Submission - Les Barnes **24/07/2010**

This submission focuses on the provision of Prosthetic and Orthotic (P&O) services throughout Australia and the need for improvements to overcome treatment inequities.

P&O EXPERIENCE

A background to the information contained, a brief summary of the extent of my P&O experience is included;

- Worked as a Prosthetist/Orthotist from 1976 to 1980 for the Commonwealth Dept. Veterans Affairs providing prosthetic and orthotic treatments in Victoria from the Repatriation Artificial Limb and Appliance Centre (RALAC) in Melbourne.
- Employed as a Tutor and later a Lecturer at La Trobe University's National Centre for Prosthetics and Orthotic (NCPO) clinic from 1980-1994 and 2000-2010 teaching Prosthetic and Orthotic education as well as providing P&O clinical treatment services.
- Manager of the P&O dept. (1994 -1999) in the Northern Territory (NT) Health Service based in the Royal Darwin Hospital administering and supplying P&O services including expanding regional P&O services throughout NT clinics.
- Established a private P&O service in Darwin (Territory Orthotics and Prosthetics) from 1999 -2000.

SUMMARY

In Australia, the P&O services are of a high international standard. However, reorganizations that have been introduced by state and federal governments have lead to numerous inequities in the provision of prosthetic and orthotic services. In 1974, the Commonwealth Government introduced the "Artificial Limb Scheme" (ALS) to provide prostheses. Although promised, no equivalent scheme for orthotic treatments have been adopted "**Orthoses (devices to support the body or a limb) are not available under the SAALS."** http://www.alsa.org.au/pub/saals.pdf although there is no clinical reason why orthoses should not be treated similarly to prostheses. Since its implementation, the ALS has not been updated to include many of the advanced components that have been developed since the scheme was implemented "…**residents of New South Wales are eligible for admission to the Artificial Limb Scheme (ALS)…. The ALS provides funding for a standard prosthetic limb"** http://www.apcprosthetics.com.au/faqs.html State governments introduced insurance schemes such as motor vehicle accident (Transport Accident Commission-TAC) and employment work place (Workcover) which have accepted the need for using advanced prosthetic components. This means that amputee clients who have state coverage from TAC, or Workcover, are able to access advanced (and more expensive) components while most ALS clients are limited by funding restrictions. **"Artificial limbs incorporating hydraulic, pneumatic, myoelectric and other non-standard components are not available through the SAALS."** http://www.alsa.org.au/pub/saals.pdf

Most orthotic clients are at an even greater disadvantage because they have to self-fund most or all the cost of their treatments that are not provided by a hospital.

DISABLED TREATMENT INEQUITIES

There are many inequities in the provision of Prosthetic and Orthotic treatment services in Australia. For the purpose of clarity, this document identifies two areas such as:- "Cross Client Inequities" and "Cross Facility Inequities". Cross Client Inequities can be defined as those unequal treatment benefits available to similar clients irrespective of their geographical location. Cross Facility Inequities are the unequal client treatments for similar groups depending on the region, state or territory geographic location.

CROSS CLIENT INEQUITIES

Disabled amputee clients may require identical prosthetic clinical services, yet inequities between those funded by the ALS and those funded by TAC or Workcover can be vastly unequal. ALS clients are limited to basic components in their prostheses whereas insurance clients have functional assessment to guide prosthetic prescription. This anomalous situation is more obvious when comparing two amputee prescription processes:-

Example 1 If we compare an amputee client who loses a limb as a result of cancer to a like amputee client who loses a limb in a motor vehicle or workplace accident, the differences are most apparent. In Victoria, the Transport Accident Commission (TAC) approves funding for client treatments from motor vehicle accidents. This structure for motor vehicle accidents applies throughout the states and territories of Australia. The cancer amputee client has their prosthesis funded by the ALS and is therefore limited to a "standard" prosthesis while the TAC assessment process uses the American "K" activity

level assessment identifying components that are suitable for the higher impact or high activity level. **"Mobility Class 4 – Unrestricted Outside Walker with very high demands. Componentry rated at this level with a maximum of $1,000 per foot. Knee unit to a value of $2700 may be provided."** http://www.health.wa.gov.au/walsa/faqs/index.cfm This means that under the ALS, the amputee client could be limited to a basic prosthesis costing about $4,000 while under the TAC (or Workcover) scheme, they may be provided with a prosthesis costing more than $60,000. Specific components (which are more expensive) are excluded from the ALS client but are recognised as beneficial and available to the TAC client.

Example 2 A child who is born with a congenital limb deficiency has an entitlement under the ALS and consequentially is inequitably treated when compared to a TAC child amputee client at the same anatomical site. Under the TAC or Workcover assessment that uses the "K" activity level assessment, which includes children who are very active members of our community and would benefit from the more advanced higher impact or high activity level prosthetic components. They are eligible for funding from TAC but are not eligible to have these funded as ALS clients. **"Mobility Class 4 – Unrestricted Outside Walker with very high demands. Componentry rated at this level with a maximum of $1,000 per foot. Knee unit to a value of $2700 may be provided."** http://www.health.wa.gov.au/walsa/faqs/index.cfm While most administrators of the state administered ALS include the ability to vary the prescriptions for needy clients, the documentation discourages the acceptance of "Non-Standard" components.

Recommendation 1

The application of a standard functional assessment like the universally applicable "K" activity level process to all Australia's P&O clients would enable all eligible disabled people to be funded for prostheses or orthoses based on their activity and functional needs rather than have some with this provision procedure, and others to be limited by financial constraints without consideration of their functional needs.

2nd Class Citizens

Another Cross Client inequity situation occurs for those 2nd class citizens who are orthotic clients. They get lesser support for orthotic health service treatment compared with more extensive treatment available for prosthetic clients. There is no equivalent of the Artificial Limb Scheme to fund basic orthotic treatments for orthotic clients. This means that orthotic clients without TAC or Workcover insurance requiring major repair or replacement of their "splints" may opt to defer treatment because of the costs involved. There is no clinical reason for a lesser treatment service or a more limited treatment protocol.

Recommendation 2

The provision of orthotic services should be funded on the basis of assessed functional need in a manner similar to amputees with TAC or Workcover funding support.

Cross Facility Inequities

In the past, the Department of Veterans Affairs was responsible for the ALS in Australian states & territories and provided most prosthetic services. While it would be unwise to reconstruct that unwieldy administrative structure, it did ensure that a more coordinated and consistent prosthetic service was available nationally. Since the dissemination in 1994-1998 of the ALS to the states, cross facility inequities have increased. There are now extensive variations between P&O treatments depending on which region, state or territory health department is providing the service. Some regions are able to be more "flexible" in the provision of services while others are less flexible because of insufficient funding available for the provision of advance prostheses and orthoses. The restriction of advanced components can directly impact on the quality of life of disabled people. Some facilities use more advanced components and others do not have funds for this treatment approach.

Recommendation 3

There is a need for an equitable, consistent, national P&O service administration to ensure that P&O treatments, techniques, components and services are provided based upon an objective functional assessment. A National Orthotic and Prosthetic Administration Committee (NOPAC) structure could be created to coordinate and oversee the provision of equitable P&O services throughout Australia and ensure that sufficient funding is gained to meet the functional needs of Australian P&O clients. To implement the decisions locally and administer the system, state/territory branches of NOPAC may need to be part of State/Territory Health Departments. It could also be useful for P&O rehabilitation research and development to be coordinated through a NOPAC.

Conclusion

Restriction of P&O treatments, components and services because of unreasonable financial or inequitable constraints, curbs the ability of people with disabilities to fully participate in our society. The perceived financial benefit of P&O service restriction is greatly outweighed by the social cost of disability debasement.