



Survey of PADP Lodgement Centres and PADP OT Assessors

6 Survey of PADP Lodgement Centres and OT Assessors

This Section presents the findings of the survey of PADP Lodgement Centres and PADP OT Assessors. The survey was conducted between 20 December 2005 and 13 January 2006. The purpose of the survey was to collect information on the resources utilised in, and time spent on, activities related to the delivery of the PADP scheme. This information was used to obtain an estimate the financial cost of the PADP scheme. The data is supplemented with data from other sources where indicated.

6.1 Summary of findings

6.1.1 The financial cost of the PADP scheme

One aim of the surveys was to obtain a better measure of the full financial cost of the PADP scheme to government. The full financial cost of the scheme is measured by the amount of funding allocated to PADP plus the additional salary (and some non-salary) costs of the resources utilised in the administration and delivery of the scheme. Table 31 estimates the annual financial cost of PADP to the NSW Government.

Table 31 Estimated financial cost of PADP to Government in 2005/06

Lodgement Centre costs ¹	Assessment costs ²	Remaining PADP budget ³	Total cost ⁴
\$2.8M	\$22.4M	\$22.6M	\$47.8M

Notes:

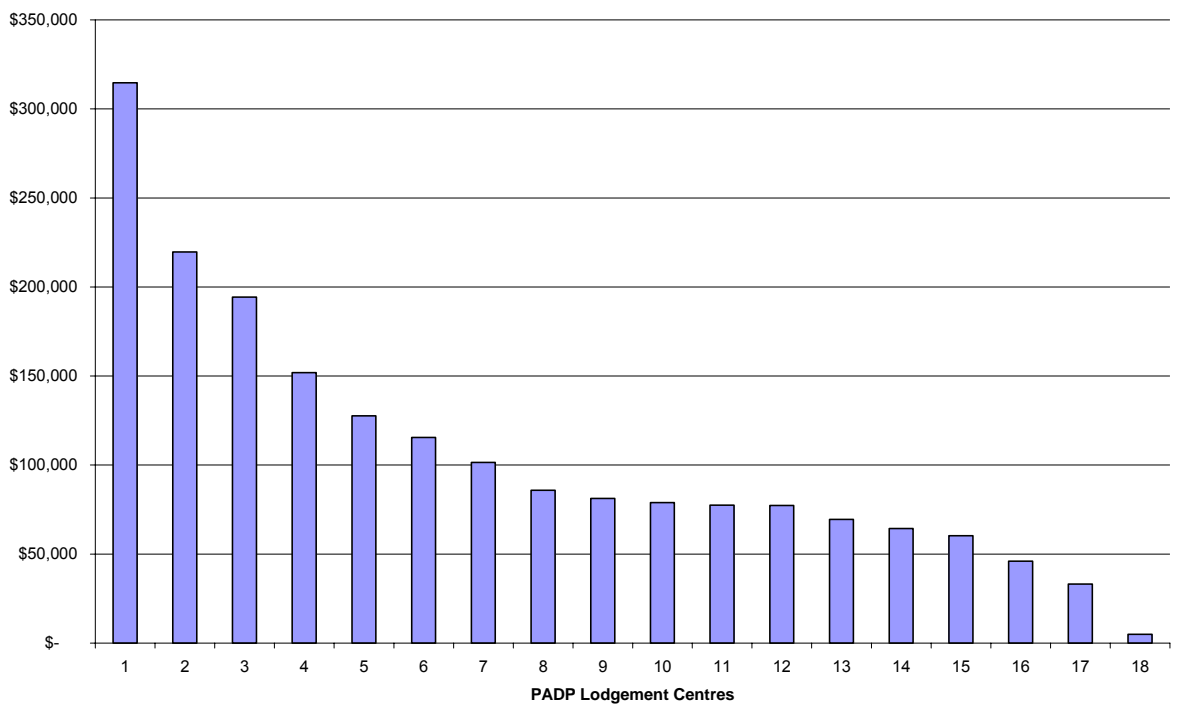
1. Lodgement Centre costs are represented by salaries (not including on-costs) and other costs identified as part of the Lodgement Centre Survey. The costs for Lodgement Centres not represented in the survey sample is estimated using an average costs for Lodgement Centres in the sample.
2. Assessment costs are represented by salary costs (not including on-costs) identified as part of the Assessor survey. The costs for Assessors not represented in the survey sample are based on a population estimate of 1,866 OT's in NSW (The Australian Institute of Health and Welfare 1998 *Occupational Therapy Labour Force Survey National Health Labour Force Series Number 21* 1998 p3). This number is reduced by 25% since 75% of the total number of NSW based OT's are involved in the prescription of PADP equipment and are funded by NSW Health.
3. Remaining PADP budget is represented by the total budget allocation for PADP in 2005/06 of \$21.8 million less the Lodgement Centre costs that are paid from the PADP budget \$1.44 million.
4. Total cost is a broad estimate and does not include and/or assumes:
 - NSW Health and DADHC head office PADP administration and policy related activities
 - Costs to the private sector
 - An allocation for Lodgement Centre overheads
 - An allocation for salary on-costs (leave, workers compensation etc.)
 - Vehicle operating costs and allowances
 - The costs associated with assessments by health professionals who are non OT's.
 - An average cost is used as the basis for extrapolating costs for the total population of Lodgement Centres and assessors.

The cost of salaries⁹ for staff directly involved in the administration of the PADP scheme and other related costs across the 26 Lodgement Centres in NSW is estimated at \$2.8 million. The cost of assessment activities, where these relate directly to the PADP scheme is estimated at \$22.4 million. Of these costs some \$1.4 million are paid from the PADP budget leaving \$22.6 million. The total cost of the scheme is therefore estimated at around \$47.8 million.

6.1.2 PADP Lodgement Centre costs

Figure 2 shows the cost of administration and coordination of PADP at the 18 Lodgement Centres represented in the survey sample.

Figure 2 Annual cost of PADP Lodgement Centre administration



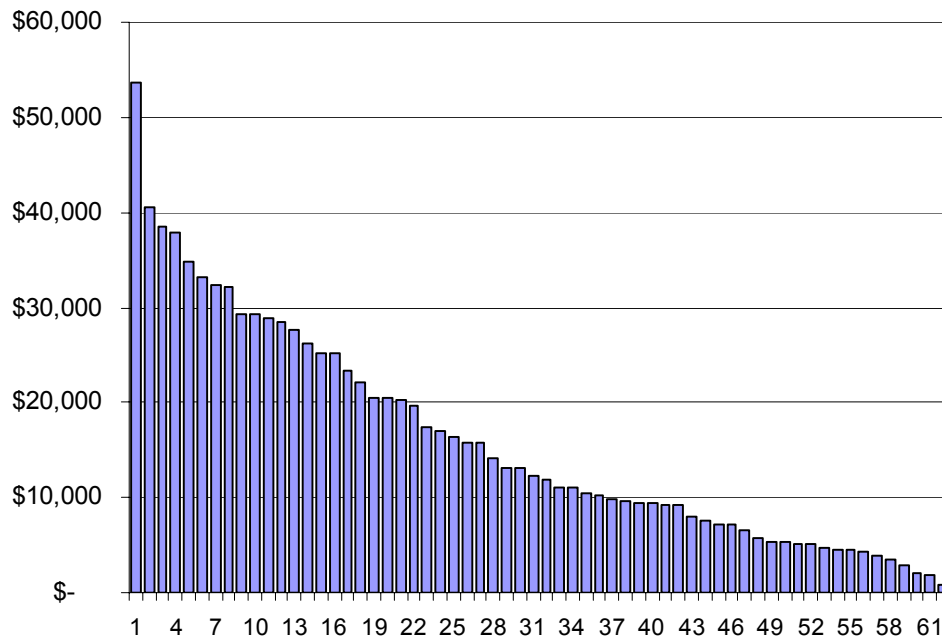
The chart above shows that the cost of salaries and other PADP costs utilised in the administration of PADP at the 18 Lodgement Centres was \$2.8 million. Costs ranged between approximately \$315,000 and \$5,000 per annum. The average cost per Lodgement Centre is \$106,000 per annum. Approximately 56% of these costs or just over \$1 million were reported to be paid from the PADP budget, leaving approximately \$1.8 million which is funded from alternative sources.

⁹ Includes non-salary costs not paid from PADP budget, such as courier and delivery costs. However these costs are largely immaterial and represent less than 7% of PADP coordination and administration costs.

6.1.3 OT Assessment costs

Figure 3 shows the cost of PADP assessment as recorded by the 62 OT assessors in the survey sample.

Figure 3 Annual cost of PADP assessment



The chart above shows that the cost of the salaries of assessors performing activities related to PADP (does not include the cost of the initial assessment) by the 62 OT's in the sample was just under \$1 million. Costs ranged between approximately \$54,000 and \$800 per annum. The average cost per assessor was approximately \$16,000 per annum.

6.1.4 Time, resources, cost and activity breakdown

PADP Lodgement Centres

Table 32 shows the breakdown of the estimated time spent by all staff across all 26 Lodgement Centres with a direct involvement in PADP, the number of full-time equivalent (FTE) resources and equivalent total cost of salaries.

Table 32 Annual estimates for PADP coordination and administration

	Time ²	Resources ³	Total Cost (Salaries only) ⁴
All Lodgement Centres in NSW(1)	118,691 hours	61 FTEs	\$2.6M
Average per Lodgement Centre	4,575 hours	2 FTEs	\$99,000

Notes:

1. The total cost for all Lodgement Centres is based on extrapolating the total cost of the sample (18 Lodgement Centres) to arrive at a total cost for all 26 Lodgement Centres in NSW.
2. The average time per annum is estimated as the average time per week multiplied by 52 weeks.
3. This estimation is based on the total time spent by staff, and does not differentiate between staff functions and grades.
4. Includes salary costs only does not include on-costs. Salary costs are calculated as a product of the time taken per activity and the cost per hour of the resource's time based on their employment grade and the public hospitals and AHSs award (NSW Health Circular 2004/96). Non-salary costs include 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.

An estimated total of 118,691 hours per annum are spent by Lodgement Centre staff directly involved in the administration and coordination of PADAP across the state. This is equivalent to approximately 61 FTEs or 2 FTEs per Lodgement Centre. The costs of salaries for these staff are estimated at \$2.6 million per annum or \$99,000 per Lodgement Centre.

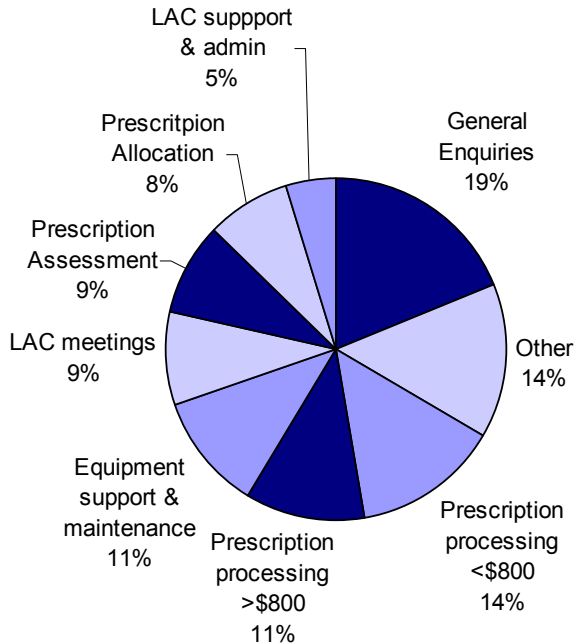
Table 33 shows the average proportion of time spent, associated FTEs and costs by PADP activity for each Lodgement Centre, based on results from the 18 Lodgement Centres in the survey sample. An explanation of the activities involved can be found in Appendix H.

Table 33 Average time, resource and salary costs at each Lodgement Centre by activity

Activity	Average time per annum (hours)	Average resources (FTEs)	Average cost per annum
General Enquiries	857	0.44	\$18,368
Prescription Assessment	344	0.18	\$7,454
Prescription Allocation	400	0.21	\$9,089
Local Advisory Committee support & admin	219	0.11	\$4,815
Local Advisory Committee meetings	311	0.16	\$8,076
Prescription processing <\$800	672	0.34	\$13,700
Prescription processing >\$800	487	0.25	\$10,332
Equipment support & maintenance	613	0.31	\$11,813
Other	673	0.34	\$14,986
Total	4,575	2	\$98,633

Figure 4 shows a breakdown of Lodgement Centre salary costs by the type of PADP coordination and administration activity.

Figure 4 Breakdown of PADP coordination and administration salary costs by activity



The findings show that an average of 0.6 FTEs per annum at each Lodgement Centre are consumed in the processing of PADP prescriptions of greater or less than \$800 at a cost of over \$24,032 per annum in salaries per Lodgement Centre. These activities include data entry, invoicing and processing of co-payments, arranging quotes, arranging equipment contracts, ordering and delivering equipment, arranging therapist appointments and consume approximately 25% of Lodgement Centre staff salary costs.

Local Advisory Committee meetings and associated activities consume an average of 0.27 FTE staff at each Lodgement Centre at a cost of over \$12,891 per annum per Lodgement Centre. These activities include determining the pathway for the prescription in terms of whether it is directed to the co-payments team or the local Advisory Committee, local Advisory Committee support and administration including arranging meetings, agendas, minutes and time spent in meetings, and consume approximately 14% of Lodgement Centre staff salary costs.

Other activities which require significant time and resource commitments are:

- responding to general enquiries about the PADP scheme (average 0.44 FTEs per Lodgement Centre and 19% of salary costs)
- equipment maintenance and support activities such as responding to requests for parts and equipment replacement and arranging pick-up/removal of equipment no longer required by the client (average 0.31 FTEs per Lodgement Centre and 11% of salary costs)

- other activities which include responding to requests from NSW Health for PADP data and information and meetings related to aspects of the PADP scheme (average 0.34 FTEs per Lodgement Centre and 14% of salary costs).

PADP OT Assessors

Table 34 shows the breakdown of the estimated time spent by all estimated OT assessors with a direct involvement in PADP and the equivalent total cost of salaries.

Table 34 Annual estimates for PADP OT assessment

	Time	Resources	Total Cost (salaries only)
All OT assessors in NSW	785,400 hours	403 FTEs	\$22,377,600
Average per OT assessor	561 hours	0.3 FTEs	\$15,984

Notes:

- 1 The average time per annum is estimated as the average time per week multiplied by 52 weeks.
- 2 The cost of each activity considers the Assessor's salary costs only, and is calculated as a product of the time taken per activity and the cost per hour of the Assessor's time based on their employment grade and the public hospitals and AHSs award (NSW Health Circular 2004/96).
- 3 Assessment costs are represented by salary costs (not including on-costs) identified as part of the Assessor survey. The costs for Assessors not represented in the survey sample are based on a population estimate of 1,866 OT's in NSW (The Australian Institute of Health and Welfare 1998 *Occupational Therapy Labour Force Survey National Health Labour Force Series Number 21* 1998 p3). It is assumed that 75% of the total number of NSW based OT's are involved in the prescription of PADP equipment and are funded by NSW Health.

An estimated total of 785,400 hours per annum are spent by OT assessors across the state on PADP related activities. This is equivalent to approximately 403 FTE OT assessors. The costs of salaries for these staff are estimated at \$22.4 million per annum or \$15,984 per assessor.

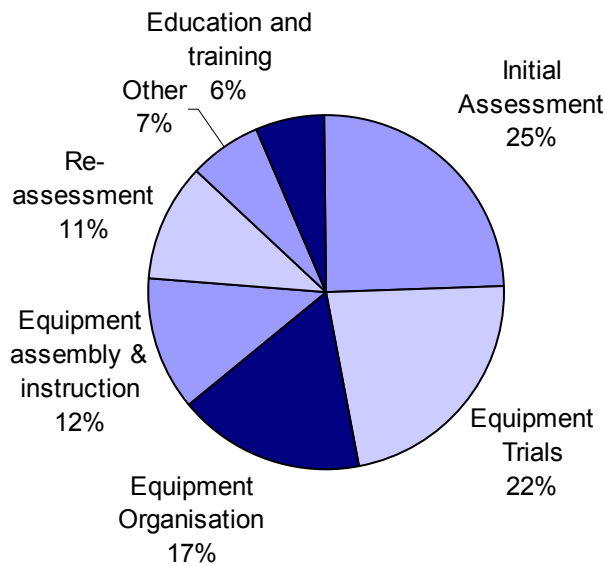
Table 35 shows the average time spent associated FTEs and costs by PADP activity per OT assessor based on the 62 OT assessors in the survey sample. An explanation of the activities involved can be found in Appendix I.

Table 35 Average time, resource and salary costs of each OT PADP assessor

Activity	Average time per annum (hours)	Average resources (FTEs)	Average cost per annum
Initial assessment	139	0.07	\$3,952
Equipment trials	67	0.03	\$1,895
Equipment organisation	90	0.05	\$2,545
Equipment assembly & instruction	119	0.06	\$3,388
Re-assessment	68	0.04	\$1,954
Other	41	0.02	\$1,182
Education and training	37	0.02	\$1,068
Total	561	0.29	\$15,984

Figure 5 shows a breakdown of the OT assessor salary costs by the type of PADP assessor activity.

Figure 5 Breakdown of PADP assessor costs by activity



The findings show that based on the 62 PADP OT assessors surveyed, an average of 0.07 FTEs per annum for each OT assessor are consumed in initial assessment activities at an average cost of approximately \$3,925 per assessor. Initial assessment activities include responding to general enquiries from potential PADP clients, their families and/or carers relating to the PADP scheme; completing the PADP application form and PADP prescription (it does not include time spent on the actual initial assessment of the patient as this is something that would ordinarily be done in the absence of the PADP scheme). Initial assessment activities consume approximately 25% of salary costs.

Re-assessments are generally required to ensure that a PADP applicant's needs have not changed in the time between the applicant's initial assessment and when the PADP equipment becomes available. Re-assessments required as a result of PADP waiting lists consume approximately 68 hours per assessor at a cost of almost \$2,000 per assessor.

Other activities which require significant time and resource commitments are:

- equipment organisation (organising equipment quotes and dealing with equipment sales reps, average 0.05 FTEs per OT assessor and 17% of salary costs)
- equipment assembly and instruction and equipment trials (average 0.09 FTEs per OT assessor and 34% of salary costs directed to PADP)
- PADP related education and training (average 0.02 FTEs per OT assessor and 6% of salary costs).



Findings and recommendations

7 Findings and recommendations

This section brings together the findings and recommendations arising from the consultations, data analysis and surveys.

7.1 Overall major issues and challenges

Challenges

There are four defining and overarching challenges that emerge in relation to the operation of this program. These are:

- The challenge of managing expectations from consumers applying to an eligibility program (where eligible persons are provided with services within budgetary constraints) in the belief that they are accessing an entitlement program (where all those who meet the entitlement receive the service).
- The challenges in delivering a predictable, consistent and reliable state-wide program within a delegated geographical management structure that has only minimal state-wide administration.
- The challenge to accurately match the available budget to the number of persons who meet the eligibility criteria.
- The challenge of creating an appropriate management and policy framework for the program in the future, as it is apparent the program has outgrown the current arrangements.

Predictability, consistency and reliability to clients

One of the challenges to this program is the variety of clients served by PADP. All age groups are represented and there is a wide range of disabilities and a range of disability within the client group. A common feature of all clients, regardless of the nature and the level of disability, is the potential improvement in the quality of life from the supply of aids and equipment through this program. The counter side to that benefit is the significant inconvenience and decline in quality of life that a failure in the program to deliver can inflict.

The review team were reminded on numerous occasions throughout the consultations of the significance of aids and equipment to individuals regardless of its value. The provision of continence pads can make social activities possible for very little cost to the program. At the other end of the scale is the major impact on quality of life a high end electric wheelchair can make for someone with a profound disability. The significance of these benefits suggests that a program such as PADP should provide each of the potential clients with some certainty as to the services the program will provide; that is a quality service should achieve a high level of consistency, predictability and reliability.

While it is not uncommon for a program funded within the state system to function as an eligibility program, the program should aim to minimise the disappointment, inconvenience and cost to individuals who apply for a service that they will not receive. The current level of inconsistency, failure of predictability and reliability across the program is unacceptably high. Contributing to this is the failure of the available funds to adequately satisfy the reasonable expectations of the client group. The current structure and administration of the program also contributes to its lack of reliability.

Another feature of the program is its growth in recent years. It is clear from the current operations that it has outgrown its current administrative and management arrangements. It was initially established to provide access for a small category of clients with a very limited budget. With 15,000 clients and over \$24 million in annual expenditure it now is in urgent need of reform to ensure that these funds are appropriately expended and the service meets the standards of operation that clients and stakeholders expect.

Quality and commitment of the PADP staff

The review team were impressed by the quality and dedication of the PADP staff within the Lodgement Centres and other services contacted as part of this review. None of the comments in relation to the management and administration of the program are intended to be inferred as a criticism of the work of these individuals. The review team noted the relative stability of the Lodgement Centre staff in a number of locations and commend them on their dedication in the face of the daily challenges and frustrations they face. The level of feeling to which the review team were exposed in this review from some clients and stakeholders may be a daily occurrence to the Lodgement Centre staff.

The review team are of the view that the Lodgement Centre staff perform their duties to a high standard within the management and administrative arrangements that are provided by the health system. As with all large systems, the inadequacies that occur are often the result of a number of individual decisions (or lack of decisions) made by competent managers and policy makers at different times, yet do not always deliver the best service over the passage of time.

7.2 Background

PADP is a geographically distributed program that is guided by a set of policies and procedures issued by the NSW Department of Health. Access and management of the program is through the Lodgement Centres. Although it is a state-wide program with the policies and procedures developed centrally, the Department does not *manage* the program; rather it *administers* it.

The Lodgement Centres are operationally part of each of the eight AHSs across NSW. In addition, there are PADP programs operating from the Spinal Injuries Units of RNSH and POW Hospital. A small paediatric PADP program operates out of the CHW.

A fuller discussion on the challenges facing the Department in creating the right balance between geographical distribution of the program, and consistency of operation is contained in Section 7.4.2 later in this report.

The managers of the AHSs and the Lodgement Centres are faced with the task of meeting the expectations of consumers and other stakeholders, their facilities and professionals within the framework of the policy and the limitations of the allocated budget.

In this section we discuss the systems around PADP within the AHSs, along with the management and process issues that have been identified and focused upon in this review.

Three processes are undertaken in PADP. These are illustrated in the process map provided in Section 2.2.1, Figure 1. These processes are:

- Assessment and prescription.
- Processing of applications.
- Assessing relative need and determining priorities.

The management issues discussed in this section include:

- Organisational structure for PADP centres.
- Adequacy of information systems.
- Structure and operation of the Advisory Committees.
- Performance criteria, standards, benchmarks and performance indicators related to processing.
- Performance criteria, standards, benchmarks and performance indicators related to assessing need and determining priorities.
- Transparency, accountability and reporting of the management of the Lodgement Centre processing and the process of assessing need and determining priority.

- Planning by local Lodgement Centres for future expenditure needs of existing clients and care planning for routine maintenance and replacement.

The administration, responsibility and policy development issues discussed in this section include:

- the Department with policy responsibility
- the Department with operational responsibility
- input from stakeholders and consumers
- governance of the program and the role of the state-wide Advisory Committee.

Cost of current operations

A survey of PADP Lodgement Centre coordinators was conducted as part of this study. A full description of this study is provided in Section 4.3 and the detailed results of this study are provided in Section 0. Eighteen of the potential 26 centres surveyed responded to the study. Extrapolating from this sample, it is estimated that currently 61 FTEs or two FTEs per Lodgement Centre are engaged on PADP coordinated and supported activities. The costs of salaries for these staff are estimated at \$2.6 million per annum or \$99,000 per Lodgement Centre. Another \$200,000 in non-salary costs were identified. Only about \$1.4 million is paid to the AHS from the PADP budget. This suggests that AHSs are subsidising PADP by at least \$1.4 million for direct coordination and administration costs.

7.3 Major recommendation – one operation for NSW

This section covers the following recommendations:

Key area	Section	Recommendation
One central administration	7.3	1, 2

PADP is a small component of the operations of the NSW health system and of the AHSs within which they operate. Within the overall span of responsibilities of senior health service managers, PADP must take its place alongside the range of day to day operational and strategic issues with which senior managers must deal. Alongside the major issues facing the health system, such as managing large budgets, complex health care systems, workforce deficiencies and acute hospital system management emergencies, the management and administration of the local PADP Lodgement Centre and equipment pool is a relatively minor administrative issue. Not surprisingly, there was a general impression gained by the review team that the efficient and effective operation of this scheme was not a high priority for local management. In some circumstances, the impression gained was that PADP is seen as a difficult program for which they would be happy not to have responsibility.

The management and policy framework for the program needs to be overhauled to create a streamlined state-wide administration that does not require policy and management input at a local level, and delivers consistent practice across the state.

There does not appear to be a strong argument to retain local administrative units other than the convenience to some, (but not all) consumers and clinicians, as the processing of large numbers of small items lends itself more efficiently to a single operation. In addition, the skills required to assess high cost, complex, single items may not always be present in each AHS.

The cost of the current operations, in direct staff time only, is approximated at 10% of the total budget. This is the estimated cost of direct coordination and administration, as no overhead costs have been included in this estimate, the true cost is probably a lot higher. If local Lodgement Centres were abolished, the saving across the AHSs would be greater than \$2.8 million. These funds could be reallocated towards a new centralised operation.

The most effective mechanism for achieving consistency is to centralise the operations of PADP and remove the need for AHS based Lodgement Centres.

Should the decision be made not to centralise the service, local centres should be reorganised to better deliver a consistent service that matches consumer expectation and meets performance indicators, benchmarks and standards.

Figure 6 provides a 'decision tree' to assist in determining the future operations of PADP and the alternatives that flow from different decisions. For example, if there is no support for electronic transfer of applications and prescriptions or for pooling of equipment, then it

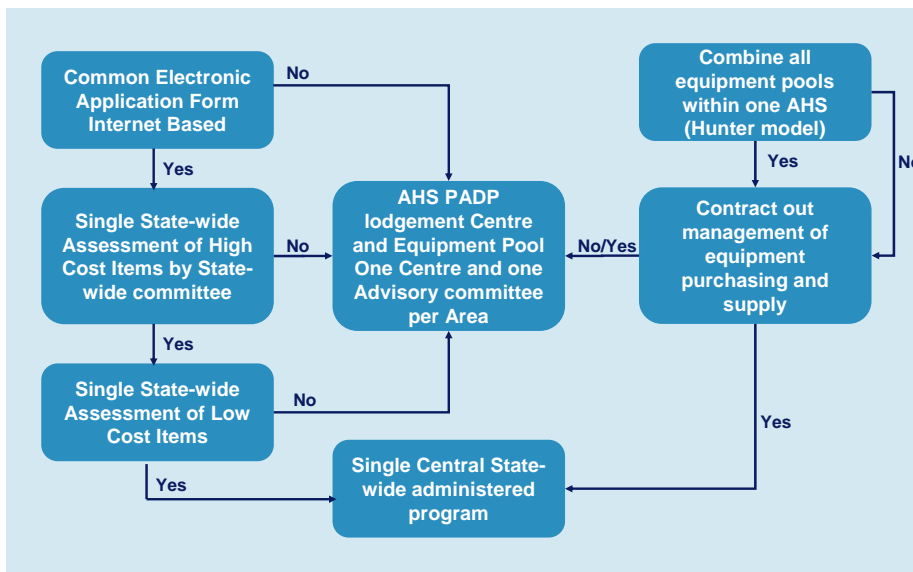
may be better to retain the current lodgement centres in each AHS, and establish processes to deal with the potential inconsistencies of decision making across the state. On the other hand, if the decision is made that electronic submission and processing is to be introduced and equipment pooled, then a single service for NSW appears to be a logical solution to many of the current difficulties. This report recommends the establishment of a state-wide Advisory Committee for providing advice for the management of high cost, complex and novel requests. It also recommends that the management of equipment pools be either rationalised or contracted out.

A central service for PADP may not need to be in one physical location centrally, but could operate in a dispersed manner with various functions located in different parts of the state, or even different organisations. For example, some of the existing lodgement centres could be redesigned to specialise in, say, processing low cost items on behalf of the central service and processing the orders for mobility equipment, communication aids etc.

A single centre would be supported by a suitably developed website and database (see Section 7.4.8 for a fuller discussion of a new information system).

Some of the current functions associated with PADP at the local level could be contracted out. One of the arguments surrounding local centres is the current role of managing the local PADP equipment pools and for coordinating the handling of equipment locally. Where that function is transferred to an area wide pool, or contracted out, that role for the local lodgement centre would no longer be required.

Figure 6 Options for the operation of Lodgement Centres and equipment pools



It was beyond the scope of this review to cost the recommendation for the establishment of a single state-wide service. A major cost of establishing such a service, would include the establishment of a suitable website and information system. The annual cost would include staff to administer the program, in addition to the processing of applications and equipment orders and the cost of advice to management about high cost and complex items.

Recommendation 1

It is strongly recommended that all PADP functions be transferred from the current Lodgement Centres to one state-wide administration covering the state.

Recommendation 2

A feasibility study should be commissioned by NSW Health to investigate the cost and challenges associated with establishing a single state-wide service to replace the current hospital based operations.

7.4 Management and administration - discussion and recommendations of key areas

Management and administration covers the following key areas:

Key area	Section	Recommendation
Processing of applications	7.4.1	1, 2
Number and organisation of Lodgement Centres	7.4.2	3
Performance criteria, standards, benchmarks and performance indicators related to assessing need and determining policy	7.4.3	4, 5
Planning for future needs of existing clients and care planning for routine maintenance and replacement	7.4.4	6, 7
Departmental responsibility for policy and operations	7.4.5	8
Governance of the program	7.4.6	9
The role of specialist 'start-up' funds	7.4.7	10
Adequacy of information systems	7.4.8	11

7.4.1 Processing of applications

Current practice

Once an application and prescription is received by the Lodgement Centre, it is then processed for eligibility and priority. The issue of eligibility criteria is discussed in Sections 7.5.6 and 7.5.7. This section discusses the processing of the application by the local Lodgement Centres and options for improving practice.

The current policy defines high cost items as those that cost over \$800 to purchase, and infers that items less than \$800 are processed by the Lodgement Centre coordinator. Lodgement Centre coordinators can be given delegated authority by the AHS to process some items that are worth more than \$800. According to the current policy, 'all applications for high cost items over \$800, borderline or difficult application should be referred to the local PADP Advisory Committee for a decision'.

Practice in relation to the processing of applications varies across the state. Some Advisory Committees have determined that only items with a value over \$3,000 need to be referred to the committee (along with borderline, difficult applications or those of a specific nature). In some locations, the Advisory Committee looks at all or most applications regardless of the value.

The level of work in the processing of applications varies significantly between applications. Some applications for low cost, frequently ordered items, such as continence products or walking frames, would presumably require little time to process and can be a function that lends itself to a streamlined process. Other pieces of equipment that are high cost and

modified for a particular client, will require individual management and may require a number of communications with the prescriber, client, Advisory Committee, senior management and the supplier before the equipment is supplied. From what the review has heard, the complexity of process tends to increase with the cost of the item.

Issues raised

The main issues raised in relation to the processing of an application were the following:

- Variation in the practices across Lodgement Centres in the dollar value of high cost items.
- The time taken to process applications.
- The difference in interpretation of the policy, resulting in a difference between centres in the items that are purchased.
- The quality and timing of communication back to the applicant.
- The frequency with which some items are purchased by individual Lodgement Centres, and the capacity of individual Lodgement Centres to negotiate an appropriate price for infrequently ordered equipment.

The review team heard of stories that some applicants have waited months to be informed as to whether their application was successful, only to be informed that they were on a waiting list. Another practice reported by members of the Advisory Committee (when commenting on the inadequacy of a prescription) was that the prescription had to wait for first scrutiny at the next meeting of the Advisory Committee – although the Lodgement Centre coordinator was reasonably certain that it did not contain sufficient information to be approved by the Committee. The Advisory Committee rejected the application with advice for the Lodgement Centre staff to seek the needed information and submit it at the next meeting of the Committee. This meant that the application was not considered for approval for up to two months from the time it was initially made. Such a delay can have a profound effect on the lives of the people making applications.

Discussion

In addition to the issues raised above, there are other issues associated with the administration of the scheme at a local level and these are discussed in the relevant sections below. These include the number of centres, local management arrangements, the structure and operation of the Advisory Committees, and the accountability of the operation of each centre. These issues overlap and the comments provided in this section rely in part on the arguments contained in these separate sections.

The overall efficiency of the operation of some Lodgement Centres needs to be considered in the light of the information uncovered in this review. In the survey of Lodgement Centre coordinators (conducted as part of this review), the cost of administration varied widely, ranging from \$315,000 to \$5,000. While surveys of this nature have inherent limitations and it would not be appropriate to focus too closely on the cost estimates, the result suggest a

wide variation in the size of Lodgement Centres across the system and a corresponding variation in experience and skills of the staff who work in them.

The bulk of the orders (by volume) processed through the centres are for low cost items, such as continence products, walking aids, shower chairs etc. Table 36 provides a breakdown of the number of items purchased in 2004-05 within cost ranges (the cost of the items is unknown in 9% of items). Of the 407,600 items purchased that year, 87% of all items purchased (354,947 items) cost less than \$100. Just over 1% of items (15,835 items) were worth more than \$1000. This suggests that the bulk of the work in processing orders is for routine purchases of low cost items. While this task may be adequately performed at the local level, it may also be a task that can be as adequately but more cost effectively undertaken on a state-wide basis by a centralised service. This table does not include data from the spinal unit set up funds and some Lodgement Centres that did not supply data in that period.

Table 36 Number and percentage of all aids purchased in 2004-05 by cost band category

Cost band	Number of items purchased	Percentage
\$0-\$100	354,947	87.07%
\$100-\$500	10,958	2.69%
\$500-\$1000	2,128	0.52%
\$1000-\$5000	2,135	0.52%
\$5000-\$10000	377	0.09%
\$10000-\$15000	219	0.05%
\$15000-\$20000	17	0.00%
Unknown	36,891	9.05%
All	407,674	100.00%

The number of high cost items purchased is relatively small – less than 1% of items (just over 600 items in this data set) that each cost more than \$5,000 were purchased during the year. Small local rural centres particularly face major challenges in processing applications of high cost complex items. The expertise involved in processing the applications will naturally vary with the nature of the equipment requested. Small centres that rarely purchase a high cost complex piece of equipment, will naturally not acquire the same expertise in these tasks as large metropolitan centres or specialist units that have more frequent requests for these items.

This review has raised for question the wisdom of requiring small Lodgement Centres and local Advisory Committees to undertake the role and burden of determining the suitability of and negotiation of the purchase of high cost and complex equipment. These tasks may best be handled by larger centres with greater expertise and equipment pools.

Options for improvement

There are three options for improving processing and purchasing arrangements:

- 1 Do nothing - retain processing of all applications within the AHSs (we recommend below that should local Lodgement Centres be retained there should be only one centre per AHS).
- 2 Centralise all processing of applications – where simple low cost items are supplied immediately, and high cost or complex options are referred to an Advisory Committee.
- 3 Split processing of applications - all high cost and complex items are immediately referred to a central committee and simple, low cost items are processed locally.

Discussion

- Option 1 - is essentially the same arrangement as the current arrangements, although it is recommended below that there be only one Lodgement Centre for each AHS. This may not provide the experience and expertise for purchasing high cost and expensive items for some centres.
- Option 2 - suggests a single 'Lodgement Centre' for the state where all applications are processed. This would allow for the efficiencies of scale that purchasing large volumes of similar items can provide, and would also allow for the expertise and purchasing power of one centre to be harnessed to purchase high cost items. Under such an arrangement, the prescribing would still be undertaken locally and the prescriber would retain the close working relationship with the client.

The central Lodgement Centre would have available a range of specialist advisers who would review high cost specialised items and unusual orders. In addition, the central Lodgement Centre could have an advisory panel that determines priority for the supply of equipment when it becomes necessary to create waiting lists. Based on the estimates arising from the survey, the savings from removing the burden of processing applications from the AHSs would be in the vicinity of 61 FTEs or \$2.6 million annually. While no estimate has been made for the cost of a central service, this level of staff and budget would appear more than adequate if these resources were to be reallocated.

- Option 3 - suggests that the bulk purchasing of low cost equipment (say less than \$1,000) could be retained at the AHS with all high cost items being processed centrally. However, if the local Lodgement Centres are retained this will not generate the administrative savings to fund a central service.

The arguments for local Lodgement Centres

In the consultations held, the advantages and disadvantages of local Lodgement Centres was discussed at some length.

With a single budget for the Program, the larger the number of Lodgement Centres the smaller is each centre's share of the overall budget and the harder it is for them to manage the request for a high cost item. Each centre has to develop its own administrative and purchasing processes and skills in dealing with suppliers, distributors and transport providers. Consequently, there needs to be a balance between the perceived advantage of 'localness' with overall program efficiency and effectiveness.

One of the issues raised concerned the involvement of local clinicians on the Advisory Committees who had clients with an application before the Lodgement Centre. As the Advisory Committees determine eligibility and priority of clients on the waiting lists, the concerns raised were about perceptions of conflicts of interest by these clinicians. The concerns were more likely to arise in health services with only a small pool of clinicians to draw upon to participate in the Advisory Committee. It is important to note that the review was not provided with any direct evidence of a conflict of interest occurring within the Lodgement Centres and the Advisory Committees. The review team was advised on more than one occasion that systems were in place at the local level to ensure that potential conflicts of interest were dealt with appropriately when they arose. Nevertheless, some consumers and consumer representatives appeared to retain these concerns.

A number of participants in the consultations spoke in favour of the benefits of the local Lodgement Centres because of the relationships that had been established between the coordinators, clinicians and the clients in a number of instances. However, these favourable comments tended to be made by those clients receiving services and those clinicians who were within the same hospital or local health service. Clients who were not receiving services (or who were on the waiting list) did not necessarily see the advantage in having the Lodgement Centre locally and some saw it as a disadvantage.

In a number of consultations, some participants commented on the perception of an advantage given to some clients and clinicians arising from the closeness of the working relationships, while also commenting that they had no evidence that this was occurring.

In one rural AHS where consultations were held, there was only one Lodgement Centre for the Area. This centre was located in a regional city although the AHS covered a wide geographic area and had other regional cities that were of reasonable size. All the members of the Advisory Committee were located in the city in which the Lodgement Centre was located and spoke of the benefits of the close working relationship with the local Lodgement Centre coordinator. The clinicians interviewed that were located in the other regional centres in the AHS admitted that they did not have the same close working relationship with the coordinator, did not have the same access to members of the Advisory Committee and were not as familiar with the PADP scheme as the clinicians that were local to the Lodgement Centre.

This example is not intended to suggest that in this instance there were any inappropriate procedures, nor that conflicts of interest were apparent. This example illustrates that the benefit of local Lodgement Centres may in fact be very local, restricted only to clients and clinicians within the same health service or town.

The benefits to the clients of the local Lodgement Centres seemed to be that the establishment of relationships made mistakes easier to rectify and problems easier to solve. Experience in the health system, and in other service systems, is that good local communication can reduce the number of complaints arising.

Each Lodgement Centre has a specified geographical area to serve. The postcodes applicable to each area are listed in the policy. Consequently, consumers must attend their local Lodgement Centre and have no options to 'shop around'. Stories heard by the review team stressed the negative aspects of local Lodgement Centres, particularly around the program requirements that allowed them to deal with only one centre, and they had no access to an alternative centre should they have a poor experience with their local coordinator or centre. More than one participant in the consultations spoke of a fear of forming a negative relationship with the local Lodgement Centre staff by making a complaint and disadvantaging themselves by doing so. Local centres do not always appear to have developed a high standard of practice in written communications. Not one centre that was involved in the consultations were able to show evidence of a standard process for informing clients on how they could complain (however, complaints mechanisms are generally well publicised within the NSW Health system). The letters that are returned to unsuccessful applicants, which were seen by the review team, made no mention of any appeals mechanism should they wish to have the decision revisited and provided only details of the local staff as the contact point.

The review team acknowledges that in some instances the local arrangements may be beneficial to some clients and clinicians. This effect appears to be limited to those individuals who enjoy a close working relationship with the centre staff. This advantage is soon eliminated by distance and in rural locations may have no benefit outside of the regional centre in which the Lodgement Centre is located. As this review recommends that there be no more than one Lodgement Centre per AHS (should the recommendation of a central service not be accepted), the advantages of 'localness' may well be enjoyed by only a small percentage of citizens within the very large areas that these Lodgement Centres will serve.

The argument in favour of local centres appears to rest solely on the benefits of the relationships that localness can foster. This advantage is reduced by perceptions of disadvantage for those who have not established a relationship with the centre or its local clinicians, and the corresponding perceptions of conflicts of interest that arise from inclusion of only local clinicians on Advisory Committees (albeit for the reasons of time and cost associated with travel). A further disadvantage is the dangers of a perceived lack of access to suitable grievance processes in (relatively) small, local communities and the perception of poor treatment if the applicant complains or establishes a negative relationship with centre staff.

Local centres do not appear to have any advantage in terms of efficiency of operations, and in fact admitted that they have difficulty in securing good prices for equipment purchased relatively infrequently.

There was one advantage for local or regional centres with which the review team agreed. It was suggested that clients may find it more acceptable to receive a notice rejecting their application or that they are on a waiting list, if it comes from the local or regional health service rather than from an impersonal state-wide service.

The review team would like to stress that not all these views were backed up by evidence. In addition the review team formed the view that some criticisms of the Lodgement Centre staff were misguided and unjustified. On the whole the team formed the view that the PADP staff performed their jobs to a high standard.

7.4.2 Number of and organisation of Lodgement Centres

Current practice

In the consultations conducted during this review, attendees were asked to consider the number of Lodgement Centres within each of the current AHSs. At the time of these consultations a number of AHSs had given consideration to the reduction in the number of centres, but the review team were unaware of any that had been closed. Table 37 indicates the number of centres within each of the AHSs. This is a legacy of the past administrative arrangements and does not reflect the wishes of the current administration. Some area managers indicated that they were interested in the outcome of this review to finalise their plans for a rationalisation of the number of centres in the area.

Table 37 Number of centres in each of the AHSs in NSW and additional health services

Health Service	No. of separate PADP Lodgement Centres at the time of this review
Greater Southern AHS	2
Greater Western AHS	3
Hunter New England AHS	3
North Coast AHS	1
Northern Sydney Central Coast AHS (including spinal set up unit)	4
South Eastern Sydney Illawarra AHS (including Justice Health and spinal set up unit)	5
Sydney South West AHS	5
Sydney West Area AHS	3
Children Hospital Westmead	1
Price of Wales Hospital – Spinal set up centre	1
Royal North Shore Hospital – Spinal set up unit	1
Total	27

There are a variety of administrative arrangements across NSW for the PADP Lodgement Centres. In some locations, such as the former Hunter AHS a single Lodgement Centre and equipment pool was established that provides services across the whole of the former AHS. They are currently in discussions with the former New England AHS teams to determine consistent area wide policy and operations. At Sutherland, within the South Eastern Sydney Illawarra AHS, the Lodgement Centre is located with the Aged Care and Rehabilitation team, under the supervision of a senior clinician and fully integrated into the aged care and rehabilitation service. However, this is one of several Lodgement Centres within the new AHS and each has a distinct administrative structure.

In some rural locations, the administration of PADP has been regarded as largely an administrative function that is not integrated into the clinical administrative stream.

While some allowance can be made for the level of administrative uncertainty associated with the reorganisation of the AHSs following the legislative changes that came into effect on 1 January 2005, it would appear that at least in some locations an unclear line of managerial responsibility and accountability has been the reality for some time.

In one rural AHS the Lodgement Centre coordinator was employed as a stores officer. While there was clarity about the administrative arrangements in relation to line management, there had been uncertainty within this AHS of the accountability concerning the performance of the program and the development of local policy development and decision making.

It was unclear how the members of the Advisory Committee for this Lodgement Centre were appointed, for how long they served, on what basis they were appointed and to whom within the AHS executive the committee reported. The meetings of the Advisory Committee appeared to be chaired by the Lodgement Centre coordinator, who also determined the agenda. Members of the Advisory Committee were unaware of the appeals process or complaints mechanism related to PADP, or how consumers would be advised if they wished to seek an appeal against a decision.

This Lodgement Centre had also adopted a number of local policy decisions that were inconsistent with the state-wide policy. However, this was also the situation in other locations where the Lodgement Centre was under clear and strong management. The review team were assured that the current arrangements were under review by the AHS executive.

The overall situation across NSW is a mixture of administrative arrangements that range from those that approach best practice (within the current policy) and those that give rise to considerable concern in terms of their links to senior management.

Issues raised

There were few issues raised in the consultations with the stakeholders and consumers, in relation to the number of centres other than those raised in relation to the argument about localness. Namely, that some saw advantages in being close to a Lodgement Centre; some would have preferred a location that was more 'arms length' lest personal relationships were to their disadvantage, and some people were indifferent to the location of the Lodgement Centre preferring it to operate efficiently and professionally rather than locally.

Options for improvement

There are three possible options in relation to the number of Lodgement Centres. These are:

- 1 Leave the number and management of Lodgement Centres to AHS to determine.
- 2 Restrict the number of Lodgement Centres to one per AHSs.

- 3 Establish one Lodgement Centre for NSW that processes all applications as argued in the section above.

Discussion

- Option 1 - although the AHSs now receive one allocation of funding under the PADP Resource Distribution Formula, this option allows AHSs to determine their own internal arrangements for the number of PADP Lodgement Centres they want to establish and maintain. Where an AHS decides to continue with more than one PADP service within its Area, the problems inherent in the current system are likely to continue. This particularly relates to the development of local practices that are not consistent with the state policy, the challenges of dealing with very high cost items within a small budget, avoiding perceptions of conflict of interest between local clinicians, the decisions of the centre and the challenges of securing the best advice on the local Advisory Committee from a relatively small group of professionals and consumers.
- Option 2 - this is not the preferred option, but is included should the preferred option not be agreed and a decision is made to continue with a decentralised model.

This option would mean that the AHSs would be directed to establish one Lodgement Centre only, within the following guidelines:

- This Lodgement Centre would be appropriately staffed to meet its area-wide function.
- The Centre would be administered within a clinical services stream of the AHS with the management of the Centre included in the job description and performance agreement of the head of that service.
- The AHS would be free to decentralise some of the operations of the Lodgement Centre, such as processing of orders and the location of the PADP equipment pools, but would be required to retain the area wide administration and control.
- There would be only one Advisory Committee in each AHS with guidelines developed around the:
 - role of the committee in determining clinical suitability of prescription or restricted to determining priority
 - mechanisms for determining priority
 - role of consumer representatives
 - accountability of the committee
 - transparency of committee proceedings
 - appointment of committee members
 - appointment of the chair

- accountability of the committee to the Area Executive
- development of standards and benchmarks for committee performance.
- The Advisory Committee would consist of a reasonable representation of the clinicians across the AHS to avoid perceptions of conflicts of interest, ensure consistency of decision making and include senior clinicians.
- The Department may choose to establish other Lodgement Centres in addition to the eight in each AHS, for both adult and paediatric set up funds (see Section 7.4.7).
- Option 3 - refer to Section 7.4.2 above for a discussion of the advantages of this option.

Recommendation 3

Should the decision be made to retain local Lodgement Centres, only one centre should be established in each AHS that has clear management and reporting arrangements, an area wide Advisory Committee and be appropriately staffed.

7.4.3 Performance criteria, standards, benchmarks and performance indicators related to assessing need and determining priority

Current practice

The current policy and guidelines for the performance of the PADP Lodgement Centres do not include any guidelines for the reporting of operations, performance or quality indicators. While the operations of PADP are part of the operations of the AHS and the hospitals to which they are attached, performance may be inferred by the overall performance of the hospital or health service. The only reporting mechanism specific to PADP is through the budget process and the information system required of the Lodgement Centres (see Section 7.4.8 for comments on the current information system).

Issues raised

In a number of the consultations, issues related to the level of transparency of operations of the PADP Lodgement Centres and the work of the local Advisory Committees was raised.

The point was made that the Lodgement Centres serve a wide range of individuals and groups who have a legitimate interest in the operations of the service. Even those professionals who are very familiar with PADP feel that they are not well informed about the operations of the centres, the decision making regarding priorities and relative performance of their local centres. As mentioned above, many of the centres have adopted local policies that are not always consistent with the state policy and this gives rise to confusion and disappointment in some circumstances.

We have made comment previously concerning the significance that the aids and equipment supplied through PADP can have on the lives of the individual clients, and the impact for those who are denied or are placed on a waiting list. A small aid (such as a continence product) or simple piece of equipment to aid in mobility can make a substantial difference to the quality of life of the individual. This can be equally true for those who need to have equipment replaced that was previously received through PADP.

For both new applicants and existing clients who need replacement equipment, receiving a letter of rejection or notification of a lengthy waiting time without any other information can give rise to a level of anger and/or suspicion that they have been treated unfairly. Some of these individuals expressed a desire to understand the way that the service operates in order to satisfy themselves that they are not being treated differently to others, and that the centre that has given them the 'bad news' is operating according to the appropriate policies and guidelines and is not spending its funding allocation inappropriately. However, in many cases they could obtain no information that informed them of the systems and decision making processes in place.

An issue that was raised repeatedly was the indeterminate nature of the waiting lists. Privately, many Lodgement Centre staff and Advisory Committee members told the review team that in their Lodgement Centres many persons in Band 3 or 4 who were placed on the waiting list for certain items, would be very unlikely to ever make their way to the top of the list based on the relative priority the Advisory Committee has given them. However, these individuals are not given this information or any other information on the waiting time for

their equipment in order to assist them to make an appropriate decision. Letters from some Lodgement Centres do not provide the applicants with adequate information on waiting times. These individuals are then placed in the difficult position of not knowing if they should make a private purchase or wait. Many wait, making do with old or inadequate equipment in the fear that if they purchase the equipment themselves, they will be subsequently informed that if they had waited just a little longer they would have been supplied the equipment by the Lodgement Centre.

A number of Lodgement Centres have placed a ceiling on the percentage of their budgets they will spend on continence products. At least one centre consulted admitted that anyone waiting for continence products at their centre would only receive aids when a person with an existing service no longer received the service. Existing clients are not reassessed and compared for relative need against clients on the waiting list. Those waiting, even those in Band 1, are often given no indication of the speed with which they are likely to move up the list.

In summary, the matters that were specifically raised with the review team were:

- Little information on appeals and complaint processes or options.
- A lack of transparency concerning available budgets and expenditure, and local rules capping levels of expenditure on particular items (there is a belief by some that oxygen and respiratory products were still supplied by PADP despite the specific policy indicating this was not the case but they had no information to either support this or to satisfy themselves that it was not so).
- Poorly available information on local policy and operational guidelines.
- No published standards to indicate satisfactory operation or performance.

These issues are illustrated by the following:

- The letters received by those denied equipment did not always include details of the mechanisms that may be available to appeal the decision if they thought the centre or the Advisory Committee had made an error.
- Many clients commented to the review team that they were given no advice of any complaints mechanism that is specific to PADP (other than the general process of raising complaints through the health system complaints mechanism).
- The centres produce no readily or publicly available information on their available budgets, how expenditure decisions are made, the workings of the Advisory Committees on relative priority, and no annual report on the centres overall operations and financial management for the year.
- There is no information available to compare the relative performance of one Lodgement Centre with another.

- There is generally no information available on the local rules and policy decisions of the local Lodgement Centres or AHS, which may be different to the state policy.
- Apart from a brochure produced to guide clients in making applications, the only information on overall state policy is the Departmental circular from 2000, which must be downloaded from the Department's website.
- There are no published performance criteria or standards such as the acceptable period before clients are notified of decisions and the acceptable period for acknowledgement of applications.
- A number of attendees commented on the poor quality of the letters they received back from the centres (an example is provided in Appendix J).

Options for improvement

These options are equally applicable should a single state-wide service be developed or if Lodgement Centres are maintained at each AHS.

These include:

- 1 The development of standards and performance indicators on the acceptable practice and performance of key procedures such as the length of time taken to process an application and to provide a response.
- 2 The development of standards about the manner in which the Lodgement Centres advise clients they are on a waiting list.
- 3 Capping waiting lists at a set period. If the Lodgement Centre cannot supply an item within a set period – say three or six months – from placing the person on the waiting list, the person would not be placed on an active waiting list. After this period the client can reactivate their application without needing to make a new application. The original application date could be taken into consideration in determining priority. In this way the person is not placed in the difficult position of believing that they will eventually be supplied with the equipment when in reality this may not be the case.
- 4 The development of standards and set procedures on the information given to those placed on a waiting list.
- 5 The production of an annual report for each centre providing information on the available budget, areas of expenditure, performance against standards and performance indicators, summary of aids and equipment provided and summary information on the activities of the Advisory Committee.

While at first glance these options may appear to add a layer of bureaucratic activity that could be seen as an impediment to efficiency, the intention is to recommend simple standards, performance indicators and reporting systems that once established will add little to the overall administrative load and will go a long way towards bringing the

operations of this program up to standards already accepted in other areas of public administration.

Recommendation 4

That standards, performance indicators, policies and procedures be established to improve transparency and accountability of the operation of Lodgement Centres. This would include the production of an annual report (that reports the available budget, expenditure against budget and performance against standards and performance indicators), and clear lines of reporting and accountability for the operations of the centres, the Advisory Committees and their members. The standards and performance indicators should cover response times, standard advice to applicants on their waiting list status and agreed procedures for advising applicants on decisions of the Lodgement Centre and the Advisory Committees.

Recommendation 5

More information is made available to consumers and applicants concerning the policies and operations of the local Lodgement Centres, especially in regard to, and capping of, expenditure and waiting list procedures and policies.

7.4.4 Planning for future needs of existing clients and care planning for routine maintenance and replacement

Current practice

Few, if any, of the Lodgement Centres has policies and procedures in place to plan effectively for replacement of equipment or to pay for routine maintenance. The current software program used by the Lodgement Centres and supplied by the Department does not provide for detailed planning of equipment replacement.

Issues raised

A number of commentators made the argument that a range of items, especially high cost items such as electric wheelchairs, required routine and predictable maintenance and that it was possible to anticipate with some reasonable level of accuracy their life expectancy and replacement time. For example, children supplied with a range of equipment will require the replacement of those items as they grow and their needs change.

There is considerable variation in practice across the Lodgement Centres in their capacity to plan for routine maintenance and repairs and for replacements. Some have systems in place for tracking routine maintenance, and some locations (e.g. Hunter) have established centralised systems for dealing with the management of all equipment provided by the AHS (see also Sections 7.6.2 and 7.6.3 on the management of equipment pools).

The argument was made that long term planning of equipment maintenance and replacement would aid in the planning of budgets, the assessment of waiting times and the overall good management of the program.

Options for improvement

There appears to be the following options:

- 1 Leave planning of future equipment needs and replacements with local AHS.
- 2 Develop policies that require Lodgement Centres to undertake detailed planning of future year's expenditure requirements related to repairs and replacements, perhaps including a client specific long term care plan.
- 3 Contract out the maintenance and replacement of equipment to an organisation specialising in this function to manage all equipment.

Discussion

The replacement of the current software is discussed in Section 7.4.8. When the new software is provided to Lodgement Centres, it should include adequate provision for the prediction of the timing of equipment maintenance and replacement and the changing needs of the clients supplied with items, especially children.

This software replacement should be accompanied with policies that require the Lodgement Centres to prepare predictions of future needs for maintenance and replacement of equipment to assist in budget preparation and planning of service delivery.

Recommendation 6

That the new software being planned by NSW Health includes adequate functionality to enable the preparation of annual plans for the maintenance and replacement of equipment already provided to clients.

Recommendation 7

That Lodgement Centres prepare annual plans for the maintenance and replacement of equipment on loan.

7.4.5 Departmental responsibility for policy and operations

Current practice

The NSW Department of Health is the department responsible for the development of current policy and operations of PADP. However PADP is a program that provides aids and equipment for persons with a disability and a majority of the persons receiving equipment are aged. Persons with an acute illness or newly discharged from hospital are ineligible for assistance from PADP. Although consumers of PADP are often users of the health system and may have continuing chronic and complex diseases, the program is not primarily aimed at persons who are ill or injured. The profile of persons eligible for PADP is more accurately those in the community who are beneficiaries of the whole of government approach to disability services and policies coordinated by the NSW Department of Disability, Ageing and Home Care (DADHC).

Although it would appear to be the logical department to have responsibility for PADP, DADHC is not currently responsible for either the policy or operations of the program other than through the NSW PADP Advisory Committee and through usual inter Departmental discussions.

Until 2005, DADHC provided approximately \$2 million per year to the PADP budget. During the period 1999/2000 to 2002/03 this contribution from DADHC (at that time the Ageing and Disability Department [ADD]) was covered by a Memorandum of Understanding (MOU) between the two departments. This amount was to provide aids and equipment for children through PADP for persons younger than 18 who meet the PADP eligibility criteria for children. Although the funding was not covered by a formal agreement after 2002/03, DADHC continued to provide this amount annually in 2003/04 and 2004/05. In 2005/06, these funds were transferred permanently to NSW Health from the Treasury and no longer require the decision by DADHC to transfer the funding.

The MOU makes clear that this funding was provided to NSW Health under the Disability Services Act (NSW) 1993 and that both departments are required to ensure that the use of the funds confirms with the Act. The MOU provides for ADD to have a responsibility to review the PADP guidelines to ensure that the guidelines comply with the Services Act. Should ADD determine following a review that the funding of PADP is not compliant with the Services Act, NSW Health 'must ensure that (any) non-compliance is rectified as soon as possible' (Clause 6.4). Under the MOU, the role of ADD is to provide notice in writing in order to require NSW Health to rectify any non-compliance and to withdraw the funding.

DADHC has recently established (December 2005) a program for the provision of equipment and aids for person in DADHC operated large facilities and group homes. This policy does not cover those persons who reside in group homes funded by DADHC but operated by a not for profit organisation. Persons with a disability who reside in a DADHC funded but not operated group homes are still reliant on PADP for assistance.

Issues raised

The review team was requested to comment on the current departmental responsibility for the development of policy and the operations of PADP. In consultations with stakeholders, clients and staff this issue was raised and comment invited.

In some consultations concern was raised about the focus of management and decision making with the health institutions that operate the program. The concerns raised by some, although no evidence was provided to suggest this is happening, was that expenditure decisions within the program may favour the health system by targeting those persons who are heavy users of the health system and perhaps disadvantaging those who are not. Another comment was that users of the health system may have an advantage in accessing PADP as they are already in the health system and their therapist is more likely to know about it and be able to access it. In interpreting these comments the issue may lie in the lack of transparency in the operations of the current program (discussed in Section 0) than in the actual decision making by health service staff, managers and policy makers.

The universal view expressed was that while there were reservations and criticisms of the current program and its operation by NSW Health, there was no support for the transfer of operations to DADHC, even though on the face of it DADHC would appear to be the department with a more natural fit for the target client group. Furthermore those consulted were unanimous in their view that DADHC would not have the operational capacity to operate this program. No one that the review team consulted argued that DADHC would be the appropriate department to manage PADP.

There were comments on the need to ensure that the programs operated by DADHC and PADP were complementary and without gaps or duplications. This was particularly concerning those persons with disabilities who were in residential care funded by DADHC and those that were in group homes funded by DADHC and operated by a NGO.

Some comment was made that DADHC should have some involvement in policy development for a program that provided aids and equipment for persons with a disability. However the mechanisms for that policy input were not clearly formulated in the discussions held and commentators did not have a clearly position on the role that DADHC should have in relation to PADP. The former MOU between the departments clearly establishes that in 2000 it was accepted that ADD had an oversight role for PADP, at least for the component of the funding it supplied.

Options for the departmental responsibility for the program

There appear to be three possible options for the future management of the program:

- 1 Retain policy and operational responsibility within NSW Health.
- 2 Transfer policy and operational responsibility to DADHC.
- 3 Involve DADHC in policy development for the program with operational responsibility retained by NSW Health.

Discussion

During the consultations there was no clear advocacy for DADHC to take responsibility for policy development for this program and no apparent wish for the Department to acquire this role, although it would appear on face value that this is a program that should fall within the sphere of DADHC responsibilities as the department is responsible for - policy, planning, resource allocation and performance measurement for the delivery of supports and services for older people, people with a disability and their carers in NSW¹⁰.

Advantages of program responsibility transferring to DADHC

There would be clear advantages to PADP being managed by DADHC. This would come from that department's capacity to coordinate whole of government policy development for people with disabilities. This would improve the potential for a removal of ambiguities, gaps and overlaps in programs. These ambiguities, gaps and overlaps currently occur around persons moving between DADHC operated group homes and non-DADHC operated group homes. There is also still some confusion around the supply of medical services such as oxygen, the supply of short term equipment to enable hospital discharge and equipment for persons with a disability.

DADHC has previously held responsibility for part funding for equipment for children with a disability. This was presumably because DADHC is the department with responsibility for policies related to children with disabilities. This funding was transferred to Health in 2005.

Disadvantages of program responsibility transferring to DADHC

DADHC is a much smaller Department and has limited local administrative capacity compared with NSW Health. As discussed above there appears to be no support among consumers and stakeholders for DADHC to assume operational responsibility for PADP. This is supported by officers in DADHC who were equally clear that the Department was not seeking to take operational responsibility for the program from Health.

However it is important to realise that this view was based on the belief that PADP would continue in its current form (27 lodgement centres, equipment purchased locally, equipment pools managed locally etc). As this review has recommended there should be one central administration with some of the functions related to procurement, supply and equipment management contracted out, the limited local administrative capacity of DADHC may not be as important in this model.

DADHC has a limited supply of clinical staff to act as advisors in relation to the determination of relative need and priority. In addition, such a transfer raised the potential for a new series of difficulties with the majority of the prescriptions written by staff employed by Health and processed by DADHC. It is not too difficult to envisage a scenario where Health staff would resist requests from DADHC for reassessments, clarifications to prescriptions or disagreements about funding and client priorities. These conflicts are

¹⁰ Downloaded from <http://www.dadhc.nsw.gov.au/dadhc/About+DADHC/> (10 March 2006).

largely avoided under the current arrangements where most of the prescribing, assessment and processing is conducted within the same department.

Advantages of the program remaining with Health

Should the program remain largely as it is currently administered (one lodgement centre in each Area Health Service) then Health would clearly have the advantage in administering it. Health has the infrastructure and management structure to enable it to be operated from multiple sites.

There would also appear to be some advantages to the program because most of the prescriptions are written by health employed staff such as occupational therapists already employed in health. As discussed above conflicts about repeat assessments, incomplete prescriptions, client priorities and funds rationing are managed within the same administration. From the survey reported above it would appear that Health staff currently substantially support PADP through the normal course of the functioning of the professionals within the health system.

Disadvantages of the program remaining with Health

There will continue to be conflicts over policy in relation to PADP while there is a split between the department having policy responsibility for whole of government disability policy and another administering a major program for people with disabilities. The current arrangements already have a dual system of care for persons within the DADHC operated group homes and non-DADHC operated group homes. This creates a lack of equity in access to services based on administrative difference irrespective of the clients needs. Without both systems under one administration there will continue to be a need to manage across competing priorities.

Recommendation 8

That should the decision be made to continue to operate AHS based Lodgement Centres, the Department of Health retain responsibility for the operation of the program and for the development of PADP.

DADHC should exercise its responsibilities for the development of policy in relation to persons with a disability in NSW by contributing to the development of policy surrounding this program through an appropriate governance mechanism that oversees this program and holds the Department of Health accountable for providing equity of access and operating the program efficiently and effectively.

Should the decision be made to move to a single state-wide system of administration with major functions contracted out then consideration be given to the transfer of the function to DADHC based on its responsibility for whole of government policy for people with disabilities.

7.4.6 Governance of the program

Current practice

The current policy provides for a NSW PADP Advisory Committee. That committee was established to 'assist in the ongoing review and development of PADP drawing on the recommendations of the NSW Equipment Study: Review of the Program of Appliances for Disabled People (1998)'. Its terms of reference (2004) are as follows.

The Committee will:

- provide a forum for a constructive exchange of information on PADP
- advise the Department on trends in the needs of people with a disability to inform ongoing policy development, state-wide planning and the undertaking of specific work aimed at strengthening PADP
- provide advice to the Department on the role, operation and development of PADP.

The membership of the Advisory Committee is drawn from peak clinical and disability groups involved in the provision of services to and the care of people with a disability, from both the public and not for profit sectors. The policy specifies that the membership consist of 25 persons.

Despite the aim of the committee being to assist the Department to review the 1998 report, the committee continues to meet with the Department and to raise issues of operation and policy with the Department.

Issues raised

PADP is a program that is of interest to a wide group of organisations and groups. As discussed elsewhere in this paper, its span of responsibility extends beyond the traditional boundary of 'health'. This suggests that groups both within health and outside of 'health' have a legitimate interest in the development of the program.

The challenge is to find the most effective mechanism for providing for the contribution of stakeholders, mechanisms for communication on issues of concern to consumers and service providers, and to provide the Department administering the Program with input on policy and operational issues. The Advisory Committee appears to be an appropriate vehicle for enabling a contribution to be made from stakeholders and for providing communication between the disability community and the Department.

However, the Advisory Committee as it is currently structured is limited in its decision making capacity and policy review role, by both its size and representative nature. The attendees are representatives sent to express the view of the organisation from which they come. Representatives, by definition, are not always free to provide the advice or to agree

to suggestions unless they have been cleared by the organisation they represent. Not all representatives on committees such as this are in a position to agree with proposals that may not be in the best interests of that organisation, although the proposals may be in the best interest of the program overall.

It is clear to the review team that there is a need for a mechanism to provide policy input to the program and a measure of accountability from the Department of Health for the operation of the program. This governance role would best be met by a small group with selected nominees from peak groups within the disability sector.

Options for improvement

There appears to be the following options:

- 1 Retain the state-wide Advisory Committee with its current role.
- 2 Establish a new body to undertake a governance function over the program, while retaining the Advisory Committee to act as a communication channel between the department and the disability committee.

Discussion

A governance body is one that focuses on policy and accountability, while leaving management and operational decision making to the appointed managers. Good governance requires managers of organisations to demonstrate appropriate planning and monitoring mechanisms and the adoption and achievement of appropriate standards. The role of a governance body is best illustrated as similar to the role of a board of directors. A governance body overseeing PADP could adopt a similar role in representing the interests of the stakeholders, without the corporate structure or legal responsibility that is usually associated with such a formal mechanism. This Steering Committee would consist of a small number of individuals appointed by the Director-General of the Department of Health based on their expertise to provide policy advice based on the best interests of the program and its recipients. Like a governing body, the Steering Committee would require the Department (as the manager of the program) to:

- develop an annual business plan identifying areas of priority and development
- develop an annual budget for the program that allocates the available funds along predetermined lines and is consistent with the overall goals of the program rather than strictly on geographical or notional lines
- produce an annual report indicating the expenditure of the funding consistent with the agreed strategy and budget
- determine a program of continuous quality improvement and demonstrate the achievement of agreed standards of operation of the program.

The Steering Committee would itself report to the Director-General once a year on the operation of the program. The budgets, plans, agreed standards and annual reports could

all be made publicly available to the Advisory Committee, consumers and the wider disability community.

Ideally the Steering Committee would consist of no more than six or eight persons with at least one senior staff member of DADHC. The role of the member from DADHC would be to function primarily as a nominee of the Director-General of Health focused on the best interests of the program and would bring to the committee the broad policy perspective and experience from DADHC.

Other members of the Steering Committee would be drawn from senior members of professional bodies, disability organisations and service providers and would be appointed by the Director-General for a fixed term. These individuals would be appointed for their unique combinations of knowledge, skills and experience that provide them with the capacity to function in a governance role, and not because of their specific membership of an organisation. Unlike the Advisory Committee, members of the Steering Committee would be appointed in an individual capacity and this appointment would not rest with the organisation with which they are associated. Individuals leaving the Committee would be replaced at the discretion of the Director-General of DADHC. Participation in the meetings of the Committee would be restricted to the appointed members and members would not have the discretion to appoint a nominee if they were unable to attend.

Recommendation 9

That the Department of Health establish a state-wide Steering Committee with a smaller membership and a focus on governance (rather than advisory responsibilities) whose role is to review the planning and performance of PADP. The Department should redefine the role of the Advisory Committee to better reflect its current role of communication between the disability community and the Department, but with no expectation for a policy oversight function.

7.4.7 Role of the specialist 'start-up' funds

Current practice

The spinal cord set up fund

The spinal set up fund (SSUF) was created in the mid 1980's to address the significant exit blocks experienced by the spinal units due to the lack of funding to purchase equipment for these state-wide units. The scheme purchases equipment for newly injured patients to facilitate their transfer to the community. Once discharged, they no longer have access to the fund and must make application to the local PADP or alternative sources of funds for additional equipment, equipment modifications or replacements.

The spinal units at POW and RNSH/RRCS both have an allocation of funds from PADP to provide for the 'set up' of spinal injury patients upon discharge from hospital. RNSH currently receives \$500,000 per annum and POW \$300,000. These amounts include \$250,000 allocated through the GMCT in 2003 (\$150,000 to RNSH and \$100,000 to POW) on top of the base funding of \$550,000 from PADP. The funds are not indexed and the SSUF continues to experience modest overruns.

The funds are administered separately; however, the units retain close ties through the NSW State Spinal Cord Injury Service (SSCIS), which incorporates POW, RNSH, RRCS, the Sydney Children's Hospital and CHW.

The SSUF is managed by the PADP coordinators of both the South Eastern Sydney Illawarra AHS and Northern Sydney Central Coast AHS as a discrete budget from the normal PADP units in these areas. It is available only to those clients who are treated by the SSCIS as inpatients at RNSH, RRCS or POW Hospital.

Equipment funded under this scheme is guided by the SSCIS prescriber guidelines to meet the clinical needs of clients. The SSCIS has established a consultation process to support clinicians in the decision making process. The funds effectively operate outside of the PADP policy although the funds are allocated as PADP. The units do not contribute data to the Department through the PADPIS.

The SSUF is intended to set the client up on their initial discharge with subsequent costs associated with their equipment needs accessed from the local PADP Lodgement Centre.

Table 38 is a sample from POW SSUF expenditure by category of equipment for 2004/2005.

Table 38 Items purchased through the SSFU at POW in 2004/05

Equipment	% Expenditure
Electric wheelchair and related equipment	32
Manual wheelchair and related equipment	22
Bedding/bed and related equipment	18
Pressure care cushions/mattress	9
Commodes/transport and related equipment	9
Hoist/slings	6
Bath/toileting	1
Mobility aids	2
Personal	1
Total budget	\$300,000

CHW (Children's Hospital Westmead)

This PADP lodgement centre has been in operation since 1990 but its role was changed in 2001. Prior to 2001 it provided PADP services to all children discharged from the CHW. In 2001, its role was restricted to providing PADP aids and equipment only for children who live in the local municipalities of Parramatta, Holroyd and Baulkham Hills which surround the hospital.

In 2005/06 the budget of \$84,000 was increased to \$300,000 based upon the review of the Resource Distribution Formula. Despite the significant increase in the budget, this fund is still restricted to local children. The children supplied with most items are those with neuromuscular disease. The set up cost for one child is in the vicinity of \$38,000. Depending on the age of the child, the costs associated are likely to be significant in the replacement of the equipment as the child ages. The Variety Club still primarily supplies equipment to those children who are patients of the CHW who live outside the three local municipalities or who may be required to wait for a long period of time to be supplied with equipment.

The CHW PADP assists the parents of children who live outside the three municipalities with the preparation of an application to their local PADP (referral letter, application form and Health Care Card details).

Issues raised

State Spinal Cord Injuries Service

The SSCIS is responsible for the coordination and provision of the services required for people who have acquired a persistent spinal cord injury, with evidence of damage to the

neural tissues, due to trauma or a non progressive disease process¹¹. Within the SSCIS the defining features of a new spinal cord injury are that it is acquired, non progressive and results in persistent damage to the neural tissue. The aetiology may be either traumatic or non traumatic in nature. Progressive conditions such as demyelinating, congenital and degenerative conditions of the spinal cord as well as compression by metastatic lesions are not the province of the SSCIS.

Under the guidelines established by SSCIS, access to the SSUF is restricted to persons who meet the definition above and only during the first inpatient episode within a SSCIS spinal unit. Funding is not available for subsequent admissions of patients in the SSCIS outreach service.

Two access issues have emerged in discussions related to the set up funds:

- It is only available to patients of these two hospitals.
- It is not available to persons who have significant disability from other causes such as acquired brain injury or progressive conditions such as those identified above.

Although the two units in POW and RNSH provide care for the majority of new spinal injury patients in NSW, some persons with spinal injury may be cared for in other hospitals such as John Hunter Hospital in Newcastle. Unless these patients are transferred to one of the two hospitals with access to the funds they are not eligible for the set up fund, despite their conditions fitting within the criteria established by SSCIS.

Traumatic brain injury (TBI)

A major group identified as having issues in relation to the cost of set up following discharge are those suffering from a traumatically acquired brain injury. Patients with acquired brain injury may face costs as high as those with a spinal injury but they have no access to the set up funds.

The following information was supplied by the NSW Brain Injury Rehabilitation Program (BIRP):

'Persons with severe traumatic brain injuries can require expensive, specialised equipment to live and participate in their local community. This equipment may include height adjustable bed, hoist, customised shower commode, power wheelchair, specialised seating, PEG nutrition/equipment, continence products and communication aids. A complete equipment package may cost in excess of \$40,000. Under the current system, regional PADP budgets are not currently able to cover the costs of this equipment package, nor can these costs be feasibly met by clients and families.'

¹¹ E.g. transverse myelitis, compression by infective process, canal stenosis, haemorrhage, or vascular occlusion.

Persons with severe traumatic brain injuries often have their discharge from hospital delayed as they are unable to obtain funding for specialised equipment in a timely manner. The cost of an increased hospital admission is then incurred by the AHS.

The PADP Equipment List specifies that technological aids to inclusion can be funded within the PADP scheme. It is the experience of practitioners within the BIRP that these products are rarely funded. For some clients of the BIRP, these products are essential to their ability to communicate and participate in daily life. The BIRP questions whether decisions about the priority of one type of equipment over another should be made at a regional PADP centre level.

Persons with severe TBI, who require high levels of care, have extremely limited community accommodation options. Many are forced to reside in residential aged care facilities. These persons often require specialised seating and mobility aids (wheelchairs), without which they are unable to participate in life both within and outside the accommodation facility. The BIRP believes that all persons with TBI who are being discharged to a nursing home should be eligible for funding assistance through PADP. Persons with brain injury, residing in the community, currently experience extensive delays while on waiting lists for PADP assistance.

In 2004 the NSW BIRP had 186 new admissions to their inpatient programs (GMCT Brain Injury Rehabilitation Directorate, 2005). Fifty seven percent (57%) of these admissions were classified as “extremely severe or chronic injuries” (defined by Post Traumatic Amnesia length of 4 weeks to more than 6 months). Of the total number of admissions to the program only 40% were eligible for compensation.

To assist in determination of the total cost of such a fund, data was collated from each BIRP inpatient unit. Each unit was asked to identify the number of clients who required high cost equipment for discharge and were ineligible for funding through a personal injury insurer. Each unit was also asked to quantify the costs of this equipment for persons with a FIM score of 1 to 4 and to identify the number of days that discharge was delayed while waiting for this equipment. Retrospective data from 2003/ 04/ 05 was captured¹².

<i>Numbers of clients who had discharge FIM scores of 1 or 2 for locomotion or transfers.</i>	<i>These two scores equate to “total” and “maximal” assistance respectively. In practical terms, individuals who score at this level would require a hoist, shower commode and wheelchair on discharge (exception small children). Category = High Cost equipment package</i>
<i>Numbers of clients who had discharge FIM scores of 3 or 4 in locomotion and transfers.</i>	<i>These two scores equate to “moderate” and “minimal assistance” for transferring and mobility. In practical terms, individuals at this level are likely to require a walking aid/ wheelchair for indoor mobility and community access. Category = Medium Cost equipment Package.</i>

¹² The BIRP acknowledges that there are a large number of people with acquired brain injuries, who do not receive services within the NSW BIRP, who also require access to adaptive equipment for discharge. Assessing the needs of this population would require a funded, state wide strategy and was not within the scope of this response paper.

Needs Assessment

The table below estimates the annual cost of equipment required for discharge for clients of NSW BIRP services. It is based on an assumption that all severely injured clients were admitted to a Sydney metropolitan brain injury inpatient unit for their acute care management.¹³

Table 39 Estimate of the average annual cost of adaptive equipment for acquired brain injury (non compensable) patients in hospitals with specialist brain injury units in NSW

	The Children's Hospital Sydney	Children's Hospital Westmead	BIRS Liverpool	BIRU Royal	Rehabilitation (Ryde)	Total
High Cost	2.5	6 (2) ¹⁴	3	4.5	5	21
Medium Cost	6	-	2	2	0	10
Estimated Annual total cost	\$55,000	\$150,000 ¹⁵	\$40,000 - \$50,000	\$50,000 - \$60,000	\$50,000	\$365,000

Apart from the costs identified in the above table there are additional costs that need to be factored into any proposed set up equipment fund. These funds are required to cover the costs of equipment for clients in regional areas (who are not admitted to the metropolitan Sydney units for inpatient management). A case example of such a client is provided below:

Mr X was a 22-year-old male who was admitted to an acute care facility in Sydney for neurosurgery subsequent to a motor vehicle accident. Following his acute care management he was transferred directly to a regional rehabilitation centre. He participated in a multidisciplinary rehabilitation program and required a manual wheelchair with a specialised seating system on discharge. His discharge was delayed until home modifications and equipment could be resourced (approximately 3 months).

It is predicted that there is likely to be a single case such as that described above for each of the regional AHSs per year. The cost for providing equipment for these clients has been calculated as \$50,000 (five AHSs without BIRP inpatient unit).

Estimated Total Costs – BIRP set up equipment fund \$415,000 per annum.

¹³ Individuals, who score higher scores on the FIM scale for mobility and transfers at discharge, may also require adaptive equipment. This equipment need, however, is extremely variable and impossible to predict without knowledge of each individual client.

¹⁴ Two children included within the data collected by the Sydney Kids Hospital were re-admissions who were requiring review of their equipment (as they had grown). These two were included within the final figures as the newly prescribed equipment was required for discharge.

¹⁵ One child required \$80,000 of equipment (ventilator dependent). Sydney Kids were able to access funding through the VDQ funds held by NSW Health. This funding pool however is under review and not usually accessible to paediatric clients.

This fund would operate in a similar manner to the spinal set up fund. Monies would be accessed by any BIRP client requiring adaptive equipment for discharge. All ongoing equipment needs and replacement equipment would need to continue to be supplied by the general PADP scheme. It is also important to note that the proposed equipment fund will only cater for the equipment needs of the most severe of cases and will not meet all the PADP needs of all the BIRP clients.

Cost Savings

It is envisaged that provision of specialised adaptive equipment, in an efficient manner, will result in cost savings for NSW Health. These savings will result from a reduction in the average length of hospital stay for persons with TBI.

Not all BIRP services were able to provide estimates of the total number of days that clients remained in hospital while waiting for equipment. Clinicians from each service documented that they had loaned ward equipment to clients to facilitate discharge. This arrangement was described as tenuous and relied on new admissions not requiring access to the same specialised equipment.

- *Total days predicted in 2004 from 2 services 70 days (Westmead – 2 clients 4-6 weeks each) 112 days (Liverpool – 3 clients 6 weeks, 2 weeks and 8 weeks respectively).*
- *Total cost to hospital 182 by \$865 = \$157,430 (\$865 - daily bed rate for inpatient BIRP rehabilitation units).*
- *If this figure is averaged and extrapolated across the five BIRP inpatient units the total savings for 2004 would equate to \$393,575.*

The NSW BIRP proposes that a setup equipment fund be established for BIRP clients to facilitate efficient and effective discharge from hospital settings’.

Limitations of the current spinal cord set up fund

There are two major limitations of the spinal cord set up fund:

- It is only available to a selection of patients with need for equipment to set them up in the community.
- It is only available while the person is an inpatient of one of the two units.

The review team has heard of instances where equipment has been ordered and purchased for patients while they are still inpatients, without the benefit of a home visit by the prescriber to ensure that the equipment ordered will work within the patient’s home. This can occur where it is not practical for the ordering clinician to make a home visit or where accommodation is not finalised at the time of placing the order. The team were informed of instances where equipment designed for chair to bed transfer did not match the

bed height and could not be used. It appears that at times equipment is ordered in advance of the final decision being made on the patient's home because they are still an inpatient.

Limitations of the CHW fund

The rules surrounding this fund are a curious mix. The fund is limited in its operations to the funding of PADP for children who live in the surrounding suburbs. It is not available to those children in the CHW who live elsewhere in the state and is not available to children in other children's hospitals in NSW. There is no equivalent fund at the other specialist children's units such as Sydney Children's Hospital and John Hunter Hospital.

These arrangements do not appear to be appropriate. Either there should be a special fund for all children in all specialist children's hospitals, or all children should be required to apply to their local PADP Lodgement Centre.

Options

There appears to be the following options:

- 1 Retain the current role of the spinal units and CHW PADP budgets.
- 2 Retain the current system of these special funds, but with clearer lines of accountability and transparency of the allocation of the PADP budgets and priority setting within the Spinal unit PADP schemes, particularly around data collection and reporting of expenditure and performance.
- 3 Expand the set up funds and increase eligibility for access to the funds to all persons in NSW Hospitals that require funds to enable them to be discharged to a non-inpatient setting.

Discussion

There appears to be a sound argument for patients in public hospitals with severe disabilities that require high cost equipment to enable them to be discharged, to have access to set up funds for this purpose. The cost of unnecessary hospital care for persons with spinal injuries or disease, or for persons with brain injury simply because of a lack of access to equipment seems an inappropriate practice. The average cost of admission for persons with spinal cord conditions in a NSW Public hospital is between \$7,836.06 and \$22,172.06¹⁶. However, the cost of the initial hospital admission would substantially exceed this average. Delays in discharge can easily result in a cost of hospital stay that exceeds the cost of the equipment and this seems particularly relevant if the cause of the delay is the inability of a system to provide the necessary set up equipment. This argument alone would seem to justify an increase in the availability of set up equipment and aids.

¹⁶ DRG B60A and B60B - persons with spinal cord conditions with or without operating room procedures and with or without catastrophic or severe co-morbidities, NSW Health, 2005, Cost of Care Standards 2005.06.

The review team heard convincing arguments that it is also cost effective for the hospital system to provide appropriate equipment to prevent avoidable admissions. It is beyond the scope of this study to estimate these costs, and the review was not able to access any reliable studies to support these claims other than those provided above for persons with brain injury. However, the review team believes that the cost of providing the most appropriate equipment to enable patients to be discharged at the appropriate time and to keep them out of hospital, would be less expensive and more appropriate than repeated and longer than necessary inpatient admissions.

There does not appear to be a sound reason for the retention of injury specific set up funds other than the desire to ensure that those that are currently eligible continue to have access to the fund. There appears to be a sound argument for a new set up fund to be established to cover all hospitals in the state. This new fund would incorporate the existing spinal injury fund, the CHW fund and would require enhancements to provide for other categories of persons with substantial set up costs, such as those with degenerative spinal injuries and acquired brain injury.

The set up fund should be administered centrally, be subject to appropriate scrutiny and provide for annual reporting to satisfy the reasonable enquiries of stakeholders. The fund should have access to specialist advisors who can provide assistance to those administering the fund to determine the appropriateness of the prescriptions and the value of the packages sought.

The need for the purchasing of equipment for an individual prior to their discharge should also be removed, as this appears to result in inappropriate decisions from time to time. The preferred option is that the application to the set up fund would be for a set value and not for a piece of equipment that is decided upon while the person is an inpatient. The application should ideally be for an amount that could be used to purchase equipment for an individual over a period. This could be achieved by the set up fund allocating a set amount of funds for a patient to be spent over say six months, to allow for some equipment to be purchased after the establishment of the person in post hospital accommodation to ensure that the equipment purchased suits this environment.

Recommendation 10

That a state-wide set up fund be established that has the following characteristics:

- Is available to all non compensable patients in a public hospital in NSW because of a catastrophic injury or disease that requires substantial equipment to allow for discharge to a community setting.
- This fund would include the existing spinal injuries set up fund available to the POW Hospital and the RNSH/RRCS and the CHW.
- The size of the set up fund should be at least \$1.8 million - \$800,000 from the existing spinal injuries fund, \$280,000 from the CHW fund (if this were to be included to cover the cost of a set up fund for children), \$415,000 for the inclusion of brain injury patients, plus an allowance to include patients in other children's hospitals and in other hospitals in NSW.

- The fund would be administered as part of the state-wide administration of PADP.
- Applications to the fund would be for a parcel of funds to be spent by the patient over a period that covers both pre and post discharge.
- An advisory group of specialist clinicians be appointed to provide advice on the appropriateness of prescriptions.
- The fund would operate by allocating the amount of funding estimated to cover the equipment needed, rather than specific pieces of equipment, but would require the equipment to be purchased within a set timeframe.

7.4.8 Adequacy of information systems

Current practice

Each of the lodgement centres uses the current PADPIS to record applications, orders and data on clients. PADPIS rests on a platform of Sybase and Powerbuilder.

Issues raised

PADPIS is outdated, prone to error and software failure. It does not interface with other systems, particularly the financial systems within the AHSs and consequently requires significant duplicate data entry. It has no provision to record waiting lists or to plan for routine maintenance or replacement of equipment loaned to clients.

In summary, it does not provide adequate, appropriate or accurate information to enable the efficient and effective operation of this program. There is a clear and urgent need to replace the current system with a new system.

Options for improvement

There appears to be the following options:

- 1 Upgrade the current system – not recommended.
- 2 Establish a new information system.

Discussion

eCAEP in Western Australia has a web based database and provides a useful model for comparison. A description of the system is provided in Section 3.1.2. A feature of this system is the access by authorised persons across the state to information on particular clients. The eCAEP allows clients to access the service from a variety of service providers in Western Australia. As the clients are not restricted to a geographical based centre, it is necessary to track individual clients to ensure that they are not provided with the same equipment from different centres.

This website for PADP would serve a number of functions:

- provide information on the program for current and future clients, stakeholders and clinicians
- provide a list of equipment available through the program and details on the equipment that will assist prescribers such as availability through government contract
- enable application forms and prescription forms to be downloaded or completed electronically

- provide access to authorised prescribers to information on equipment prescribed, ordered and supplied to individual clients to enable them to monitor progress with application and detect 'shopping around' behaviour by individual clients
- enable prescribers to develop care plans for the future maintenance and replacement of equipment
- provide confidential 'chat rooms' and information bulletins for prescribers related to individual pieces of equipment and types of clients
- provide prescribers with data on changes to the program, new equipment listed or other useful information.

The database for PADP would have the following functions:

<ul style="list-style-type: none"> • Financial management - invoicing, ordering, budget control, client co-contribution. 	<ul style="list-style-type: none"> • Asset management – tracking, depreciation, maintenance schedule.
<ul style="list-style-type: none"> • Supplier information - identifying information, contact details. 	<ul style="list-style-type: none"> • Equipment/appliance information - equipment list, specifications, government contract price.
<ul style="list-style-type: none"> • Waiting list. 	<ul style="list-style-type: none"> • A client module which would include: <ul style="list-style-type: none"> – Contact details – Demographic information – Living circumstances including carer – Diagnosis – Disability.
<ul style="list-style-type: none"> • A health provider module would include: <ul style="list-style-type: none"> – Health service – Prescriber – identifying information, qualifications, accreditation status, and contact details. 	<ul style="list-style-type: none"> • An episode module which would include: <ul style="list-style-type: none"> – Referral – Assessment – Treatment.
<ul style="list-style-type: none"> • Prescription. 	<ul style="list-style-type: none"> • Adverse events.
<ul style="list-style-type: none"> • Tools which would include: <ul style="list-style-type: none"> – Assessment – Priority rating – Referral – Prescriber guidelines. 	<ul style="list-style-type: none"> • Software interface issues: <ul style="list-style-type: none"> – E-referral capacity for external referrers – Financial interface.
<ul style="list-style-type: none"> • Clinical interface, to either map or transfer clinical information. 	

The introduction of a new information system for PADP would be a major investment. It is not possible to estimate the cost of the introduction of a new system as there are many variables that impact on the cost. The functionality of the system, whether it is purchased or

built, the level of access and the number of users, and the complexity of the portal and database will all have an impact on the system. However, a new internet based information system has the potential to improve the efficiency of the system, increase the information available to consumers and carers and provide greater transparency and equity over the current system.

It is strongly recommended.

Recommendation 11

That the current information system be replaced, as a matter of urgency, with a new system that allows improved management and reporting of the program and access by authorised users to client and program information. This new data system would underpin the single state-wide service.

7.5 Discussion and recommendations related to access and eligibility

Access and eligibility covers the following key areas:

Key area	Section	Recommendation
Assessment and prescriptions	7.5.1	12, 13
Qualification and experience of the prescribers	7.5.2	14, 15, 16
Information on the program and access to application forms	7.5.3	17
Availability of an equipment list and continued maintenance of an equipment list (including Government contract arrangements)	7.5.4	18
Client co-payments	7.5.5	19
Clarity around eligibility based on income	7.5.6	20
Clarity around eligibility based on residency and services	7.5.7	21, 22
Management of increasing demand for continence products	7.5.8	23, 24
Definition of a high cost item	7.5.9	25, 26

7.5.1 Assessment and Prescriptions

Current policy

The current policy is unclear and ambiguous.

To be eligible for PADP a client must first be referred by a 'doctor' (see page 28 of the Circular number 2000/103). They are then required to obtain an assessment from a suitably qualified professional (Section 14 of the PADP policy). The current policy is somewhat unclear and also includes references to a 'diagnostic referrer' (Table 2, page 30 of the PADP policy), a 'prescriber' (Section 14 and Table 2 of the PADP policy) and an 'authorised prescriber'. The term 'diagnostic referrer' appears to mean the same as 'doctor' in another part of the policy. The terms 'authorised prescriber' and 'prescriber' appear to be used interchangeably (Section 14.1 and Table 2 of the PADP policy). The term 'authorised prescriber' is also used in Appendix 2 (of the PADP policy) to refer to the codes related to areas of practice (cardiology, dermatology, endocrinology etc).

Although specifying the requirement to have a referral and a prescription, the policy allows for the provision of a prescription by the 'local health service' in certain circumstances (Section 14.3 of the PADP policy).

The body of the policy does not specify the role of the 'diagnostic referrer' or doctor; this is mentioned only in Appendix 1. On page 28 (Appendix 1 of the PADP policy), it states that 'the role of the doctor is to diagnose or confirm diagnosis at initial contact with PADP or whenever the condition changes for which equipment is required' (page 28 of the PADP policy).

Table 2 of the policy lists the categories of ‘diagnostic referrer’ and ‘prescriber’ for each equipment category.

The policy does not specify a form for the referral, what information the referral should contain or how a Lodgement Centre would determine if the referral was valid or not valid.

There is no prescription form for use by prescribers to the PADP program. The policy specifies the information to be provided by the prescriber using the ‘prescriber’s stationery’.

The policy makes no reference to an application form or minimum data to be supplied by the applicant.

Current practice

Each Lodgement Centre uses its own application form. While there may be some Lodgement Centres that share an application form there is no common application form available across the state.

Current practice appears to follow the general approach of the policy. Several Lodgement Centres have devised their own prescription forms for use by prescribers rather than rely on the submission of an assessment ‘on the prescribers stationery’. In some locations more than one centre uses the same form.

The role of the Lodgement Centre coordinator is to make an initial assessment of the application form and the prescription (and presumably the appropriateness of the referral).

Issues raised

Necessity for referral from a medical practitioner

In a number of the consultations that were conducted during this review, the issue of the need for a medical referral to another professional who will then act as prescriber was questioned. The current policy indicates that a medical practitioner can act as the prescriber for some items of equipment such as, ‘aids to nutrition’, ‘pain management’, or ‘prostheses’ (presumably without the need for the involvement of another professional). However, under the current policy medical practitioners cannot prescribe the most common items supplied such as ‘beds or sleeping equipment’, ‘continence aids’, or ‘mobility aids’.

Examples of the redundancy of a medical referral were in relation to persons with an obvious and permanent disability, such as paraplegia or cerebral palsy. The need for a referral from a general practitioner or a specialist medical practitioner for a person obviously confined to a wheel chair in order for an OT or a physiotherapist to write a prescription, does not appear to have a sufficient justification to warrant the inconvenience and cost to all parties.

A convincing argument was also made in relation to persons seeking continence products where the prescriber was a continence nurse specialist or nurse consultant. Continence nurse advisors are available in all AHSs in NSW, and it was argued to the review team that

they have considerably more skill in assisting clients in managing their incontinence problems than the average general practitioner.

There are many examples of government programs and benefits that do not require a medical referral. These include the application for a carers allowance and a referral to an aged care assessment team. The review team is not aware of any legal reason why a medical referral is required in PADP.

If there is a need for a medical referral it could be in those situations where the condition may not be permanent or may fluctuate in its severity. This could be managed by the introduction of a question on the application/prescription form requiring the prescriber to indicate if the condition is permanent or indefinite, and unlikely to lessen to the extent that the equipment may no longer be needed. Should the prescriber be unable or unwilling to answer this question, they would be advised to seek a referral from a medical professional or other health care professional who is competent to make that judgement.

Recommendation 12

That the requirement for a referral by a medical practitioner on 'initial access to PADP or when the condition changes' for all equipment categories be removed, and that this requirement should apply only in those categories of clients where the condition may not be permanent (or indefinite) or may fluctuate in its severity.

Recommendation 13

That a single prescription form and a single application form are introduced across all PADP Lodgement Centres and that these can be downloaded and submitted via the website.

7.5.2 Qualification and experience of the prescribers

Current practice

The policy does not specify sub speciality qualifications in relation to the prescribing of types of equipment, only the qualifications of the professional. Currently any OT can prescribe mobility equipment including high cost complex one-off items.

Issues raised

In a number of consultations the issue of the skill of the prescribers was raised, although for different reasons. Broadly speaking, the Lodgement Centre coordinators, Advisory Committee members and health service managers raised the issue of the skills of some professionals, especially relatively new graduates in rural locations who are required to make assessments for complex mobility aids and equipment. Skilled and experienced professionals on the other hand questioned the appropriateness of the Lodgement Centre staff and Advisory Committee members in making judgements on the quality of their assessments. Thirdly, the quality of assessments made in a clinical setting where there is no onsite inspection of the appropriateness of the equipment for domestic use was questioned (such as the need to match heights of beds to other equipment for transfers etc).

This gave rise to two topics of discussion:

- how to ensure that the assessment and prescription was undertaken by a professional with the appropriate skills and experience
- how to ensure that the Lodgement Centre staff and Advisory Committee members recognised a skilled assessment and did not refuse an application or alter an application when it had been completed by a competent and expert clinician.

Discussion

The challenges facing health and community service agencies in attracting and keeping skilled therapists and professionals in rural locations is well recognised. Many health services outside metropolitan and major regional centres carry vacancies for key staff for long periods, and when they do attract staff, they may only be able to secure their services for relatively short periods. These professionals often work in relative isolation from their peers and may have difficulty in securing appropriate professional supervision and support. Completing a complex assessment is a challenge for many of these professionals. They may lack reliable internet access to specific information on available equipment, access to experienced staff and access to equipment suppliers. This situation is exacerbated by the small size of many rural based PADP centres that have limited budgets and limited previous experience in supplying the equipment needed.

The question arises as to the level of professional competence that is required before a professional can appropriately make an assessment for a complex piece of mobility equipment, or any other equipment for that matter.

This situation appears to give rise to the consideration of the development of appropriate professional guidelines within key professions (e.g. OT's) and standards of professional competence in making assessments for aids and equipment. It also raises the question of the access of health professionals in rural locations to more senior and experienced professionals to provide professional support and guidance.

The almost reverse situation has been reported to the review. This has occurred where the prescriber is a senior and experienced professional practicing in a specialist unit. In some cases reported to the reviewers, these professionals have had the experience of the local Lodgement Centre staff, and in some cases the Advisory Committees, questioning the appropriateness of their assessments and the equipment they have prescribed.

The review team also heard of comments raised in relation to the assessment of needs and prescription of equipment by hospital based professionals who do not conduct the assessment at the place where the person will be living on discharge. In some cases, this may be impractical due to distance and in others impossible as the client's residence may not be determined at the time of assessment. This issue is more fully discussed in relation to the specialist spinal injury units in Section 7.4.7.

The practice of the Bathurst Lodgement Centre was raised with members of the review team by a number of professionals and consumers.

This Lodgement Centre incorporates or works closely with a workshop that undertakes its own modifications of equipment to meet client's needs – the Bathurst Seating Clinic. Comments were raised in relation to the appropriateness of the continuing practice of a local workshop to make or modify equipment. Most similar services elsewhere in the state, such as the Spastic Centre, have discontinued this practice and now rely on specialist equipment manufacturers for these tasks. Concerns were also raised in relation to meeting Australian Standards for equipment, achieving a result of appropriate quality and standard with the equipment manufactured or modified, legal liability of the employing agency if skilled specialists are not engaged in these tasks, and the need for continual liaison with the assessing professional.

The review team did not visit the Bathurst Lodgement Centre but did interview staff from there by teleconference.

Recommendation 14

That the issue of an apparent lack of guidance in the skills necessary for the safe and competent prescribing of equipment by therapists be brought to the attention of the appropriate professional association (especially in relation to occupational therapy as this profession prepares the majority of prescriptions), with the view that standards of professional competence be reviewed or established in relation to this area of practice.

Recommendation 15

That consideration is given to the establishment of the role of state-wide advisors within PADP, whose role will be to review prescriptions and applications for complex and high cost items, especially in relation to mobility equipment.

Recommendation 16

That the role and function of the Bathurst Seating clinic should be reviewed by a competent professional or team who are able to form a judgement as to the appropriateness and safety of the continuing practice of this clinic in undertaking its own modification and construction of mobility equipment.

7.5.3 Information on the program and access to application forms

Current practice

A brochure on the program has been produced by the Department of Health; it is widely distributed throughout the health system and is available from the Department's website. The brochure outlines the program in brief but does not fully explain eligibility and does not contain an application form. Also available from the website is the Department's official policy (59 pages), which can be freely downloaded (although finding it requires searching in the A-Z listing of publications). Although the Department does not actively promote PADP, websites of other organisations (e.g. Carers NSW and Physical Disability Council of NSW) provide information on PADP. There is no Department initiated website or pages on the Department's website devoted to the program.

Application forms need to be accessed from the Lodgement Centre to which the application is being made. Application forms are not available over the internet. There is not a common application form across the program as a whole. A draft common application form had been devised by the Department in association with the Lodgement Centre representatives for some time, but had not been introduced.

There is no 1800 number that provides access to centralised information.

Issues raised

Information on the program

At the consultations, some attendees believed that the lack of information available on the program was not a major issue. The opinion was that most people who needed aids and equipment and were eligible under PADP were receiving care from a health or community care professional who knew about the program and the potential clients were informed about the program by these professionals. However, these comments tended to come from the professionals themselves, and by evidence of their attendance at the consultations, were professionals who had already heard about PADP.

Alternative opinions were raised that there was no guarantee that all persons who are eligible know about the program or have a mechanism for finding out about it. One client attending one of the public consultations informed the review team that she had only recently found out about the program and she has subsequently received orthotic shoes through PADP. She has apparently been eligible for many years but had not been informed of the program, had not come across any information about it and had previously met the expense herself with some difficulty.

The view was expressed by some that the information available on the eligibility criteria for the program was minimal, and should prospective applicants wish to explore the eligibility criteria they needed to download the whole policy document and find the relevant sections. The policy document was not viewed as particularly 'user friendly'.

Some stakeholders were of the view that providing more information on the program would lead to more applications and would add to the long waiting lists experienced in many

centres, it may also exacerbate the problem of being unable to meet demand. This view was not shared by the majority of those attending the consultations who viewed the provision of more information as an equity issue. All persons who were potentially eligible had a right to be informed about the program.

Application forms

Those stakeholders, prescribers and professionals who deal with more than one Lodgement Centre (those in specialist hospitals or non-government-organisations) expressed great frustration with the diversity of procedures for making applications between the different centres. The comment was made that it was difficult to understand why a single form had not been introduced already, as it seemed such a simple solution to a significant issue of equity of access and efficiency of operation.

There was universal agreement to the concept of a single state-wide application form that would be used by all Lodgement Centres. This should be available on the internet from where it could be easily downloaded, but also available for faxing and in hard copy.

1800 number

A single state-wide 1800 number has been suggested as a user friendly mechanism to provide access to information on the program. This idea has merit and could be linked to one of the major centres, shared between different centres on a rostered basis or linked to the state-wide Lodgement Centre if that option is chosen.

Options for improvement

There appear to be the following options (which are not mutually exclusive):

- 1 Retain current practice – each centre has own application form and there is no additional effort on the part of the Department to publicise the program.
- 2 Establish a universal 1800 number for people seeking information on the program.
- 3 Establish a website or a page within NSW Health's website, or a link to another website (in such a manner that it is easily found from the most popular search engines), to ensure that 'user friendly' information on the program is easily available, including clear eligibility criteria, an up-to-date list of equipment, a downloadable application form, with capacity for lodging applications electronically, current wait list statistics and an emphasis on email communication.

Recommendation 17

That the Department undertake the following initiatives to provide more easily available and accessible information on the program:

- Develop a single application form for use at any Lodgement Centre.
- Establish a web page on PADP or a new website providing information on PADP which includes clear eligibility criteria, an up-to-date list of aids and equipment

available, a downloadable application form, a capacity for lodging applications electronically, current wait list statistics, and access to information on the program by email.

- Establish a 1800 number to an appropriate service to provide information on the program.

7.5.4 Availability of an equipment list and continued maintenance of an equipment list (including Government contract arrangements)

Current practice

Table 3 of the current policy is entitled PADP Equipment List and consists of 16 list categories that describe the nature of the equipment in each category, what is included and what is excluded and availability. The 16 categories are:

- Aids to Nutrition
- Alarms
- Beds and Sleeping equipment
- Communication Aids
- Contenance aids
- Environmental Control Aids
- Mobility Aids
- Monitoring Equipment
- Orthoses and Footwear
- Pain Management Aids
- Pressure Garments and Pressure relief Equipment
- Prostheses
- Seating Equipment
- Technological Aids and Inclusion
- Toileting and Showering Aids
- Transfer Aids.

Although titled an 'equipment list' it is more accurately a description of the type of equipment that is available through PADP. For example, the section 'Beds and Sleeping' does not list individual products or items but types of equipment:

- Pressure relief mattresses.

- Electrically operated hi lo beds including beds with elevating head and knee breaks including appropriate mattress.
- Pressure care mattresses and or overlays’.
- Other bed frames, such as a monkey board.
- Sheepskins, cradles and over bed tables.

Once the application and prescription have been lodged, PADP coordinators and Advisory committee members determine if the request for equipment is consistent with the description of the type of equipment. The local AHS and Advisory Committee may determine the priority of particular pieces of equipment and also decide to supply items that are not on the list if a suitable case is made.

Issues raised

There were a number of issues raised in relation to the current equipment list. These are:

- There may be a variety of brands and makers that may meet the general description of the equipment that is included on the ‘list’, but there is no information provided by PADP that assists those making the prescriptions or ordering the equipment to guide them towards preferred brands or manufacturers or the price they should pay for items.
- Prescribers are required to research the equipment manufacturers and/or suppliers themselves to get information on products and prices especially where the equipment is not on government contract or access this information from another source (such as the Independent Living Centre). This is time consuming for OT’s particularly for items they may not regularly order.
- Prescribers and applicants are not always sure that the equipment they are requesting will meet the definition of a ‘basic item’. Section 10 of the PADP policy states that *‘PADP is only required to meet the cost of the most appropriate basic item to meet a person’s personal care, mobility needs and increase their independence’*. Discretion around the definition of basic items, local health services and Advisory Committees adds to concerns about inequity across the system.
- There is no easy way for prescribers or coordinators to find out from PADP if a particular item is under government contract, if it is not recommended for any reason or if others have found it unsuitable. There is currently no mechanism for prescribers to share views with others who have ordered equipment from PADP and the program does not assist in the passing on of information on the experiences of other Lodgement Centres
- The list is not easily available on the internet and consequently is not updated regularly.

Options for improvement

There appears to be the following options:

- 1 Retain the current equipment list that is restricted to 'types of equipment', but not individual items to allow maximum flexibility within the program.
- 2 Establish and maintain a defined equipment list within PADP that specifies the products and equipment available to aid both clients and prescribers in deciding to place an application.
- 3 Contract out the responsibility for the establishment and maintenance of the equipment list to a specialist provider (e.g. the Independent Living Centre or a private for profit provider).

Discussion

The comments and issues raised appeared reasonable to the review team.

In most cases the issues that were raised in relation to the equipment list were in reference mainly to equipment and not disposable items. Often the lack of certainty was around items ordered relatively infrequently or from individual prescribers who would not often be called upon to order equipment of that type.

A major area of confusion has arisen over the definition of a 'basic' item, and it would assist prescribers and clients if the definition of a basic item was available for each of the major types of equipment, or actually listing the preferred basic items or examples of them. Alternative information could be made available for some types of equipment, that is, those that would not normally be included as a 'basic' piece of equipment.

There appears a good argument to reduce uncertainty as to the likelihood of a particular order being successful and of reducing the time taken by prescribers in ordering equipment. It seems reasonable that consumers have access to a list of equipment that will be supplied by the program and, by exclusion, not supplied.

Not all items or categories of items would lend themselves to inclusion on the equipment list. For example, the wide range of equipment and software that would fall within the scope of 'Communication Aids' may not lend itself to a defined list as it may change rapidly. There may not be a need to list all low cost items such as nutritional aids or continence products. At the other end of the scale individually modified or designed equipment would not, by definition, be covered by a defined list. However, the bulk of durable equipment items, e.g. electric beds, bathroom products, some mobility aids, appear to lend themselves to listing.

There is some work in establishing and maintaining such as list in a timely manner. The NSW Department of Health may not be the most appropriate group to undertake this task and consideration could be given to the possibility of contracting this responsibility to an external agency. There are a number of agencies that currently provide lists of equipment and internet access to prescribers and the public. For example, the Independent Living Centre NSW already maintains a substantial list and information on suppliers in NSW. They

provide a good example of the type of organisation that could be contracted by NSW Health to provide such as service on behalf of PADP.

The list of equipment should be easily available and best accessed by the internet (with suitable hard copy available for those without computer access). The website that houses the list could have pages available only for registered users that may provide for discussion pages, or where they could access comments from others on equipment tips and comments. The website would ideally be accessed through the same portal that provides basic details on PADP (see comments above).

Recommendation 18

That a defined equipment list be established and maintained on a publicly available website and with some pages available only for authorised prescribers. That consideration is given to contracting out to a not-for-profit organisation the establishment and maintenance of the list. This organisation would specialise in providing information on aids and equipment for people with a disability.

7.5.5 Client co-payments

Current practice

Each client supplied with any item is required to make a co-payment of \$100 in any year they are supplied with an item. Only one payment of \$100 is required irrespective of the number of, and the value of the items supplied.

Clients with equipment on loan pay no co-payment other than in the year they are first supplied with the equipment.

Co-payments charged to clients are paid back into the PADP budget. Currently the co-payment would raise about \$1,500,000 in additional funding (or 7%) if all clients are charged the co-payment. AHSs have the discretion to waive the co-payment in cases of hardship. Practice varies across the Lodgement Centres as to the percentage of clients who pay, but no details are available on the actual percentage of clients charged or the amount generated.

The co-payment was first introduced in 2000 and has not been altered since.

Those clients receiving products continuously prior to the new policy being introduced do not have to pay the annual co-payment.

Issues raised

There was generally acceptance among those consulted that the co-payment should be raised, but a lack of consensus on the amount that it should be raised by. Raising the co-payment will cause difficulty for some to make the co-payment at the time it was due.

Discussion concerned the apparent inequity of a client paying \$100 as co-payment only once for equipment valued at over \$10,000 and which they would keep for 10 years, while others paid \$100 a year for less than \$1,000 of supplies each year.

Some Lodgement Centres allowed clients to make the payments in instalments.

There was strong support to discontinue the 'grand parenting' arrangement whereby persons receiving goods prior to 2000 do not pay the annual \$100.

Options

There appears to be the following options:

- 1 Leave the co-payment at the current level and with the current rules.
- 2 Compulsory co-payments from each person for each year they have the equipment.
- 3 Increase the co-payment and introduce annual indexation.

- 4 Allow persons receiving disposables, e.g. continence products, to spend up to the co-payment and produce receipts in lieu of a cash payment to PADP.
- 5 Discontinue the 'grand parenting' arrangements.

Discussion

An annual co-payment and ease of which co-payments are made would appear to be reasonable adjustments. An increase in the co-payment would be supported by most stakeholders, although there will be wide variation in the view of what is a reasonable increase.

Even doubling the co-payment would still be a small price to pay for those on higher incomes and receiving expensive equipment. A higher co-payment is recommended below for those in the second tier of eligibility.

Recommendation 19

That the following initiatives be undertaken in relation to co-payments:

- Increase co-payment to at least \$200 annually.
- Require persons with equipment on loan to make the co-payment each year they have the equipment.
- Discontinue the grand-parenting arrangements that have been in place since 2000.
- Allow those with disposable supplies (such as continence products) to have the option to produce receipts, to the value of the co-payment, in lieu of a cash payment each year.

7.5.6 Clarity around eligibility criteria based on income

Current practice

The current eligibility criteria is complex, not clearly explained in the policy or brochure, poorly understood and interpreted in a range of ways across NSW. The policy identifies four income Bands – Bands 1, 2, 3 and 4.

- 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.

The policy states that applicants in Bands 1-3 have priority over applicants within Band 4, except with approval of local Advisory Committees, and that a high cost item is anything over \$800.

There is no income test applied to applications for persons under the age of 16.

Issues raised

The following difficulties were noted with the current eligibility criteria:

- The salary levels are based on information obtained from the ATO for the year 1997/98 and have not been indexed since that time.
- The eligibility for Band 1 includes people with a part pension and the income levels for eligibility for Band 2 have now fallen below the income levels for people with a part pension i.e., persons eligible for Band 1 (highest priority) may now have an income higher than persons in Band 2.
- Band 1 includes people with a Health Care Card. Some Health Care Card holders are eligible because of their disability related to mobility and not income. Consequently,

some Health Care Card holders can have relatively high incomes and still fall into Band 1.

- There does not appear to be any difference in practical terms between Band 3 and Band 4 and no information to Lodgement Centre staff or Advisory Committee members on why there is a separate Band 3 and Band 4, except that a Band 3 person can theoretically access equipment less than \$800.
- Some parents of children have a high income but their children are not subject to an income test.
- Different Lodgement Centres have different rules as to how they apply the policies. Some do not place people in Bands 3 or 4 on a waiting list as they believe that they will never be supplied. In at least one centre, the income test is rarely applied on the basis that only those eligible would apply and wait for the equipment – anyone who can afford to pay for it would do so anyway and avoid the difficulty of waiting.

Options

There appears to be the following options:

- 1 Retain the current Bands and update income levels only.
- 2 Reduce the number of income Bands to 2 (with new income levels), and give priority to persons in Band 1 and place all persons in Band 2 on a waiting list.
- 3 Introduce an income test for families of children under the age of 16, but at a higher level than individuals over 16.
- 4 Introduce an interest free loan scheme for very high cost items for people with an income over the top of Band 2.
- 5 Establish performance standards for the supply of equipment within a time period for persons in Band 1.
- 6 Introduce a cut off period for the waiting list after which the applicant must reactivate their application or be removed from the waiting list.

Discussion

Ideally in a program of this nature the available budget will meet the needs of all those who fall eligible – that is, the eligibility criteria restricts those who are eligible to a number that can be provided with aids or equipment within the available budget. Problems arise when there is an imbalance between eligibility and budget.

An income (or wealth) test for a program of this nature needs to meet the test of simplicity, clarity, objectivity and efficiency of application. It must be clear and easy to understand for those making an application and the prescribers, and clear and easy to administer by those managing the program. The current eligibility criteria appear to fail this test.

A major cause of dissatisfaction with PADP is the waiting lists and the uncertainty faced by those who do not know if they will ever be supplied with equipment, this tends to apply to those in Bands other than Band 1; however some Band 1 persons also have to wait. In addition, the current system of Bands is confusing and the income levels are not indexed and are applied differently between centres.

There seems no good reason to assess the income of people who get their income from a pension or part pension differently to people whose income is the same but receive it from a non pension source (e.g. a self funded retiree or employed person on a low salary). The only justification for separately identifying persons on a pension as a separate category should be because they have already met an income test and should not be subject to a second one. They should not be more eligible than a person on the same income who has not previously been subject to an income test.

The issue of children is complex and emotive. An argument can be made that in some circumstances the parents of children face the same level of cost associated with the disability of the child as a person over 16, and in these circumstances a different income test for children does not have merit. On the other hand, parents of children with a disability are likely to be faced with a range of additional costs and challenges associated with the child's disability, such as special motor vehicles or restrictions on the working hours of the parents as their child requires longer carer time. The view was expressed that the number of 'rich' parents of disabled children making applications to PADP is small and that the vexed issue of an income test for children applicants is not worth the hassle for such a small number.

Income alone as test of eligibility was questioned in a number of the consultations. Expenditure from that income will vary between individuals e.g., depending on whether they live alone, rent or own their home. The point was made, and agreed on several occasions, that people with a disability face a wide range of costs in addition to that of equipment and aids. These costs include home modifications, adapted motor vehicles, carers and therapy. These all have an impact on the available income and will have a different impact depending on the nature of the disability. While these are valid arguments the test of simplicity outlined above needs to be kept in mind.

An eligibility test that attempts to take into consideration the cost of different disabilities, the assets of the applicant and the availability of formal or informal care will certainly fail the test of simplicity, clarity, objectivity and efficiency of application.

The 'sudden death' nature of a single point of income is also one of concern. There may seem some element of unfairness in one person being eligible when another who earns just a few dollars more is not. This phenomenon is encountered in a wide range of Government programs and there does not appear to be any alternative easily available.

While acknowledging the intention of the program to target persons who are financially disadvantaged, the situation of persons faced with the need to purchase very expensive items deserves consideration. One suggestion is that the income of a person facing the purchase of a very expensive piece of equipment could have their income discounted by the value of the equipment for the year of the purchase, and this discounted income test could make them eligible for PADP. For example, a person with an income of \$35,000

needing an electric wheelchair valued at \$10,000 would be assessed as having an adjusted income for that year of \$25,000. However, this may seem unfair to a person on the same income that needs equipment or aids each year where using the discounted income test would not bring their adjusted income down to the cut off level for PADP. In these examples the first persons equipment, worth \$10,000, may last 10 years while the second needs aids or equipment at a cost of \$1,000 each year for the next ten years (in addition, under the current co-payment arrangements the person needing the \$10,000 piece of equipment pays only one \$100 co-payment and the other pays \$100 per year for 10 years).

The mechanism recommended below requires all those whose adjusted income is over the top level for the first (lower) income test, and less than \$45,000 for an individual adjusted income, to make a co-payment representing 50% of the cost of the item up to a total co-payment of \$10,000. This would be accompanied by a high yearly co-payment of, for example, \$1,000. This yearly co-payment would preclude those on a relatively high adjusted income applying for aids and equipment that cost less than \$1,000.

High adjusted income group

The review team is aware that there a small number of individuals with adjusted incomes over \$45,000 that, from time to time, require high cost items that are beyond their capacity to afford. We suggest that PADP could provide assistance to those individuals that are faced with the cost of items over a certain price, say \$10,000, by providing them with what would effectively be an interest free loan. Under this arrangement, they would make a 50% co-payment at the time the equipment is purchased and repay the balance over, for example, 5 years.

High co-payment and ownership

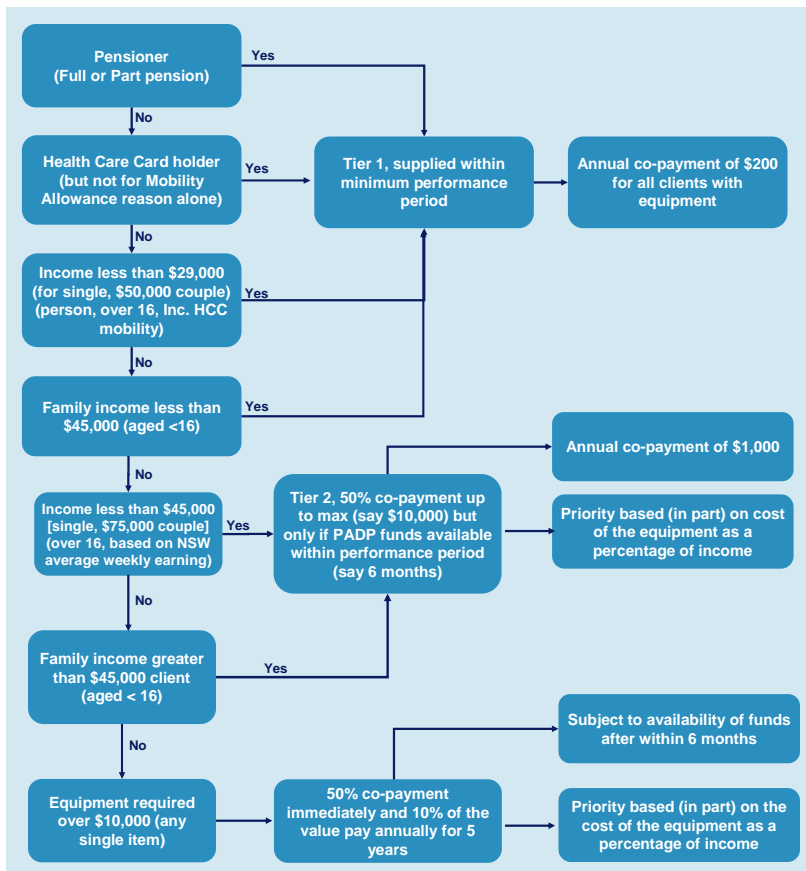
The issue of ownership of the equipment has been raised with the review team in those circumstances where clients are making large co-payments, such as those in the proposed Tier 2 and the high adjusted income group. Two options are possible:

- Persons in these categories could be offered the opportunity to own the equipment and make application, without guarantee of success, to PADP when repairs and replacement are required.
- They could elect for PADP to retain ownership and take responsibility for repairs and replacement.

The option of transferring ownership to the individual may also be reasonable for low cost items that may have not have future use if returned to PADP (see Section 7.6.1). However, there may be the need to determine if any legal issues are likely to arise associated with the transfer of ownership and liability.

An illustration of the preferred model is provided in Figure 7.

Figure 7 Recommended eligibility criteria for PADP



Recommendation 20

Establish only two income Tiers.

Tier 1 would include:

- All pensioners, part pensioners and Health Care Card holders, except holders whose sole justification for a Health Care Card is the mobility allowance criteria.
- All persons receiving an adjusted income less than \$29,683 (this has been indexed from the current Band 2 and is approximately the same real income level as a single person receiving a full pension plus benefits¹⁷).
- People who are Health Care Card holders because of mobility allowance criteria would be subjected to the same income test as non Health Care Card holders.
- Children whose parents earn an adjusted income less than \$45,000 (the income for Band 2).

¹⁷ The cost of pension benefits is included in Appendix 11.

Tier 2 would include:

- All applicants aged over the age of 16 whose adjusted income is less than the average income for NSW (around \$45,000 for singles and \$75,000 for couples) and greater than the top limit for Tier 1.
- Children whose parents combined adjusted income is higher than \$45,000.

Tier 2 would have the following rules:

- Applicants are required to make an annual co-payment of \$1,000 for each year they have equipment.
- Eligible persons could expect to be allocated funds only when all people in Tier 1 have received aids or equipment.
- Applicants would be expected to make a 50% co-payment for the cost of the item up to a limit of \$10,000.
- Persons seeking equipment with a cost greater than \$20,000 would not be required to make a co-payment greater than \$10,000.
- Applicants in this Tier will be priority ordered, in part, based on the percentage of their total adjusted income that the cost of the equipment represents, with those whose equipment needs form a higher percentage of their total adjusted income being given a higher priority (priority would also include consideration of relative needs and improvement in quality of life from the equipment).

Persons in both Tiers would have their income adjusted to reflect the cost of the PADP item requested (that is, a person with an annual unadjusted income of \$54,000 requesting equipment to the value of \$10,000 would have their annual income in the year of the request to \$44,000).

Adjusted income tests should take into consideration the expected income for the year of the application if the person's income has changed significantly since the previous year's income assessment by the ATO.

High income earners faced with the prospect of purchasing very high cost items should have access to PADP for 50% of the initial cost with an option to repay the balance over 5 years.

Legal advice should be sought on providing clients with the option of having ownership transferred to them in those circumstances where they make a large co-payment.

7.5.7 Clarity around eligibility based on residency and services

Current practice

Residents of aged care facilities funded by the Commonwealth under the Aged Care Program are currently eligible for PADP for any items of equipment and aids that are not included under the list of items and services in Schedule 1 of the Aged Care Act Quality of Care Principles. However, there is a lack of clarity as to the procedures that apply to persons in receipt of CACP and EACH packages.

Residents of large facilities and group homes operated by DADHC are eligible for aids and equipment that are not part of the usual care provided by DADHC; this is through the AIDAS program introduced by DADHC in December 2005.

Issues raised

The CACP and EACH program have been widely extended during the life of the current PADP policy and there appears to be a need for the policy to be clear on the eligibility of persons under these programs. For example, the Aged Care Principles is clear that residential aged care facilities are required to provide continence products and mobility aids, such as walking frames and wheelchairs (but excluding motorised wheelchairs and custom made aids). This also applies to providers of EACH packages. However, some coordinators were unclear of the extent that providers of CACP and EACH were required to supply equipment and what transfer arrangements should apply when people with PADP equipment commence on a CACP or EACH program.

At the commencement of this review, there was a lack of clarity in relation to the eligibility of persons in DADHC operated aged care facilities to aids and equipment provided by PADP. In December 2005, DADHC released the AIDAS policy to clarify eligibility for persons in their facilities. This new policy was not widely known by the attendees at the consultations due to timing of its release.

AIDAS does not cover residents of facilities and group homes operated by NGO's but funded by DADHC. Residents of these facilities may be supplied with equipment by the organisation operating these facilities and are eligible for application to PADP like any other person in NSW.

Discussion

The establishment of a separate scheme for residents of DADHC funded and operated schemes that does not include DADHC funded but not operated schemes, requires PADP coordinators to satisfy themselves that the application of a group home resident is not eligible under AIDAS. Coordinators commented that they often did not know the operator of a group home from the application alone, and were not sure how they would make this determination.

DADHC officials were asked by the review team to provide advice on what information is available to PADP coordinators to assist them in making determinations as to the nature of the operator of the group home. DADHC advised that all the managers of their facilities are

aware of AIDAS and would not be making an application to PADP. They advised that, therefore, any applications for a person with a disability residing in a group home would be from a group home not covered by AIDAS and they would be eligible for PADP. While there is a lack of clarity around the continuation of the provision of aids and equipment for persons who transfer between facilities and group homes operated by DADHC and other operators, and between the home and DADHC operated facilities, the review team were advised that transfers in and out of DADHC homes were relatively infrequent. It would appear that should such a transfer occur, involving persons with equipment supplied by either PADP or AIDAS, clarification of continuing responsibility should be determined on a case by case basis.

Despite recent introductions and reassurances that the potential for confusion is small and infrequent, the existence of two different programs with different eligibility arrangements and funding rules creates the potential for a lack of equity for persons with equal need within the NSW government sector. While there is a need for a program that covers the management of services and use of funds within DADHC owned facilities, this does not in itself justify the existence of two different equipment schemes in NSW for people with disabilities.

The situation as it now exists, is that the health system is purchasing large volumes of aids and equipment through a well established system (although in need of improvement), which provides it with considerable purchasing power and economies of scale. On the other hand, DADHC is operating a small separate program purchasing small volumes and often infrequently. It would appear that advantages may be available to DAHC if it used the PADP system to purchase and supply the equipment needed by residents in their own facilities. PADP (as it currently operates and also in the form that is recommended), could easily cope with some ambiguity around different procedures for purchasing aids and equipment for persons resident in DADHC group homes.

AIDAS (Aids for Individuals in DADHC Accommodation Services)

DADHC is responsible for the provision of aids and appliances for clients living in the accommodation services it operates; this is achieved through its AIDAS scheme. AIDAS provides funding for personal aids and appliances for clients living in accommodation services who demonstrate a high need for an aid to assist their functioning in everyday life.

The primary objectives of AIDAS are to:

- 1 enable or enhance a client's ability to function
- 2 maintain the client's independence
- 3 assist the client to meet their potential.

Eligible clients are all permanent client-residents, of all ages living in DADHC operated accommodation services (e.g. a large residence or group home).

For those clients who can afford to contribute, a small and scaled 'user fee' contribution is charged.

The categories of individual appliances and assistive equipment for clients on the AIDAS aids and appliance list includes: Communication aids and appliances; continence aids; pressure reduction; beds and sleeping equipment; seating and positioning aids; nutrition, feeding and eating; orthotic appliances; pressure garments; prosthesis; mobility aids; and repairs and modifications.

There is also a list of equipment to support clients in accommodation services, these categories include: railings and ramps; environmental control aids; tables; wheelchair hoists; client transfer and lifting appliances; bathing aids; toileting aids; and suction aids.

The requirement for aids or appliances is primarily based on the client's diagnosed and long term disability and is accompanied by a professional, clinical or therapeutic assessment and/or an identified need determined through the Individual Planning and Health Care planning processes which may change with the client's condition.

All non-consumable aids and appliances purchased under AIDAS remain the property of DADHC, and once the appliance is no longer used by the client it is made available for allocation to another client, if appropriate.

The management of AIDAS occurs through six regional AIDAS committees across NSW. The primary functions of these committees are to maintain state-wide consistency in allocating funds and to ensure equity throughout the process of decision making.

Table 40 Comparison of PADP and AIDAS

Program component	PADP	AIDAS
Eligibility	<p>Eligibility for PADP is based on five principles as follows:</p> <ul style="list-style-type: none"> • People with disabilities have full rights of citizenship. • Access to PADP is based on need. • Assessment and provision of assistance is person-centred. • Eligibility for PADP recognises the crucial distinction between medically defined impairment and socially constructed disability which results in additional costs to the individual to enable independent living within the community. • Assessment and provision of assistance recognises the importance of enhancing participation in family and community activities and preventing premature or inappropriate entry to institutional care. <p>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.</p>	<p>All permanent client-residents, of all ages living in DADHC operated accommodation services are eligible for AIDAS, that is clients living in a:</p> <ul style="list-style-type: none"> • large residence • group home. <p>AIDAS is for clients who require an aid to assist their functioning in everyday life.</p>
Equipment	<p>The categories of items provided by PADP are:</p> <ul style="list-style-type: none"> • Aids to nutrition • Alarms • Beds and sleeping equipment • Communication aids • Continence aids • Environmental control aids • Mobility aids • Monitoring equipment • Orthoses and footwear • Pain management aids • Pressure garments and pressure relief equipment • Prostheses • Seating equipment • Technological aids to inclusion • Toileting and showering aids • Transfer aids. 	<p>The categories of individual appliances and assistive equipment for clients on the AIDAS aids and appliance list includes:</p> <ul style="list-style-type: none"> • Communication aids and appliances • Continence aids • Pressure reduction • Beds and sleeping equipment • Seating and positioning aids • Nutrition • Feeding and eating • Orthotic appliances • Pressure garments • Prosthesis • Mobility aids. <p>There is also a list of equipment to support clients in accommodation services, these categories include: railings and ramps; environmental control aids; tables; wheelchair hoists; client transfer and lifting appliances bathing aids; toileting aids; and suction aids.</p>

Recommendation 21

That clarification of the eligibility for clients in receipt of CACP is sought by NSW Health from the Australian Government Department of Health and Ageing and advice is provided to Lodgement Centre coordinators on the arrangement that should apply when persons with PADP equipment commence on an EACH or CACP program.

Recommendation 22

That the management of the AIDAS program related to the purchasing and supply of equipment be transferred to PADP, and PADP coordinators be provided with guidelines on the different criteria operating in relation to the funding of equipment purchased through AIDAS. Responsibility for policy development would remain with DADHC, with shared

involvement in the determination of consistent application of policies across the state. PADP coordinators will be required to monitor and report, over a period of six months, any circumstances where there appears a lack of clarity on eligibility under PADP or AIDAS of an application for PADP, and following this period that the two Departments meet to determine if any action is required.

7.5.8 Management of increasing demand for continence products

Current practice

Many Lodgement Centre coordinators reported that this was a growing area of demand for PADP. The proportion of funding for continence products ranges between 20% and 30% of expenditure within most Lodgement Centres. The majority of continence products are supplied to persons over the age of 65.

Clients of working age (17 to 65) whose continence is related to a permanent neurological condition or permanent and severe intellectual impairment are eligible for continence products under CAAS, the scheme operated by the Commonwealth. Clients eligible for CAAS must first exhaust their allowance under CAAS before they can make an application for assistance from PADP.

CAAS and the scheme operating for DVA clients are both contracted out to private providers. DVA clients were supplied under PADP, but were transferred to new arrangements in 2004.

PADP coordinators order a large volume of continence products through government contracted suppliers. These suppliers also deliver the products they supply in most locations around NSW. The price paid under government contract usually includes a component to pay for delivery costs and may be higher than the same products available through retail outlets locally.

AHSs have the authority to prioritise the list of available PADP items according to local demand and budgetary constraints (clause 6.3 of the policy). Many Lodgement Centres and AHSs have introduced a 'cap' (for example, 30% of total budget) on the level of expenditure for continence products through their centre or Area. Once the cap has been applied, new applicants for continence products must wait until the expenditure on continence products falls below the 'cap' – presumably due to a client's death; move to residential care or out of the Lodgement Centre catchment area. Applicants on the waiting lists are assessed for priority based on need against others on the waiting list, but not against those already receiving products.

In some locations, clients receiving products are reassessed by a continence nurse in the local area on an annual basis to ensure that they are only receiving the products they require. Where the clients circumstances have changed, the products supplied through PADP may be increased or decreased. This is not a universal practice across all Areas.

The PADP policy limits supply to a set number of items per client per month.

Issues raised

Advocates and stakeholders for persons with a mobility problem were particularly concerned about the percentage of the available funds under PADP being spent on continence products. The view was expressed that this was not an appropriate use of PADP and was not part of the original intention of the program. Some commented that this was similar to the issue of oxygen and respiratory products that were primarily related to a

health issue, and that up until these products were removed from PADP, were continuing to consume a greater and greater percentage of the budget. In addition, concern was raised that the increase in life expectancy being experienced in Australia and the expected large increase in the number of persons over 65 in the next few years as the 'baby boomers' age, would put an increasing demand on the program for persons with a continence problem due to age.

However, the point was made on several occasions that many of the persons in receipt of continence products were persons with a disability not related to age, and the distinction of the cause of the continence was not always as clear cut as it was in the case of oxygen. It was argued that it was not practical to try and make a distinction between those with a need for continence products because of one reason or another.

The application of local rules related to a 'cap' on expenditure gives rise to inequity across different Lodgement Centres. There is a variation across the state in the percentage of the PADP budget spent on continence and not all Lodgement Centres have a waiting list for continence products. Some have only a low number of persons waiting for continence products and they may be waiting, along with applicants for other products, because of overall budget constraints and not just because of a local limit on expenditure on continence products. It is unclear why there is an imbalance between centres on continence expenditure. Possible explanations may be related to the attitude of local clinicians, such as continence nurses and general practitioners, or a failure of the budgetary process used by the Department to allocate the available funds between Areas, making appropriate allowance for demographic difference between areas.

The interface with the CAAS scheme was also raised in a number of consultations. The CAAS scheme is capped at a relatively low annual limit of \$470 compared with PADP, which does not have a financial cap for each client. Clients of CAAS who have spent their annual allocation are required to wait until the next year before they are eligible for further assistance under that scheme. Clients that need continence products beyond the allocated CAAS limit are eligible for PADP.

Another issue with CAAS was the potential for 'gaming' by clients, whereby a client can spend their CAAS allocation by 'stocking up' on related products as skin creams that are not supplied by PADP. When they have exhausted their allocation, they fall back on PADP for their continence products for the rest of the year. In addition, PADP coordinators are required to make special arrangement for people eligible for CAAS by keeping them on as active clients during the part of the year when they are receiving their CAAS eligibility and not receiving PADP supplies. General practice appears to be that once they have exhausted their CAAS eligibility they then resume supply through PADP without the need to reapply, even though other clients may be on the waiting list for continence products and are not receiving them because of a local cap on continence expenditure.

Some clients claim to need a greater monthly supply than the limits set by the PADP policy. Some commentators observed that the \$100 co-payment was too low and that even pensioners can afford to purchase a percentage of the products themselves.

Options for improvement

There appears to be the following options for improvement:

- 1 Leave the setting of limits on continence products and priority setting procedures to local Advisory Committees, and establish state-wide guidelines for quarantining of continence products at the local level.
- 2 Review the variation in expenditure across Lodgement Centres to determine an explanation for different levels of demand and, using these findings, review the resource distribution formula (RDF) used to allocate Area Budgets.
- 3 Remove continence products from PADP and establish a separate scheme within NSW Health (similar to oxygen), this could include contracting-out a separate continence produce program to specialist provider (similar to CAAS or DVA).
- 4 Remove persons eligible for CAAS from PADP (this would bring PADP in line with some other states).
- 5 Require a yearly reassessment by the continence nurse advisor of every continence client.

Discussion

Inequity of access to PADP will continue while AHSs have the discretion to determine their own priorities for expenditure on continence products. As equity issues are a major cause of dissatisfaction within PADP, this does not appear to be a suitable option. There is no clear explanation for the apparent local variation in demand for continence products. Further investigation is needed to determine if this issue relates to Lodgement Centre procedures, clinician practice or is a failure of the budgetary process. However, the effort required addressing the issue may be resolved by introducing a state-wide system for processing applications for continence products. There were 4,524 people supplied with continence products supplied in 2003/04 (which equates to 20.4% of the total equipment expenditure), which suggests this is a suitable component of the program that lends itself to an efficient centralised function. Efficiency gains can be expected by a single state service as this component of PADP requires a relatively routine process for assessment and purchasing of a large number of similar products. Complex cases or unusual circumstances could be dealt with by reference to a senior advisor available to PADP for this purpose, rather than left to the decision making of local committees who may not have this expertise available to them.

Centralising the service provides the opportunity for contracting it out to an external provider (in the manner of DVA or CAAS). External providers would receive prescriptions from authorised prescribers and an application form from clients with income and other details. Eligible clients would be automatically supplied with services. Contracting-out this function would require the development of very clear and rigid criteria for assessment and eligibility. A contracted out program would become an entitlement program rather than the eligibility program it currently is (currently eligible clients will only receive the service subject to financial and availability constraints, that is, not everyone eligible receives the

services). It would be inappropriate to contract to an external provider rationing and priority decision making between one client and another. In a contracted-out program, everyone who needs the program and meets the criteria is provided with the products. Such an arrangement may prove difficult to establish a fixed budget for, and the Department of Health would need to determine whether the external operator stopped supply once a certain expenditure level had been reached or continue to fund eligible applicants and require the Department to meet any budget overrun. Budget overruns are not consistent with the current operation of the PADP.

As continence products are generally of a low cost for an individual item, increasing the co-payment appears to be a reasonable and acceptable mechanism of sharing costs and increase the number of clients that can be served within the current budget. The current co-payment of \$100 has not been increased since 2000 and could be increased to \$200, or even \$500. Lump sum payments can prove difficult for those on fixed low incomes. The requirement for the individual to make a cash payment could be removed and replaced with a new eligibility test that requires them to produce proof that they had purchased products, up to the value of the co-payment, before supply could commence. This would be a yearly requirement. A procedure for exceptional circumstances could apply but be determined by the Department, not the external provider.

Consideration could be given to the removal of persons eligible for CAAS from eligibility under PADP. This would bring PADP in line with other states. However, this would require removing entitlement to a group of clients who are currently eligible and may prove difficult to introduce. The introduction of a higher co-payment, as suggested in the paragraph above, may remove the eligibility for some persons who are also eligible for CAAS.

Recommendation 23

Centralise the processing of continence products to a single state-wide program and assess the feasibility of contracting this component of PADP to an external contractor after determining clear and strict eligibility criteria.

Recommendation 24

Increase the co-payment for continence products up to \$200 (currently \$100), and allow the co-payment conditions to be met by the client by producing proof that they had purchased products up to the value of the co-payment in each financial year prior to receiving products through PADP. This co-payment would not include the value of products already supplied through CAAS, and would have to be met by the CAAS eligible client after they have exhausted their CAAS entitlement.

7.5.9 Definition of a high cost item

Current practice

A high cost item is defined in the current policy as any piece of equipment over \$800. Applications for high cost items must be reviewed by the local Advisory Committee. This policy is not followed in all Lodgement Centres. Some have set the level at \$3,000, and a number of centres have levels between \$800 and \$3,000.

Issues raised

There does not appear to be any reason to maintain the level of a high cost item at \$800. While it is not clear why this figure was determined initially, although it is thought to have related to the cost of a base model manual wheelchair, there was universal agreement that it should be increased.

The impact of the current level is that there are many items referred to the local Advisory Committee. Many of these are straightforward purchases and referral to the committee effectively slows down the processing of the applications. Lodgement Centre coordinators generally refer to the Advisory Committee any items about which they are unsure or find to be unusual.

Options for improvement

There appears to be the following options:

- 1 Retain the current definition of a high cost item at \$800.
- 2 Increase the level at which a high cost item commences to \$3,000.
- 3 Leave the definition of high cost (and complex) items to local committees.
- 4 Establish a range of floor prices for each category of equipment that defines a high cost item (e.g. a different price may be established for mobility equipment to communication devices).

Discussion

There appeared to be general agreement that \$3,000 was a more appropriate level for high cost items if this distinction was to be retained in the future. This level would seem to be appropriate in a well managed centre that was well integrated into the clinical services of the area, and where there were sound management systems for supervision and accountability. Coordinators should continue to refer to management and the Advisory Committee any items of concern or of an unusual nature.

Leaving the decision on what is a high cost items with local managers may lead to a continuation of the current concerns about equity.

An alternative to a set high cost item price is for a level to be set for each category of item. For example, the level for a mobility item may be higher than that for a communication item. This model has merit, and it is suggested that further consideration be given to this idea in conjunction with the recommendation that a defined list of equipment be determined and maintained.

Recommendation 25

That the defined level of a high cost item be increased to \$3,000 in association with improved management and accountability systems across all Lodgement Centres.

Recommendation 26

That consideration is given to the procedure of establishing a 'high cost item' level for each category of equipment, in association with the recommendation to establish and maintain a single list of aids and equipment.

7.6 Discussion and recommendations related to the management of equipment

Management of equipment covers the following key areas:

Key area	Section	Recommendation
Maintenance and repair of equipment	7.6.1	27
Potential for integration with other equipment pools	7.6.2	28
Potential for contracting out part or all of the management of equipment pools	7.6.3	29
Change of name	7.6.4	30

7.6.1 Maintenance and repair of equipment

Current practice

The current policy states that all equipment is owned by the health services through PADP, and clients are required to return equipment to PADP when it is no longer needed. Each piece of equipment should be labelled with the contact details of the Lodgement Centre from which it was provided.

When equipment is in need of service and repairs it is the responsibility of PADP to arrange for these, or for a replacement.

Practice varies in the way in which all pieces of equipment are labelled or tagged. In some centres (such as Hunter) the practice is that, where practical, all equipment is delivered to the Lodgement Centre prior to being delivered to the client so that the equipment can be labelled with PADP identification. In other Lodgement Centres, equipment is delivered directly to the client and a label is sent to them with a request to attach it to the equipment.

Issues raised

There were a number of issues raised in relation to these issues, these are summarised below:

- Cost of recovery of low cost equipment - in a number of cases, low cost equipment supplied by PADP may not be cost effective to retrieve. When the cost of staff time, transport and space is taken into account, the cost of retrieval, handling, cleaning, recording and storing items (such as used shower chairs) may be more than the initial purchase price (a few hundred dollars). In addition, it may be in such poor repair when returned that it is of no further use.
- Dumping of equipment by clients or their family - a number of incidences were reported to the review team of equipment with a PADP label being found at council rubbish dumps, 'opportunity shops', or offered for sale. It was acknowledged that this

can occur when equipment has been held for a long period and the client dies, the family may not be aware of the equipments origin. These stories related both to low cost items and also to items such as standard wheelchairs that could be reused.

- Repairs of essential equipment can be slow and a major inconvenience to the client - the review team was informed of a number of incidences of major inconvenience to clients needing repair or maintenance, which included:
 - A long wait for funds to be available for the repairs.
 - Delays in processing the order for repair, ordering or supply of new parts.
 - Long delays in sending the equipment for repairs by the manufacturer and making do with inadequate equipment.
 - Inappropriate or poor quality work done in the repair.
 - Losing track of equipment when a person moves.
- The risks associated with the inadequately cleaned or stored equipment - some Lodgement Centre staff commented on the lack of resources to retrieve, check, repair, clean or store equipment and the risk this poses to clients, staff and NSW Health. These risks are:
 - Potential for cross infection of clients and staff from poorly cleaned equipment.
 - Risk of harm to clients from faulty equipment because of a failure to detect faults or from faults arising from inappropriate maintenance or storage.
 - Subsequent legal risks to the health system of supplying faulty equipment.
 - Risk to staff from the storage and handling of faulty equipment.
- Inadequacy of the current information system to assist in managing equipment - an inadequacy of the PADPIS was blamed for some of these problems. The current information system is less than ideal for tracking equipment, scheduling routine maintenance and planning for redundancy.

Options for improvement

There appears to be the following options:

- 1 Leave policy and procedure related to equipment retrieval, repairs, recording, storage and maintenance to local AHSs.
- 2 Establish state-wide guidelines on which items need to be retrieved and which can be effectively given to the client, and link these policies to a new information system.

- 3 Centralise or contract out the handling of equipment to ensure that appropriate systems and processes are in place to manage equipment.

Discussion

A policy that requires all pieces of equipment to be returned when no longer needed should be reviewed for cost effectiveness and efficiency. It may be more appropriate to leave low cost items with clients for their disposal when no longer required. It is beyond the scope of this review to detail the types of items that are not cost effective to recover or to reuse.

Scheduled maintenance and planned redundancy should be a relatively easy mechanism to include in an information system, and with the planned replacement of the PADPIS, this functionality should be included in the replacement system.

There is a real risk to clients and staff from inadequate cleaning, repairs, storage and maintenance of equipment. This is particularly a risk in those locations where there are not skilled staff allocated to these tasks, and it falls to clerical or clinical staff to perform these roles. The amalgamation of the AHSs into larger units creates the opportunity for these functions to be more appropriately managed on an Area-wide basis.

Further recommendations in relation to the future management of equipment are provided in the sections below.

Recommendation 27

The policy that all equipment remains the property of PADP should be reviewed to determine if it is less risky and more cost effective (in terms of the staff handling cost and storage costs) for some low cost items to be effectively given to the clients.

The new PADPIS should have functionality that enables equipment to be better registered for appropriate retrieval (or non retrieval), tracked for routine maintenance and programmed for planned replacement.

7.6.2 Potential for integration with other equipment pools

Current practice

There are a number of equipment pools in each AHS. Each PADP Lodgement Centre has a PADP equipment pool of returned equipment. There are also ELP's in each acute hospital and pools associated with some specialist services, such as palliative care, paediatrics and community health. In a number of cases, perhaps a majority, these equipment pools do not loan to each other.

Issues raised

There are examples of best practice in relation to equipment pools across some AHS. The Hunter New England AHS has a single pool for the Hunter sub-area.

Equipment management best practice

The Hunter Equipment Service (HES) is located at Wallsend Hospital and consists of the combined Area hospital loan pools and the Hunter PADP pool. It was established six years ago by executive directive as a response to the recommendations made in the previous review of PADP. This central service manages all aspects of purchasing, delivery, retrieval, storage and maintenance for patient and client equipment in the AHS.

The HES maintains 11 satellite sites at hospitals around the Hunter sub-area with an impress of equipment for local use. The range and number of pieces of equipment located at each satellite site has been established based on experience. All the sites are managed from the HES and regularly checked and restocked. The local sites are managed with the occupational therapy service and these sites advise the HES of equipment loaned. The HES invoices discharged patients a \$40 loan fee. Where equipment is required longer than six months, the equipment register and financial journal is adjusted to transfer the equipment to PADP. This process is seamless to the client.

The HES maintains the asset register for all patient and client equipment supplied within the AHS. The database has been established by the HES and links to the Areas financial systems on a regular basis.

A number of AHSs (such as Western Sydney) are currently investigating the possibility of establishing a single equipment management service for their area in a manner similar to the Hunter.

In other parts of the state, equipment pools are actively and jealously guarded. The review team heard of locations where a single person maintains the key to the equipment store and all applications for loans must be made to that person. Staff in rural locations indicated that some rural hospitals would be most reluctant to lend equipment to the hospital in the next town, although this hospital was within the same region. The explanation given was the need to keep control of equipment bought from donations to that hospital or brought with that particular hospital's funds. In some locations, the PADP and the hospital loan pools are under separate management and there may be few opportunities for the pools to

make cross loans. In other locations, the equipment pools are fully integrated and are managed seamlessly.

Options for improvement

There appears to be the following options:

- 1 Retain current policy of leaving the practices related to equipment pools to local hospitals and AHSs.
- 2 Establish one combined equipment pool in each AHS under central management (but with local distribution depots and stores as necessary).
- 3 Establish a state-wide single list of equipment held in hospital and PADP pools that is accessible to all hospitals and health services.

Discussion

While the current practice of having individual loan pools in each hospital and separate PADP pools (in different, and often in several locations) within an AHS may have been developed for sensible and logical reasons, there seems no sound reason for maintaining this practice. The reorganisation of the AHS into larger administrative units creates the opportunity to establish a single equipment service within each AHS.

Many, but not all, AHSs will need to overcome the tyranny of distance in relation to the supply and retrieval of equipment, and there may be a need to establish sub-pools across the AHS for quick supply of some items. The establishment of separate physical locations of equipment does not preclude the establishment of a central administrative structure for the management of equipment within the AHS. This central administrative arrangement could be given full responsibility for the purchasing, delivery, retrieval and maintenance of equipment within the Area regardless of whether the equipment is purchased from an individual hospital, trust fund, donation or the PADP budget. The establishment of a suitable information system could easily track the path and life of a piece of equipment purchased from a particular source; this would enable accountability as to the origin of the funds.

The establishment of a single equipment service within the AHSs will enable improved management and accountability of equipment across the NSW Health system. The establishment of centralised equipment management provides the opportunity for better budgeting and accountability of equipment, improved maintenance of equipment by skilled staff and the establishment of comparable performance measures. This reform provides the opportunity to establish appropriate guidelines within NSW Health.

Recommendation 28

Each AHS should combine all equipment pools within their Area under a single management structure. This administrative process would be responsible to ensure all equipment, regardless of the origin of the funds that purchased it, is available for the most appropriate use within the Area. The single equipment management service will need to establish a number of different sites across the Area to store equipment for quick access

for local health services. These sites should be managed and supplied by the central equipment service.

Guidelines, policies, performance indicators and benchmarks should be established to cover the management of the single equipment services within the AHSs.

7.6.3 Potential for contracting out part or all of the management of equipment pools

Current practice

There are a number of examples across Australia where organisations have contracted out the supply of equipment to disabled persons. In Victoria, the Victorian Accident Commission contracts with a single private provider to provide equipment on its behalf. Similar arrangements are also in place for DVA and for some aspects of the Victorian A&EP run by the Victorian DHS.

While these arrangements vary, contracting can be arranged across different programs that cover the following options:

- Equipment is purchased, owned and stored by the Service or Program and the contractor is engaged to supply, retrieve, maintain and manage the equipment the equipment pool.
- Equipment is purchased and owned by the Service or Program but the contractor stores the equipment at their own site and undertakes all other functions.
- Contractor takes over purchasing and all other functions, but ownership is retained by the Program or Service.
- Contractor undertakes purchasing and owns the equipment, and contracts to provide all other functions to the Service or Program.

Issues raised

The issues raised in relation the management of hospital loan pools and PADP pools have been discussed in the sections above.

The South Western Sydney AHS has been in negotiation with a private provider to undertake a pilot to contract for the supply and maintenance of equipment for discharged patients to replace the current system of the Hospital ELP. Under this arrangement, the contractor would own the equipment and supply it to the discharged patient. The AHS would pay the contractor the first two months rental fee and charge the patient the usual loan fee charge. After two months, the contractor would negotiate with the patient as to whether they wished to continue to rent the equipment. At that time, the patient either surrenders it back to the contractor or agrees to use the equipment and takes over the rental payments previously made by the AHS.

The intention of the pilot is to trial the hospital equipment loan arrangements first and then trial the management of the PADP equipment at a later date. While the trial was initially intended to begin on 1 March 2006, the arrangements have been postponed while awaiting the recommendations of this review.

In planning the initial pilot, it appears that it would not be cost effective for the contractor to supply only one hospital. The estimated cost to the AHS for the supply of two months of equipment for patients discharged over a year was in the range of \$4,000 to \$5,000.

Options for improvement

There appears to be the following options:

- 1 Contract out some aspects of the management of equipment (e.g. delivery, retrieval, maintenance, repairs, register).
- 2 Contract out all aspects of equipment management (e.g. purchasing, assets register, delivery, installations, training support, retrieval, repairs, replacement, training etc).

Recommendation 29

A pilot program commencing with Liverpool Hospital should be undertaken over a suitable period, say six months, to trial contracting out arrangements for the supply of equipment for two months for discharged patients and subsequently evaluated. A formal objective evaluation should be conducted of the pilot including measures of access, efficiency, cost effectiveness, and staff and client satisfaction.

Should the initial evaluation be favourable, the trial should be extended to include hospital loan arrangements for an entire AHS and also include PADP, with a similar evaluation process.

Based on these trials, consideration should be given to contracting out all aspects of equipment purchasing and management. Contracts could be on an Area by Area arrangement or for the whole state.

7.6.4 Change of Name

During the review several comments were made that the current name of the program, making reference to 'disabled people' is inappropriate. The consensus is that a preferred name would be Program of Aids for People with Disabilities – PAPD.

Recommendation 30

That the name of the program be changed to Program of Aids for People with Disabilities – PAPD.