test.. • HCC holders who do not meet the income test should be excluded, as this would facilitate equity of access to PADP.
Banding system	<p>Alternate banding schemes</p> <ul style="list-style-type: none"> • Create bands based on client's income that remains after the costs associated with an individual's disability (e.g. home modifications, transport costs) are deducted from their income. Don't want banding system to act as a disincentive to employment. • Create access bands that consider all social and economic issues associated with an individual's daily living (e.g. family commitments, employment and cost of the disability [as above]). • Bands for funding should be based on different types of equipment. • The banding should finish at Band 2 if PADP wishes to continue to fully subsidise aides and equipment, and would need to be indexed on an annual basis. If PADP changed to a subsidy system, then four bands could remain with different subsidy amounts granted to each band. <p>Increasing the upper limits of bands 3 and 4</p> <ul style="list-style-type: none"> • These bands have not been adjusted according to the consumer price index (CPI). High cost items, as per Bands 3 and 4 could be increased to at least \$1,500-\$2,000. • If there are restrictions on eligibility it should only apply when people fall into a high income category that has taken into consideration the factors associated with a disability. • Cutting out the eligibility at Band 2 would mean that a person with a disability who is working would be punished. <p>Alternate funding arrangements</p> <ul style="list-style-type: none"> • Allotment of equipment should be based on clinical or functional need only not the banding system. • Adopt an asset test similar to asset tests used by Centrelink. • Funding should be based on the cost of an item, therefore if the item is not over a certain amount (e.g.

Access, eligibility and the target population	
Issues	Comments from consultations and feedback
	<p>\$100), then PADP does not provide funding for that item.</p> <ul style="list-style-type: none"> • Development of separate funding brackets for one-off items and continuing items. • Address the option of providing interest free loans to clients who wish to purchase their own equipment or provide information on alternative options for accessing equipment e.g. charities. • There should be means testing for people of all ages. • There needs to be a simple solution, whereby people are eligible or they are not. <p>Retention of current banding system</p> <ul style="list-style-type: none"> • Support is given to the current banding system and the four levels should remain. • The current eligibility is satisfactory. The change in criteria for children has improved access for families with children who have disabilities.
Continence products	<p>Management of continence products</p> <ul style="list-style-type: none"> • Clients receiving continence products need to be assessed on a regular basis. There are currently no protocols for reassessment which needs to be undertaken sometime between 6 - 24 months of initial assessment. In addition, all new clients needing continence aides should be assessed by a nurse continence advisor. • Requires a separate budget, one similar to how oxygen is managed, as continence is a different business to manage. • Clients with continence needs often have equipment requirements as well; these should be addressed through the one point of entry. • By moving continence to another area, there will still be the same inherent problems and no solution. • There should be the creation of a fixed budget for continence products, through an annual modification of the budget which is decided through consulting the waiting list data. • Inconsistencies exist in how the PADP policy on continence is implemented by the different PADP centres. • Only continence advisors or nurses should be able to prescribe continence products as GP's are often not aware of the underlying problems or range of services and products that they can prescribe to a client. • PADP should request that GP's confirm there is a medical condition when supplying continence items. • The amount of money spent on continence products needs to be audited regularly, and ensure continence products are limited to 33% of the overall budget. When one client ceases to use their PADP entitlements, the next client on the waiting list should begin to have continence products supplied. • The highest priority should be for clients that require catheters. • Clients who receive continence products should be required to pay a higher co-payment, e.g. \$200 per year. This is justified due to the increased amount of administration associated with the delivery and supply of incontinence pads. • Continence will continue to grow and take away from the mobility budget. It is attractive to centralise continence support, however it may take away some of the incentive for local areas to do preventative work for continence. <p>Children's continence products</p> <ul style="list-style-type: none"> • A need to increase funding for children's incontinence needs, as the current system does not provide adequate funding for a child with high continence needs. <p>Overlap with Continence Aides Assistance Scheme (CAAS)</p> <ul style="list-style-type: none"> • There is currently too much duplication with CAAS, it is possible to move all continence clients from PADP under CAAS and increasing health promotion funding to prevent and improve continence management. • PADP administrators have found that clients who are on the CAAS program do not use their allocated

Access, eligibility and the target population	
Issues	Comments from consultations and feedback
	<p>funding for continence products or the funds do not last the entire 12months. This means clients then request assistance from PADP to meet this short fall. A suggestion is to limit CAAS recipients to six months of continence products.</p> <ul style="list-style-type: none"> • As incontinence is associated with ageing, and ageing is a federal responsibility, it has been suggested that PADP, as a state program should not be funding continence products for aged individuals. • There has been a suggestion that PADP uses cheaper continence products than CAAS, and PADP clients are therefore going through twice as many as CAAS clients. • Amalgamate PADP and CAAS into PADP. Each registered client would have a continence assessment conducted and have an annual budget allocated per year to obtain these items. If the cost of the products is less than \$100 in a calendar year, the client would be ineligible. The suggested criteria for this scheme is: <ul style="list-style-type: none"> – Pensioner (aged, disability) or child with a disability (aged 5+) – palliative care – permanent indwelling catheter/self intermittent catheterization – disabled but working (spinal injury/MS) <p>The process would involve:</p> <ul style="list-style-type: none"> – The client must be able to demonstrate they have attempted to undertake management plans to treat incontinence before having access to the products – A client with spinal injuries needs to be assessed by a spinal injuries nurse to ensure that products being used are appropriate. – The client can only purchase products approved by the continence nurse. If alternative products are required they need to be approved by the referring continence nurse.

Funding and supply of equipment

Funding and supply of equipment	
Issues	Comments from consultations and feedback
Equipment list	<p>Creation of a standardised equipment list</p> <ul style="list-style-type: none"> The existence of the PADP equipment list and its availability to be viewed online can at times be misleading as it creates unrealistic expectations for clients who in reality live in an area where local PADP lodgement centres will never have the funds to purchase certain items or may have to long periods of time to receive the equipment. About 50-60% of the current equipment prescribed could be explicitly stated on equipment list e.g. standard items such as toilet seats and chairs. For the remaining 40-50%, local prescribers could use their discretion when prescribing personalised products. It would be difficult to develop a definitive equipment list, it would be easier to develop an exclusions list. A concern about standardising equipment would be that it is difficult to maintain an up-to-date list. It would need to be reviewed at least annually to keep up with the technological changes to equipment. More detail on the current list may be adequate, e.g. there is a lack of guidelines for what footwear and orthoses should be supplied by PADP. OT's find the current list useable but nursing and dietetics have difficulties with the current form. A possibility would be to review some areas of the list while keeping others the same. A concern with creating an equipment list is clients may 'self-prescribe' items on the list and advocate for what they think they need rather than allowing a clinician to determine what is suitable. The range of items covered by PADP needs to be more comprehensive. In the case of children, smaller items such as eating utensils or restraints are cheap but over time do add up to a substantial amount. The equipment list should also cover modifications to cars, so children/clients can be transported. A solution suggested is for the government to liaise with car manufacturers to pre-build cars with the modifications required already built into the car. There is regular pressure to add medical items to the equipment list. However, treatment and monitoring items are the responsibility of the AHS. A definitive list of continence aides and appliances should be developed that also includes annual limits e.g. 80 pads per month. <p>Creation of a database for equipment</p> <ul style="list-style-type: none"> There is a need for a database that informs about regular services to equipment in an attempt prevent the need for expensive repairs/maintenance or replacements. If there was a creation of a database, there needs to be a 100% commitment to using and maintaining the database, so the administration of the database does not affect the timely delivery of equipment. This database could be administrated centrally. The Independent Living Centre feels it would make sense for them to manage an equipment list or database. An estimated cost to the program would be one extra full time person to continually update the list/database. The list/database could identify preferred providers, and reassess these on a yearly basis. For rural centres, the Independent Living Centre's expertise could be used to help overcome issues with suppliers in these areas, i.e. make the supply of equipment to rural areas more financially viable. Create a database/website whereby other PADP centres have access to equipment that is currently in storage which would allow therapists to prescribe existing equipment instead of ordering new equipment. The database would also assist with having maintenance occur in accordance with manufactures guidelines, so the client is covered by the warranty. The equipment would need to be housed where a therapist could have access to redistribute the equipment. One possibility would be to ask the Independent Living Centre to house ex-stock. An issue highlighted with the suggestion of a database is that many PADP lodgement centres have previously tried this with the DVA system. There was little success achieved due to the special needs of

Funding and supply of equipment	
Issues	Comments from consultations and feedback
	<p>clients, transporting and having access to appropriate clinicians to assess what repairs and maintenance was needed on equipment.</p> <p>Equipment believed to be of low priority</p> <ul style="list-style-type: none"> • Communication devices are believed to be of low priority to lodgement centres and local Advisory Committees. • PADP covers the provision of air conditioners, which are vital to people who's neurological disability affects their capacity to self regulate body temperature. It is felt that PADP puts a very low priority on the provision and installation of air conditioners. • It is the experience of some health professionals that technological aides are rarely funded, for some clients these products are essential to their ability to communicate and participate in daily life. • Scooters are unlikely to be funded and other powered mobility aides involve a two to three year delay in funding. • Clients requiring intermittent catheters for purpose of self-catheterisation should dispose of their catheters after each use, this would then equate to 150 catheters per month. Currently, PADP only supplies a maximum of 30 intermittent catheters per month, therefore many clients have to purchase the remainder themselves at a cost of \$1 per catheter. • Breast prostheses appear to be at the bottom of the PADP staffs priority list. • Supporting the provision of home enteral nutrition has benefits to NSW Health and to home enteral nutrition patients as medically stable patients can receive their nutrition at home without the need for admission to hospital and have improved quality of life residing at home. For PADP to comply with the Therapeutic Goods Administration regulations, PADP would need to supply one giving set and container each day instead of the current one to three supplied per week. • Dressings were removed from the equipment list after the previous PADP review. This has significantly disadvantaged the population of children with epidermolysis bullosa who need specific life long skin care consumables in order to access school and their community. • There is a lack of funding for sleep positioning systems.
Maintenance and repairs	<p>The cost of maintenance and repairs</p> <ul style="list-style-type: none"> • PADP often selects the item that is cheapest, but this item may not be the cheapest item in the long run, due to the product requiring more repairs and maintenance than a more expensive but superior product. • Need a mechanism to match cost of repairs and maintenance back to the original product to identify if the cheapest product purchased is still the cheapest after repairs/maintenance are factored in. • There are some serious OH&S issues of ageing equipment which could pose a liability threat to PADP. • When an individual is eligible under PADP but is provided with equipment outside of the program by a non-government organisation, repairs should be funded under PADP. As in the long term, this will provide savings to PADP by ensuring equipment provided by charities is maintained in good working order and preventing for some time, the need for new equipment to be provided under PADP. <p>Creation of a database for equipment</p> <ul style="list-style-type: none"> • This would allow for consistency across centres when handling maintenance and repairs for equipment. It would ensure that there was standard practice for all PADP lodgement centres in line with OH&S and Infection Control policies. • Tracking systems for equipment maintenance, repairs and returns are difficult to run and costly to maintain. An alternative is to have suppliers contracted to run maintenance schedules. <p>Comments on the policy prior to 2001</p> <ul style="list-style-type: none"> • Prior to the new policy in 2001, clients were required to contribute to the repairs of equipment, however this has been removed. <p>Clarification of what constitutes a 'replacement'</p> <ul style="list-style-type: none"> • Clarification of what constitutes a replacement is needed e.g. is it the same item, or is it an upgrade to a

Funding and supply of equipment	
Issues	Comments from consultations and feedback
	newer model?
Delivery and return of equipment	<p>Timely receipt of equipment for clients</p> <ul style="list-style-type: none"> • There is a need to decrease the time between approval for equipment and clients receiving equipment, as the client's condition or therapist may change and equipment models may be superseded. This is especially evident when dealing with children, as children need all relevant items of equipment in order to function. • Ensuring there is continuous feedback about the progress of a client's application between PADP, therapist, client and client's family. Include an acknowledgement of receipt of the PADP application and information about likely waiting times. • The need for PADP to have a procedure in place to handle urgent requests for equipment. <p>The quality of equipment supplied</p> <ul style="list-style-type: none"> • In the case of footwear, poor quality and inappropriate footwear is supplied which instead of assisting the client exacerbates the problem. <p>Returning equipment</p> <ul style="list-style-type: none"> • The establishment of a method is needed to ensure equipment is returned when it is no longer needed by the client or the client has passed away. • The PADP coordinator should not have the authority to re-issue equipment because in many circumstances they are not qualified to perform this role. A qualified maintenance person is required. • To encourage the return of equipment, clients should be charged an annual fee for using equipment that is supplied by PADP. Once, the equipment is no longer needed, the client would return the item to PADP, and the annual fee would cease to be charged. • Equipment is generally returned at the end of its useful life. • Some high cost items are very specialised and can not be adapted for further use at a reasonable cost. <p>Procedures for delivery and set up of equipment</p> <ul style="list-style-type: none"> • To ensure clients and the families of clients are aware of how to correctly use the equipment, a standard procedure is needed whereby once the equipment is delivered, the therapist is present to demonstrate the correct and safe way to use the equipment. This is of particular concern to those in rural areas. • The therapist should also take an A4 page detailing responsibilities of the client and servicing arrangements. • A need for the therapist to have regular consultations with the client after they have received the equipment to ensure the equipment is still suitable and meeting the clients needs. <p>Cost saving initiatives</p> <ul style="list-style-type: none"> • To save money and time, products that are delivered four times a year could be delivered in bulk, once a year, e.g. continence products.
Government contracts/ tendering	<p>Increased use of Government contracts and tendering</p> <ul style="list-style-type: none"> • The quality of products has decreased in order to bring down the costs to the program. • Use Government contracts to supply standard equipment to reduce costs and increase PADP's ability to provide equipment to more clients. • Encourage tendering for niche and specialised products. Address the option of having one tender for each niche area that covers all states and territories equipment funding programs to improve the commercial viability of this option. This would allow for similar economies of scale affect as government contracts. • If Government contracts are an option for the PADP program, PADP users should be consulted to ensure the contracts are won by business that provide the most effective and efficient products for PADP users. • In the case of low cost items, Government tenders should be requested. If a therapist requires

Funding and supply of equipment	
Issues	Comments from consultations and feedback
	<p>something that is not on contract, a separate form should be submitted to PADP justifying the recommendation.</p> <ul style="list-style-type: none"> • Consider the option of having joint contracts between PADP and DADHC for the supply of certain aides and equipment. • Effort would need to be made in expanding Government can be supplied through Government contract currently. • Limitations exist for the tendering of highly specialised items. Utilisation of service contracts or agreements and business processes such as volume discounts or preferred suppliers may provide opportunities for efficiencies outside of the tendering process.
Suppliers	<ul style="list-style-type: none"> • Suppliers need to have more responsibility for the equipment supplied, i.e. the provision of warranties. • Need to look at options for trialling or leasing high cost equipment before ordering the equipment. • Ensure there is a commitment to quotes by suppliers. • Addressing the option of sourcing equipment from overseas.
Equipment loan pools	<p>Integration of PADP loan pool and hospital loan pools</p> <ul style="list-style-type: none"> • Currently, there are many different loan pools with different equipment and procedures which need standardisation. • Integrate the hospital and PADP equipment pools to ensure assets from both pools are used to their maximum capacity either across the AHS or State. • Alternatively, have an advisor who has access to all the equipment held within state pools and can be contacted by prescribers before going through the prescription process to see if there is any returned equipment that meets their client's needs. • The hospital loan pools are generally tiny, under funded and only provide basic equipment that doesn't meet the need of clients with specialist requirements e.g. those with spinal injury. • Currently, there is a general a sense of ownership with equipment in loan pools, if the equipment was put on a list it may go elsewhere. • A gap exists in the continuity of care due to the policy stating that clients can not access PADP funding until three months after discharge from hospital as the client has access to the hospital equipment loan pool for three months. <p>Availability of equipment in loan pools</p> <ul style="list-style-type: none"> • There is a high demand for certain pieces of equipment and loan pools don't have these available to distribute to a client once an application is received, factors contributing to this includes budgetary constraints and the logistics of receiving/delivering equipment. • PADP needs more funding in order for clients to get their equipment in a timely manner.
High cost items	<ul style="list-style-type: none"> • There is a general consensus that the \$800 figure that currently constitutes a high cost item is too low. However, there is no general consensus on what figure could be substituted, with \$2,000 being a more appropriate amount. However, this would then require further review of the funding distributions across low cost and high cost items. • For items under \$2,000, a manager who had experience in prescribing these items could review theses low cost items prior to approval. If there was uncertainty in approving the application, then the application could be reviewed by the advisory committee. • Approximately 20% of items are very high cost, very specialised equipment that takes a long time for the client to receive. • Maintenance contracts should be a mandatory component of all high cost item applications. • The raising of the high cost items to \$2,000 is likely to result in a greater amount of inappropriate

Funding and supply of equipment	
Issues	Comments from consultations and feedback
	<p>equipment being approved and may have implications for the pricing of equipment.</p> <ul style="list-style-type: none">• In the context of limited budgets this is a need to go through the local advisory committee, therefore the current system should be retained where all applications greater than \$800 must seek approval from a local advisory committee.

Written Submissions

The following written submissions were received:

- Bankstown Aged Care Assessment Team
- CNC Palliative Care and Cancer Services GWAHS
- Home Based Therapy Program Concord Hospital
- Northcott Society
- Director Occupational Therapy SSWAHS
- Combined Pensioners and Superannuants Association of New South Wales Inc.
- The Spastic Centre
- Lymphoedema Royal Prince Alfred Hospital
- New England HACC
- Council of Social Service of New South Wales (NCOSS)
- Hunter New England Area Health
- Technical Aid to the Disabled NSW
- ACROD NSW
- Greater Southern Area Health Service
- MS Society
- NSW Brain Injury Rehabilitation Program
- GMCT Home Enteral Nutrition Working Group.
- Continence Advisor Lourdes Hospital
- CNC Continence Sydney West Area Health Service
- Independent Living Centre
- The Spastic Centre Rural Therapy Services Orana Far West-Dubbo
- NSW State Spinal Cord Injury Service
- Association Nurse Continence Advisors NSW
- The Diabetes Centre Royal Prince Alfred Hospital
- Lismore Lodgement Centre
- Calvary Rehabilitation and Geriatric Services
- Multicultural Disability Advocacy Association of NSW
- Western Sydney Intellectual Disability Support Group
- Institute for Family Advocacy & Leadership Development Assoc. Inc
- Carers NSW
- Prince of Wales Community Health Service
- Western Sydney Intellectual Disability Support Group
- Spinal Cord Injuries Australia
- Physical Disability Council
- Royal Institute for Deaf and Blind Children

Appendix G PADP Lodgement Centre and PADP Coordinator contact list

Coordinator Contact List

	Name	Email	Address	Phone	Fax
The Children's Hospital Westmead					
	Jennifer Law Haydee Llanos	Jennifer.law@hnehealth.nsw.gov.au haydeel@chw.edu.au	Locked Bag 4001 WESTMEAD NSW 2145	02 9845 2549	02 9845 2564
Greater Southern Area Health Service					
Greater Murray Lodgement Centre	Lynne Coad/Judy Morton Marianne Lackner – Aged Services Program Manager	Lynne.coad@swsahs.nsw.gov.au	PO Box 8546 KOORINGAL NSW 2650	02 6933 8020	02 6933 8023
Southern Area Lodgement Centre	Kathryn Gilchrist Beth Monk	Kathryn.gilchrist@sahs.nhs.gov.au beth.monk@sahs.nhs.gov.au	St John of God Hospital PO Box 274 GOULBURN NSW 2580	02 4823 7949	02 4823 7929
Greater Western Area Health Services					
Far West Lodgement Centre	Peter Ball	pball@gwahs.health.nsw.gov.au	Broken Hill Base Hospital PO Box 457 BROKEN HILL NSW 2880	02 8080 1444	02 80801690
Macquarie Lodgement Centre	Tim Mitchell Jan Steel	tmitchell@chcs.com.au jsteel@chcs.com.au	Lourdes Hospital Cobbora Road DUBBO NSW 2830	02 6841 8554	02 6884 1778
Mid Western Lodgement Centre	Noela Lucas Peter Hurst	Noela.lucas@gwahs.health.nsw.gov.au Peter.hurst@gwahs.health.nsw.gov.au	Bathurst Base Hospital Howick Street BATHURST NSW 2795	02 6339 5315	02 6339 5357

	Name	Email	Address	Phone	Fax
Hunter New England Area Health Service					
Hunter Area Health Service	Lynette Gunning Anneke Redman	Lynette.gunning@hne.health.nsw.gov.au Anneke.redman@hne.health.nsw.gov.au	Locked Bag 11 WALLSEND NSW 2287	02 4924 6245	02 4924 6242
Northern Lodgement Centre	Chris Perfrement	cperfrement@hne.health.nsw.gov.au	Locked Bag 9783 TAMWORTH NSW 2348	02 6767 8326	02 6766 1017
Lower Mid North Coast Lodgement Centre	Keith Hardy Ken Hampson	khardy@doh.health.nsw.gov.au	Manning Base Hospital PO Box 35 (York St) TAREE NSW 2430	02 6592 9402	02 6592 9691
North Coast Area Health Service					
Northern Rivers Lodgement Centre	Pam Finnigan Chris Went	chrisw@nrahs.health.nsw.gov.au	NCAHS	02 6627 9514	02 6621 2049
Northern Sydney Central Coast Area Health Service					
Central Coast Lodgement Centre	Margaret English Kerry Stevenson	menglish@doh.health.nsw.gov.au kstevenson@doh.health.nsw.gov.au	CCH Distribution Centre PO Box 361 GOSFORD NSW 2250	02 4336 8823	02 4336 8819
Northern Sydney Lodgement Centres	Diane Chivers	dchivers@doh.health.nsw.gov.au	Hornsby & Ku-ring-gai Hospital Palmerston Road HORNSBY NSW 2077	02 9477 9418	02 9477 9704
	Jill Sullivan	jsullivan@doh.health.nsw.gov	Ryde Hospital & Community Services Denistone Road EASTWOOD NSW 2122	02 9858 7968 02 9858 7799	02 9858 7712

	Name	Email	Address	Phone	Fax
	Carolyn Lofts Di Trickett	clofts@doh.health.nsw.gov.au tricked@doh.health.nsw.gov.au	Northern Beaches, Manly Hospital Darley Road MANLY NSW 2095	02 9976 9636 02 9976 9963	02 9976 9598
South Eastern Sydney & Illawarra Area Health Service					
Illawarra Lodgement Centre	Carolyn Moselen Jan Erven	moselenc@iahs.nsw.gov.au	Port Kembla Hospital PO Box 21 WARRAWONG NSW 2502	02 4223 8243	02 4223 8246
South Eastern Sydney Lodgement Centre	Gabrielle Barrett Kirstin Mbothu	barrettg@sesahs.nsw.gov.au	Prince of Wales Hospital RANDWICK	02 9382 8115	02 9382 8265
	Perona Winterstein Lyn Riley		Calvary Hospital Rocky Point Road KOGARAH NSW 2217	02 9553 3000	02 9553 3130
	Shirley McLaughlin Dr Phillip Conroy Elizabeth Koffe		Sutherland Hospital Locked Bag 21 TAREN POINT NSW 2229	02 9540 7531 02 9540 7470	02 9540 7711
Sydney South West Area Health Service					
Central Sydney Lodgement Centre	Sharron Wessels Les Hillier	Sharron.wessels@email.cs.nsw.gov.au les@email.cs.nsw.gov.au	Balmain Hospital Booth Street BLAMAIN NSW 2041	02 9395 2068	02 9395 2069
South Western Sydney Lodgement Centres	Marilyn Cupitt	Marilyn.cupitt@swsahs.nsw.gov.au	Bowral District Hospital PO Box 268 BOWRAL NSW 2576	02 4861 0273	02 4861 0251

	Name	Email	Address	Phone	Fax
	Pauline Lynch	Pauline.lynch@swsahs.nsw.gov.au	Camden Hospital PO Box 99 CAMDEN NSW 2570	02 4654 6312	02 4654 6313
	Diane Reid	Diane.reid@swsahs.nsw.gov.au	Bankstown/Lidcombe Hospital Eldridge Road BANKSTOWN NSW 2200	02 9722 7263	02 9722 7190
	Rose Lubyckij Wendy Harmer	Rosemary.lubyckij@swsahs.nsw.gov.au	Liverpool Hospital Elizabeth Street LIVERPOOL NSW 2170	02 9828 4691	02 9828 4695
Sydney West Area Health Service					
Wentworth Lodgement Centre	Sue Crosbie Karen Arblaster	crosbis@wahs.nsw.gov.au arblask@wahs.nsw.gov.au	PO Box 63 PENRITH NSW 2751	02 4734 2801	02 4734 3402
Western Sydney Lodgement Centre	Judith Collins	Judith_collins@wsahs.nsw.gov.au	Mt Druitt Hospital Railway Street MT DRUITT NSW 2770	02 9881 1842	02 9811 1825
	Sue Drain	Sue_drain@wsahs.nsw.gov.au	St Joseph's Hospital PO Box 211 REGENTS PARK NSW 2143	02 9749 0202	02 9649 8810
Justice Health Service					
	Michelle Murphy	Michele.murphy@justicehealth.nsw.gov.au	PO Box 150 MATRAVILLE NSW 2036	02 9661 1924	

Assessors Contact List

	Name	Email	Address	Phone	Fax
Sydney South West Area Health Service					
Eastern zone	Lesley Cherry Area Director Occ Therapy	lesley.cherry@email.cs.nsw.gov.au	Royal Prince Alfred Hospital QE II Building, Level 4 Missenden Road CAMPERDOWN NSW 2050	(02) 9515 9920	(02) 9515 9928
Western zone	Daena Wilson Service Manager Occupational Therapy Dept	daena.wilson@swhs.nsw.gov.au	The Bankstown-Lidcombe Hospital Eldridge Road Bankstown NSW 2200	02 9722 7141	02 9722 7125
Northern Sydney Central Coast Area Health Service					
	Michelle Williams Occupational Therapist in Charge	miwillia@nscchahs.health.nsw.gov.au	Ryde Hospital Denistone Road Eastwood NSW 2122	(02) 9858 7974	(02) 9858 7775
	Elizabeth Lwin Area Occupational Therapy Manager	elwin@doh.health.nsw.gov.au	Gosford Hospital PO Box 361 Gosford, NSW 2250	(02) 4320 2160	(02) 4320 2430
South Eastern Sydney / Illawarra Area Health Service					
	Joan Jackman Manager	jackmanj@sesahs.nsw.gov.au	Prince of Wales Hospital High Street Randwick NSW 2031	(02) 9382 2837	(02) 9382 2842
	Jan Erven Occupational Therapy Advisor	ervenj@iahs.nsw.gov.au	Port Kembla Hospital PO Box 21 Warrawong, NSW 2502	(02) 4223 8250	(02) 4276 4111

	Name	Email	Address	Phone	Fax
Sydney West Area Health Service					
	Karen Arblaster	ablask@wahs.nsw.gov.au	Nepean Hospital PO Box 63 Penrith, NSW 2751	(02) 4734 3101	(02) 4734 3478
East & Central	Sapna Lazarus Occupational Therapy Director	asapnal@imag.wsahs.nsw.gov.au	Westmead Hospital Darcy Road Westmead, NSW 2145	(02) 9845 6500	(02) 984 7102
Hunter / New England Area Health Service					
	Kim Nguyen Area Director Occupational Therapy	kim.nguyen@hnehealth.nsw.gov.au	Wallsend Campus Longworth Ave Wallsend, NSW 2287	(02) 4924 6359	(02) 4924 6006
	Michelle Gallagher Occupational Therapy Advisor	michelle.gallagher@hnehealth.nsw.gov.au	Quirindi Health Service PO Box 120 Quirindi, NSW 2343	(02) 6746 0205	(02) 6746 0230
North Coast Area Health Service					
Mid north coast	Rosie Meury Occupational Therapy Clinical Advisor	rmeury@mncahs.health.nsw.gov.au	Port Macquarie Community Health Campus	(02) 6588 8228	(02) 6588 2785
Northern Rivers	Andrew Maglaras Clinical Senior Occupational Therapy	andrewma@nrahs.nsw.gov.au	Tweed Heads Community Health Service PO Box 904 Tweed Heads, NSW 2485	(07) 5506 7555	(07) 5506 7578

	Name	Email	Address	Phone	Fax
Greater Western Area Health Service					
	Joan Murphy Occupational Therapist	joan.murphy@gwahs.health.nsw.gov.au	Greater Western Health Service 2 Palmer Street Dubbo, NSW 2830	(02) 6885 8999	(02) 6885 8901
	Michelle Coore Occupational Therapy Advisor	michelle.coore@gwahs.health.nsw.gov.au	Orange Base Hospital PO Box 319 Orange, NSW 2800	(02) 6393 3361	(02) 6393 3364
Greater Southern Area Health Service					
	Andrea Marsden Occupational Therapist	andrea.marsden@sahs.nsw.gov.au	Locked Bag 15 Goulburn NSW 2580	(02) 4827 3950	(02) 4827 3958
SAHS side	Domenico Tripodi Occupational Therapist	domenicotripodi@sahs.nsw.gov.au	Cooma CHC	(02) 6455 3201	(02) 6455 3360
	Joy Gadd Occupational Therapist	joyg@umhcs.vic.gov.au	Upper Murray Health PO Box 200 Corryong, Vic 3707	(02) 6076 1355	(02) 6076 1739
AAOT-NSW	Executive Director AAOT-NSW	info@otnsw.com.au	Unit 20, 8 Avenue of the Americas Newington NSW 2127	(02) 9648 3225	(02) 9737 0023

Appendix H Lodgement Centre Staff Survey Questionnaire

Review of the Program of Appliances for Disabled People

PADP Coordinator Survey

The project

Thank you for participating in the review of the Program of Appliances for Disabled People (PADP). The review is being undertaken by PricewaterhouseCoopers (PwC) on behalf of the NSW Department of Health (the Department) and will make important recommendations on the way in which the program is delivered into the future.

This survey

This survey is designed to collect information on the cost of the PADP scheme. We request that **PADP Coordinators be responsible for completing the survey** in consultation with Area Health Service (AHS) staff and Local Advisory Committee (LAC) members involved in PADP.

The survey has been developed in consultation with several PADP Coordinators who have helped us to design the survey. We realise that this is a busy time of year, and we have attempted to ensure that the questionnaire does not take too long to complete. We estimate that it should take no longer than 10 minutes.

When providing your answers please consider the following:

- We are attempting to estimate a 'broad snapshot' of the time and resources involved in delivering PADP – your best estimates are all that is required.
- We are seeking information on arrangements for 2005 unless otherwise specified.
- We are seeking the weekly time spent on each activity - some activities may not take place in each week so the estimate should be the average time per month
- You are not required to provide an estimate of overheads (building outgoings, telephone, stationery, cleaning, security etc). These costs will be estimated as part of the analysis.

We would appreciate if you could please return completed questionnaires (fax or email) to **Mark Galvin** (details below) by **Friday 13 January 2006**. If you require assistance with any aspect of the survey please do not hesitate to contact one of the members of the PwC team.

<p>Mark Galvin Manager PricewaterhouseCoopers Phone (02) 8266 9270 Mobile 0422 009 718 Fax (02) 8286 9270 Email mark.galvin@au.pwc.com</p>
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Review of the Program of Appliances for Disabled People

PADP Coordinator Survey

Instructions

Please read the following instructions carefully. PADP Coordinators should complete the survey in consultation with other AHS staff and LAC members as required.

1. PADP Coordinator Details

Please provide your details below.

Respondents name	
Region	
Address	
Contact phone	
Email address	

2. PADP Resource details

Please complete Table 1 below for all AHS staff whose duties include direct responsibility for the administration or coordination of PADP in your area. Please also include AHS staff and members of the LAC. *Please note that PADP assessors will be surveyed separately and do not need to be recorded below.*

Table 1

Staff ID Marker	Title	Employment Grade*	No. hours spent on PADP	% of hours spent on PADP paid from PADP budget
A	PADP Coordinator			
B				
C				
D				
E				
Etc...				

Please insert additional rows as required

* This is your grade/level as per the public hospitals and area health services award (NSW Health Circular 2004/96).

3. Resource time summary

Please estimate the number of hours each staff spends in each week on activities related to PADP in Table 2. Further details of these activities are contained in Table 3. Some of these activities may not take place in each week so the estimates should be the average hours for a month. The total hours for each person should equal the total of hours recorded in Table 1 above. The example line represents a staff member who works full-time on PADP and attends a 5 hour LAC meeting once a month and takes 30 minutes travel each way (*5 hours in meetings plus 1 hour travel divided by 4 weeks = 1.5 hours per week*).

Table 2

Process category	Eligibility		Prioritisation			Prescription processing		Equipment support and maintenance	Other	Total
	General enquiries	Prescription assessment	Prescription allocation	LAC support and admin	LAC Meetings	< \$800	>\$800	Equipment support & maintenance	Other	Total
Example	3hrs	4hrs	5hrs	5hrs	1.5hrs	5hrs	4hrs	5hrs	5hrs	37.5hrs
Staff ID Marker -A										
B										
C										
D										
Etc...										

Please insert additional rows as required

Table 3

Process category	Activities
Eligibility	<ul style="list-style-type: none"> • <i>General enquiries</i> from potential PADP clients, their families and/or carers, therapists relating to the PADP scheme. • <i>Prescription assessment</i> relates to assessing prescriptions for completeness and eligibility
Prioritisation:	<ul style="list-style-type: none"> • <i>Prescription allocation</i> relates to determining the pathway for the prescription in terms of whether it is directed to the co-payments team or the LAC. • <i>LAC support and administration</i> including arranging meetings, agendas, meeting minutes etc. • <i>LAC meetings</i> time spent in meetings as well as an estimate of travel time for all participants.
Prescription processing	<ul style="list-style-type: none"> • <i>Processing prescriptions less than \$800</i> which may include data entry, invoicing and processing of co-payments. • <i>Processing prescriptions greater than \$800</i> which may include data entry, arranging quotes, arranging equipment contracts, ordering and delivering equipment, arranging therapist appointments.
Equipment maintenance and support:	<ul style="list-style-type: none"> • <i>Equipment maintenance & support</i> including: <ul style="list-style-type: none"> – annual programmed preventative maintenance – responding to requests for parts and equipment replacement – pick-up/removal of equipment no longer required by the client.
Other activities	<ul style="list-style-type: none"> • <i>Other activities</i> including: <ul style="list-style-type: none"> – responding to requests from NSW Health for PADP data and information – ad-hoc and or scheduled meetings related to aspects of the PADP scheme.

4. Other costs

Please provide details of the cost of any capital equipment, courier pick-up or delivery costs etc. related directly to the PADP scheme that are **NOT paid** from the PADP budget.

Cost item	Cost (\$)

Please insert additional rows as required

5. Submission of completed questionnaire

Thank you for taking the time to complete this questionnaire. Please email, post or fax your completed questionnaire to Mark Galvin using the details below:

Mark Galvin
PricewaterhouseCoopers
GPO Box 2650
Sydney NSW 1171
Phone (02) 8266 9270
Mobile 0422 009 718
Fax: (02) 8286 9270
Email: mark.galvin@au.pwc.com

Appendix I PADP Occupational Therapist PADP Assessor Survey Questionnaire

Review of the Program of Appliances for Disabled People

PADP Assessors Survey

The project

Thank you for participating in the review of the Program of Appliances for Disabled People (PADP). The review is being undertaken by PricewaterhouseCoopers (PwC) on behalf of the NSW Department of Health (the Department) and will make important recommendations on the way in which the program is delivered into the future.

This survey

This survey is designed to collect information on the cost of the PADP scheme. We realise that this is a busy time of year, and we have attempted to ensure that the questionnaire does not take too long to complete. We estimate that it should take no longer than 10 minutes.

When providing your answers please consider the following:

- We are attempting to estimate a 'broad snapshot' of the time and resources involved in delivering PADP – your best estimates are all that is required.
- We are seeking information on arrangements for 2005 unless otherwise specified.
- We are seeking the weekly time spent on each activity - some activities may not take place in each week so the estimate should be the average time per month
- You are not required to provide an estimate of overheads (building outgoing, telephone, stationery, cleaning, security etc).

We would appreciate if you could please return completed questionnaires (fax or email) to **Mark Galvin** (details below) by **Friday 13 January 2006**. If you require assistance with any aspect of the survey please do not hesitate to contact one of the members of the PwC team.

<p>Mark Galvin Manager PricewaterhouseCoopers Phone (02) 8266 9270 Mobile 0422 009 718 Fax (02) 8286 9270 Email mark.galvin@au.pwc.com</p>

Review of the Program of Appliances for Disabled People

PADP Assessor Survey (Occupational Therapists)

Instructions

Please read the following instructions carefully before completing the survey.

1. Respondent Details

Please provide your details below.

Respondents name	
Employment Grade*	
Region	
Address	
Contact phone	
Email address	

* This is your grade/level as per the public hospitals and area health services award (NSW Health Circular 2004/96).

2. Resource time summary

Please estimate the number of hours you spend in each week on activities related to PADP in table 2. It is important that we capture information that is related to PADP only. The following provides some examples of what should and should not be included in the questionnaire:

- the time taken to undertake an initial assessment of a patient should **not be included** (where this would generally occur as part of your duties whether the PADP scheme existed or not).
- the time taken to re-assess a patient who has been on the PADP waiting list **should be included**.
- the time taken to fill out the prescription for PADP equipment is a PADP related activity and **should be included**.

Further details of these activities are contained in Table 3. Some of these activities may not take place in each week so the estimates should be the average hours for a month. The example line represents a full-time OT who spends approximately half their time on PADP related activities.

Table 2

Process category	Initial assessment	Re-assessment	PADP Equipment tasks			Education and Training	Other	Total
Activity	Initial assessment (PADP activities only)	Re-assessment	Organisation (i.e. quotes)	Equipment trials	Equipment assembly & instruction	Education and Training	Other	Total
Example	2hrs	4hrs	3hrs	3hrs	3hrs	2hrs	2hrs	19hrs

Table 3

Process category	Activities
Initial assessment	<ul style="list-style-type: none"> • <i>General enquiries</i> from potential PADP clients, their families and/or carers, therapists relating to the PADP scheme. • <i>Initial application</i> – relates to completing the PADP application form for PADP eligibility • <i>Prescription completion</i>- relates to completing the PADP prescription - it does not include the actual assessment of the patient where this is part of your everyday duties. • <i>Checklists</i> – Completing relevant PADP checklists (where relevant)
Re-assessment	<ul style="list-style-type: none"> • <i>Re-assessment</i>- relates to confirming the patients prescription to ensure that it is still accurate usually following a period when the patient was on the PADP waiting list. Please include travel time if the specific purpose of the visit is to re-assess the PADP prescription. • <i>Completing</i>- relevant checklists (where relevant)
PADP equipment tasks	<ul style="list-style-type: none"> • <i>Organisation of PADP equipment</i> – involves organising mandatory quotes for equipment, dealing with sales reps • <i>Equipment trials</i> – time spent in trailing equipment suitability with patients. Include travel time where this is the specific purpose of the visit • <i>Equipment assembly & instruction</i> relates to assembling equipment supplied as part of the PADP scheme and instructing the patient on how to use the equipment. Include travel time where this is the specific purpose of the visit
Education and training	<ul style="list-style-type: none"> • <i>Education and training</i> refers to the time spent in and/or organising meetings/seminars/training groups where the specific purpose of the forum is related to the PADP scheme.
Other activities	<ul style="list-style-type: none"> • <i>Other activities</i> may include general administration, attendance at meetings, reporting on aspects of the scheme, providing expert advice to the AHS or LAC meeting on matters relating to the PADP scheme.

5. Submission of completed questionnaire

Thank you for taking the time to complete this questionnaire. Please email, post or fax your completed questionnaire to PwC using the details below:

Mark Galvin
PricewaterhouseCoopers
GPO Box 2650
Sydney NSW 1171
Fax: (02) 8286 9270
Email: mark.galvin@au.pwc.com

Appendix J Example letter



GREATER SOUTHERN
AREA HEALTH SERVICE
NSW HEALTH

Incorporating

Health Services
Adelong
Albury
Ardlethan
Barellan
Barham
Barmedman
Ballou
Batemans Bay
Bega
Berrigan
Bombala
Boorowa
Braidwood
Coolamon-
Ganmain
Coleambally
Cooma
Cootamundra
Corowa
Crookwell
Culcairn
Darlington Point
Delegate
Deniliquin
Eden
Finley
Goulburn
Griffith
Gundagai
Gunning
Hay
Henty
Hillston
Holbrook
Jerilderie
Jindabyne
Junee
Leeton
Lockhart
Mathoura
Moama
Moruya
Moulamein
Murrumburrah
Harden
Narooma
Narrandera
Pambula
Queanbeyan
Tarcutta
Temora
The Rock
Tocumwal
Tooleybuc
Tumbarumba
Tumut
Ungarie
Urana
Wagga Wagga
Weethalle
West Wyalong
Yass
Young

12th September 2005

Re: PADP

We have received your application for assistance with an electric wheelchair.

Unfortunately, the PADP program is unable to be of assistance to you at this time.

This is because you do not have a pension or a health care card - this is one of the main pre-requisites for eligibility with the program.

As well, on the financial details provided on your application, you do not come within any of the bands, i.e. bands 1, 2, 3 or 4 which offers a wide range of options for people applying to PADP for assistance.

Your cheque for \$100.00 is therefore returned to you.

We have spoken to _____ the therapist involved with your application and she will contact you with other options which could be investigated.

We regret not being able to assist you.

Should you have any queries at all, please don't hesitate to contact our office.

Yours faithfully,

PADP Co-Ordinator
On Behalf of the PADP Advisory Committee

**Better Health for
Rural Australia**

Greater Southern Area Health Service
ABN 17 196 442 397
GPO Box 1845 (34 Lowe Street) Queanbeyan NSW 2620
Tel (02) 6128 9777 Fax (02) 6299 6363
Email corporate@gsahs.health.nsw.gov.au
Website www.gsahs.health.nsw.gov.au

Appendix K Final eligibility criteria

Purpose and scope

The purpose of this brief is to review the income threshold specified in the PADP eligibility criteria and to propose an alternative methodology which has potential to address some of the deficiencies in the current method of assessing financial disadvantage. There are a number of remaining issues with respect to the criteria which are not considered here (such as treatment of children). Many of these issues are outlined in the Physical Disability Council of Australia Discussion Paper 2000.

PADP financial eligibility criteria

The PADP scheme assesses the eligibility of applicants in four bands according to certain financial criteria (NSW Health 2005 p5). Band 1 requires the applicant to hold a valid Centrelink pension or a Health Care Card. Applicants within Bands 2-4 must fall within specified income bands that determine the applicant's relative level of financial disadvantage. Applicants within Bands 1-3 generally have priority over applicants within Band 4.²⁵

Financial eligibility for the PADP scheme is determined for all people within the PADP target population aged 16 and above whose taxable income²⁶ in the preceding financial year was:

- **Band 2:** less than or equal to \$26,759 for an individual or \$45,490 for a couple or family (NSW Health 2005 p 5). The income bands are based on the mean income of residents in the 10 postcode areas with the lowest incomes in NSW in 1997/98.
- **Band 3:** less than or equal to \$39,941 for an individual or \$67,899 for a couple or family (NSW Health 2005 p 5). The income bands are based on the mean income for all NSW residents in 1997/98.
- **Band 4:** above \$39,941 for an individual or \$67,899 for a couple of family adjusted for dependents who are eligible to apply for high cost items only.

The first issue is that by using 1997/98 as the base year for the income threshold and holding it static over time, the figures do not reflect income and price growth since 1997/98. A person with an annual income of \$26,759 in 1997/98 could purchase more goods and services than a person earning the same amount in 2005/06. By holding the income threshold static people earning above \$26,759 in 2005/06 would not be eligible for Band 2 even though their ability to afford equipment may not have changed.

²⁵ Applicants within Band 4 may take priority over applicants within Bands 1-3 with the approval of Local Advisory Committees.

²⁶ These figures include \$5,000 per annum to cover the cost of a disability. A further \$1,500 per dependent person is to be added to the single and family income figures for applicants with dependents

A second issue is the basis for arriving at the threshold for a single person, couple or family. The method of determining the base income threshold (although the actual figure is dated) appears to be reasonable - persons within the target population who are below average income earners are captured. This paper will look at some high level options for determining a base financial threshold for the scheme. However, it is a policy decision for the government to articulate the level of financial disadvantage the scheme should be targeting.

Applicant affordability

The rationale for a financial eligibility threshold is that PADP is designed for those who are financially disadvantaged and less able to afford equipment. A critical element of the income threshold is 'affordability' or the level of annual income at which an individual or family requires government assistance in order to acquire equipment through the PADP scheme.

Affordability is generally influenced by the two main factors of income and price changes. If prices increase at a greater rate than incomes, affordability is negatively affected and vice versa. It is therefore important that the calculation of the financial eligibility threshold can be adjusted to ensure parity in applicant affordability over time by incorporating a mechanism to adjust the figure for price movements.

Changes in welfare recipient income are likely to reflect a situation closer to that of a low income earner than changes in all incomes²⁷. Since 1997/98, welfare recipient incomes grew by approximately 3 per cent per annum²⁸ (by contrast NSW average income increased by approximately 5 per cent per annum²⁹). Over a comparable period NSW CPI experienced 2.5 per cent growth³⁰. It would appear that welfare income is quite closely correlated to price growth which would provide a sound basis for adjusting the annual income threshold figure.³¹

Maximum income threshold

The current method of determining the base income threshold (although the actual figure is dated) appears to be reasonable - persons within the target population who are below average income earners are captured. The actual income threshold is a policy decision that needs to be made by government in terms of the level of financial disadvantage targeted by the PADP scheme.

²⁷ This is because the NSW average earnings measure includes all incomes including those negotiated by high income earners.

²⁸ Based on the income of a single adult who receives the maximum social security payments and has no other income (Melbourne Institute of Applied Economic and Social Research). Available data allowed us to calculate the change between March 2000 and March 2005 only.

²⁹ ABS Time series 6302.0 Average Weekly Earnings, Australia. Table 12A Average Weekly Earnings, NSW (dollars) seasonally adjusted. Earnings, NSW, Persons, Full Time, adult, Ordinary time earnings. February 1998 and August 2005.

³⁰ ABS Cat. 6401.0 Consumer Price Index, Australia. 2001 and 2005. *Note* that CPI measures the price changes of a basket of goods and services. A more appropriate measure of a persons ability to afford the equipment may be to use the average price growth of the equipment and consumables listed under the PADP scheme.

³¹ The mechanism used by government to adjust welfare benefits would need to be investigated but it appears by virtue of the close correlation between price and income changes that CPI is one input.

Assuming that the PADP scheme is designed to target the most financially disadvantaged people within its target population group, a point of reference for disadvantage could be provided by the Henderson Poverty Line (HPL). The HPL was developed as part of the Australian Government Commission of Inquiry into Poverty (1973). The HPL is calculated from ABS estimates of household disposable income and population. The HPL is updated quarterly by the Melbourne Institute of Applied Economic and Social Research.

As for the method described in the previous section, the HBL method incorporates a mechanism to allow for price changes as it is derived by estimating how much disposable income is required by individuals and families to cover essential living costs. The HBL represents a very basic standard of living which is perhaps too severe for assessing PADP eligibility. It is therefore suggested for use as a point of reference for eligibility rather than as the adopted income threshold.

Revising the income threshold

The table below shows the current annual income threshold for PADP Band 2 (single person). The current annual income threshold is compared with three alternatives:

- **Alternative 1** annual income threshold derived by inflating the PADP figures at the rate of income growth experienced by welfare recipients.³²
- **Alternative 2** annual HPL as calculated by the Melbourne Institute of Applied Economic and Social Research.
- **Alternative 3** annual income threshold calculated as a midpoint of alternatives 1 and 2.

Annual maximum income threshold for PADP Band 2 (single person)

	2000/01	2001/02	2002/03	2003/04	2004/05
PADP income threshold	\$ 26,759	\$ 26,759	\$ 26,759	\$ 26,759	\$ 26,759
Alternatives					
1 - welfare income growth	\$ 28,817	\$ 29,537	\$ 30,275	\$ 31,032	\$ 31,808
2 - Poverty line	\$ 11,949	\$ 12,370	\$ 12,466	\$ 13,608	\$ 16,554
3 - Midpoint of alternatives 1&2	\$ 20,383	\$ 20,953	\$ 21,371	\$ 22,320	\$ 24,181

The table shows that the current annual income threshold for a single person of \$26,759 is \$5,049 higher than it would be if it was adjusted in line with changes in welfare income under alternative 1. This means that in 2004/05 those people with incomes between \$26,759 and \$31,808 applying for PADP would have been classed within Band 3 despite having the same ability to afford the equipment as they would have earning \$26,759 in 1997/98.

³² We have used the 1997/98 figure as the basis for inflating the annual income figure. An updated annual income figure could be obtained from the 2001 census. It would require an ABS consultancy to obtain the necessary postcode breakdown to obtain this figure.

Whether alternative 1 of \$31,808 in 2004/05 represents the most appropriate level of income is a matter for Government. However, by comparison the poverty line in the same year at \$16,554 per annum is just over half of this alternative 1 amount. A mid-point of alternatives 1 and 2 of \$24,181 per annum in 2004/05 may be an appropriate method level of targeting the most financially disadvantaged people within the target population.

Next steps

For the PwC team to meet and discuss the issues raised in this brief.

Brief prepared by:

Mark Galvin

PricewaterhouseCoopers

30 November 2005

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