We wish to thank the Productivity Commission for the opportunity to provide information to assist the Commission in its efforts to improve disability care across Australia. Our area of expertise is in the provision of prosthetic services. Collectively we have over 100 years of experience providing services to Australian amputees. We also have extensive knowledge and experience of how prosthetic care and treatment is provided internationally.

Amputee Services:

Within the 8 states & territories of Australia the current models of prosthetic service provision were introduced as an outcome of recommendations from an Industry Commission Report around "Aids and appliances to people with disabilities" from July 1990. These recommendations led to the devolution of the Nationally funded model of prosthetic service provision that was provided under the Free Limb Scheme (FLS) which had been introduced in 1973. The management of Prosthetic Care is run by the individual State Departments of Health, with each State using different administrative systems.

This devolution has lead to significantly different funding models, as well as different models of care being provided to amputees across Australia. For example: Victoria developed their programs within existing hospital structures and in conjunction with private contractors, while all the other states/territories introduced centralized delineation of services under an Artificial Limb Scheme, (ALS). These schemes require a minimum of 3 months from the time of amputation prior to being able to access services which is not considered to be best practice.

While service provision varies between states, territories & rural or regional areas, the services need to cover an "acute care phase" which may incorporate Pre-operative consultation & Early management treatments through such programs as the application of a Removable Rigid Dressing (RRD) and follow up compression therapies, interim services, and rehabilitation provision. (These services are currently funded under "Health" through such programs as Casemix funding.)

Following the rehabilitation phase, the service provision that needs to be accessed are those that support and assist with the lifelong management required following limb loss. These services are generally community based and are required to be accessed by clients for ongoing prosthetic care which may or may not include primary (everyday) prostheses, recreational prostheses, shower prostheses, and associated consumables. (These services are generally funded from various "disability portfolios".)

Diminishing services

There has been a diminishing of services & funds in real terms since the devolution of services to the state based ALS'. The "Review of the Commonwealth's Free Limb Scheme" report of September 1990 indicated that the provision of services for amputees would include cosmetic limbs, recreational limb and spare limbs as standard practice. (See Appendix B) These are no longer available to ALS funded clients.

There have also been limited improvements to services across Australia in terms of access to appropriate 21st century technologies. Average funding of a prosthesis has not increased in real terms

from the appropriate technologies of the 1970's. Most ALS' have seen only CPI increases in funding rather than Health CPI which would indicate that in real terms the program has either stagnated or suffered funding reductions. This has led to lower levels of care or compromised the outcome for the client. Sometimes the focus appears to be on cost minimization rather than the clients need. That is a general view shared by the practitioners in the sector.

The current under provision of services to Australian amputees can be seen starkly demonstrated by reviewing the services provided to those clients who have 3rd party insurance to assist with their care. The services that are provided are based on their needs from a "wholistic person centred" approach rather than a "this is the best we can do" approach.

Those who are covered by 3rd party insurance funded are not told that they can only have one device every 3 years, that there is no provision for limbs that assist with activities of daily living (ADL), ADL's such as showering or limbs that would assist with recreational activities - that when you want to go to the beach with your family you must hop with crutches as your limb will not last if it gets wet & sandy.

We believe that with a renewed national focus that service provision to amputees can be significantly improved. That amputee Australians can live much healthier and productive lives if the service provision of care and treatment programs were improved.

To ensure a service that is equitable and provides appropriate up to date prosthetic service provision to all Australians with limb loss, regardless of where they live, we recommend to the commission that the following initiatives be implemented:

1. **Establishment of a national scheme for prosthetic service provision**
2. **Establishment of a national prosthetic management panel**
3. **National data collection & benchmarking be set up for amputee services**
4. **Prosthetic workforce development plan is established and implemented**
5. **Prosthetic Service provision is provided by of both public and private service providers**
6. **Review & Re-structuring of Compensation Based Payouts**
7. **Prosthetic service provision be funded under a Medicare model**.

Many of these suggested reforms are inexpensive to implement and involve simple changes to current administration. Indeed some measures will reduce costs in the overall Health budget.

Thank you for your consideration of these recommendations.

APC prosthetics

Executive summary of recommendations:

1. **Establishment of a national scheme for prosthetic service provision**

1.1. This will ensure equity and equality of service provision for all amputees across Australia, irrespective of location or funding source and will ensure the removal of the current tiered systems of service provision.

1.2. More transparent and direct funding model which provides choice to the consumer (National based system for amputee funding.)

1.3. That funding for Amputee services be linked to the more appropriate Health CPI index and not the standard CPI index.

1.4. Increase funding for prosthetic components significantly to allow application of appropriate technology for all Australian amputees. Current approved technology is 1980s standard and moving backwards

1.5. Establish prescription rights & registration for AOPA P&O's

1.6. Voucher system to provide users with freedom of choice

2. **Establishment of a national management panel (incorporating users, professionals and government health department representatives) to review services, develop policy and manage projects**

2.1 Commit to best global practice with regular reviews of system by independent international and national P&O experts/ peers

2.2 Identify world's best practice and use this as the basis for a model of care

2.3 Use of "whole body impairment" system as basis for use of enhanced "K classification"

2.4 Funding based on enhanced "K classification"

2.5 Defined period of care linked to enhanced "K classification" system with mechanisms for regular review.

2.6 Development of national consumer federation for amputees to ensure a consumer "Voice"

3. **National data collection & benchmarking**

3.1 Research & establish benchmarks for current best practice in the industrial world for amputee management

4. **Plan for workforce development**

5. **Provide mixture of both public and private service providers**

5.1 Ensuring that with public private partnerships there are accurate cost structures in place and that the National Competition Principles are upheld.

6. **Review & Re-structuring of Compensation based payouts**

6.1 Ensure that life-long services are provided rather than lump sum payouts. With the ongoing developments in technology there can be no future security for clients who have payouts.

7. Prosthetic service provision be funded under a Medicare model.

7.1 Use of the Medicare levy for services

7.2 Consider funding Amputee services from a proportion of the taxes raised from the sale of tobacco products

Objectives to be achieved:

1. **Establishment of a national scheme for prosthetic service provision**

1.1 ***This will ensure equity and equality of service provision for all amputees across Australia, irrespective of location or funding source and will ensure the removal of the current tiered systems of service provision****.*

1.1.1 The need for a national framework is due to the significant disparity between and within states for services. Disparity arises both from geographical location and the cause of amputation. All amputees, no matter where they live in Australia should be able to expect an uncompromised service provision with appropriate prescriptions to maintain their quality of life.

1.1.2 While there are limited resources available for the provision of prosthetic services these resources need to be able to meet the individual amputee's care needs. Currently there are numerous layers of bureaucracy, that need to be funded, which, in essence, cause a "doubling up" of administration costs for each state & territory. Eg Policy development – information packs for users are all done by individual jurisdictions.

1.1.3 This will ensure equability of service for all Australians – no matter where they live - with the most appropriate service & device provision.

1.1.4 The new scheme should be open to anybody defined as disabled. Similar to Medicare – fair and equitable to everyone in Australia. Eligibility should also cover those who were born with the disability not just new incidents. It should also be for people with existing disabilities.

1.1.5 It will remove the inequality that is created by the "cause of amputation". The different prosthetic outcomes and long term rehabilitation results are vastly different when there is eligibility for 3rd party funding that provides a wholistic person centred approach rather than a "this is the best we can do" approach. This can make a huge difference to long term costs to the community especially when the person is attempting to return to work.

1.2 More transparent and direct funding model which provides choice to the consumer (National based system for amputee funding)

1.2.1 As indicated in the introduction there are 2 very distinct funding stages for prosthetic service provision. This creates a "funding divide". Some of the challenges created by this "divide" is that clients may begin their journey with a

limited choice of componentry due to the funding constraints within the hospital budgets & then have to re-train when they are accepted under the lifetime management programs such as the state based Artificial Limb Services. These services, which are run across Australia, generally have a minimum of 3 months time period from point of amputation prior to funding. This can reduce outcomes & increases costs. It also causes the client unnecessary stress in what is already a very stressful period for them.

1.2.2 This would also see a shift to the provision of a more wholistic view of funding. With programs that currently have the equivalent of static or reduced funding – for example increases in funding which are at CPI rather than Health CPI - there is no ability or "will" to seek global solutions. When the upfront cost of a service is greater but the outcome will produce savings to external health program then these services are not able to be considered as it "doesn't help our budget". For example, providing prostheses that improve comfort and fit will reduce GP visits & improve accessibility issues – such as reducing the need for home supports, carers, etc or the ability to work full time.

1.2.3 Another example would be where improvements to socket design have been utilized in Victoria & South Australia, with an initial increase in upfront costs but longer term value due to decreased ongoing visits and replacements as well as improved lifestyles – greater health and wellness. *(Bright spots - CGMC & OPSA)*

1.2.4 Currently there is no mechanism or body that considers the whole cost to the Health system of the treatment.

1.3 That funding for Amputee Services be linked to the more appropriate Health CPI index and not the standard CPI index.

1.4 Increase funding for prosthetic components significantly to allow application of appropriate technology for all Australian amputees. Current technology is 1980s standard and moving backwards

1.4.1 There have been limited improvements to services across Australia in terms of access to appropriate 21st century technologies. Average funding of a prosthesis has not increased in real terms from the appropriate technologies of the 1970's. (As indicated, increases in funding with CPI rather than Health CPI would see a program stagnant or reducing in funds.)

1.4.2 This would allow all Australian amputees to have prosthetic provision available to them that assists with better functional outcomes, such as easier integration back into society and decrease the life time costs to the community.

1.4.3 The introduction of national standards for componentary provision should also implement active promotion of services with co-contribution encouraged.

1.4.4 This should incorporate coding structures that are currently being constructed under the ICF &ISO standards which will assist with classification programs. For example: the Cliq classification, which is currently being developed within the Netherlands, utilizes principles that assist with the incorporation of electronic healthcare records.

1.4.5 The Industry Commission of 1990 was informed that: The availability of only standard limbs under the FLS was criticised by a number of participants. Workers compensation patients and veterans, who are not subject to restrictive prescriptions, were said to be routinely provided with higher-performing componentry considered more appropriate to their need.

(1) This practice that was identified in 1990 as a problem that still exists today. This Commissions recommendation needs to be enacted today.

1.5 Establish prescription rights & registration for AOPA certified P&O's

1.5.1 Certification/registration for prosthetists is required. This would require shifting from a self regulating profession to one that sits under the Australian Health Professional Regulation Agency.

1.5.2 Certification/registration for service providers and facilities is required. Developing criteria for facility accreditation would incorporate ISO compliances.

1.5.3 Funding for the enhanced "K classification" would be based on recommendations by AOPA in conjunction with the national funding/controlling body. They would establish a schedule of prosthesis types, components, hours etc which would then be used as the basis for establishing the funding available according to the classification.

1.5.4 AOPA would be the profession's peak body and all industry/professional discussion could be run through AOPA. They would need to greatly increase their fees and be run along similar lines as the AMA.

1.6 Establish a Voucher system to provide users with freedom of choice

1.6.1 A voucher system would be utilized for the provision of prosthetic services. The rehabilitation specialist would send the MDT's assessment and enhanced "K

classification" to be authorised by the national funding body who in turn will send the voucher to the patient and/or prosthetist.

1.6.2 This would include provision of a recreational type prosthesis which would tie in with the classification.

1.6.3 There would be a "provision of care" period tied into the voucher, during which the service provider is obligated to provide prosthetic treatment and provision at the set schedule for a period of time.

2 Establishment of a national management panel (incorporating users, professionals and government health department representatives) to review services, develop policy and manage projects

2.1 Commit to best global practice with regular reviews of system by independent international and national P&O experts/ peers

2.1.1 The policy maker that states "comfort is a lifestyle choice" not a functional requirement to a person with an amputation does not understand what is required to function and thrive as a human being or what being uncomfortable means when you are required to wear a limb for 12-18hrs a day.

To say that you can function with shoes that are too stiff or rub and then expect a person to do more than the basic ADL's is to relegate an individual to living as a second class citizen. To expect someone to wear anything for 12-18 hours a day everyday without "comfort" is cruel.

2.1.2 The panel would be required to fully review the scheme every 5 years.

2.1.3 Rather than having a lowest common denominator approach applied to amputee services we see this panel as taking a note of the "bright spots" from particular states or services globally, and providing a continuous quality improvement approach to services. Pilot programs could be run in different states trialing different methods and technologies. The results of the trials could be shared nationally.

2.1.4 This will ensure that there is a greater participation in & understanding of decisions made through the involvement of consumer groups & service providers.

2.1.4.1 For example: Currently in NSW – a prescription may be raised at a clinic with the MDT – which & who have been accredited by EnableNSW - this is then sent for "approval" to EnableNSW only to have its appropriateness questioned by someone who has never seen the client.

2.1.5 It will also provide the ability to rollout quality service improvements on a national scale.

2.1.5.1 For example: Early intervention Programs such as RRD provision & interim service provision are widely accepted in some areas and not in others.

2.2 Identify world's best practice and use this as the basis for a model of care

2.2.1 The current basis of service delivery is "where is the funding coming from?"; rather than, "what is the most appropriate model of care for a person with an amputation". At point of amputation they are funded under "Health" for their acute care and then as they move to ability as an amputee either with or without a prosthesis they are funded under "Disability services". This demarcation of funding can lead to people falling through the cracks or being left in "limbo" while awaiting access to a specific service. This is not world's best practice!

2.2.2 Interim care, while separated from definitive care, would have the same set of rules applied to both in terms of funding, defined period of care, and K classification assessment requirements.

2.2.3 The use of RRD would be part of world's best practice and the hospital based physiotherapist would be providing this treatment.

2.2.4 For example: Recent reviews of services to traumatic amputees have been published by the US Veterans Administration. They have stated that the improvements to their model have created a "paradigm shift" that has "been the major reason service members with limb loss elect to continue their military career." Their services were redesigned to "achieve the highest level of physical, psychological and emotional function." (2)

2.2.5 It utilised a "person centred approach" that "recognised the need to partner with the veteran with limb loss for lifelong VA support". Recognition of the importance peer support – helping fellow wounded survivors - has been a significant part of their program. (2)

2.3 Use of "whole body impairment" system as basis for use of enhanced "K classification"

2.4 Funding based on an enhanced "K classification"

2.4.1 Funding for prosthetic care should be based upon the K classification, and this should be enhanced to provide greater finesse for each classification. Something similar which specialists use to measure "whole body impairment". Each K classification will then have a set fee for provision of prosthesis and/or prostheses

for a particular patient, and there will be a "defined period of care" timeframe that the funding will cover. By accepting the patient, the service provider will cover all prosthetic costs including componentry, treatment, training, repairs, adjustments, consultations etc for a set time frame.

2.4.2 All amputees must be assessed by the MDT. The rehabilitation specialist will coordinate the assessment and classification of the patient according to the above. This classification then determines the funding available for a prosthesis/prostheses and the prosthetist then fits what he/she believes the client needs using the funding level available. If the prosthetist believes the classification is inadequate or the client appears to gain a higher classification over time than originally assessed, the client must return to the rehabilitation specialist for another assessment. This entire exercise will eliminate any bias or favouritism amongst clinical teams. The client will naturally be reviewed and cared for by the clinical team, but we separate the classification and actual prescription.

2.5 Defined period of care linked to enhanced "K classification" system with mechanisms for regular review.

2.6 Development of national consumer federation for amputees to ensure a "Voice"

2.6.1 This group would provide information around services as well as ongoing peer support programs and inclusion in policy programs.

2.6.2 A national federation for amputee consumers. It would be a Federation for all amputee user groups to provide a cohesive voice for Australian amputees and it would allow the current functions of local peer support to be maintained while still having an ability to represent the whole community on a national scale to prevent the current disparity of services across Australia.

2.6.3 With current state based funding, amputees are unable to have a collective voice that can be heard. They are currently a minority within a minority. Funding for these services has not been truly reviewed from a national perspective to ensure equability of access since before the introduction of the state based services. This means that small programs inside large state health budgets are consistently being required to make the same percentage cuts as the larger programs. This prevents amputees from effective representation in advocating ongoing advancements to improve their functional outcomes. This puts amputees at a disadvantage to larger and better funded community groups.

3 National data collection & benchmarking

3.1 Research & establish benchmarks for current best practice in the industrial world for amputee management

3.1.1 Current leaders in the area of amputee care and treatment are the North American and Western European countries, in particular the Netherlands. Australia could learn from these countries practices.

3.1.2 Being a national scheme would enable the set up of a more effective data collection system around amputee service provision. It would ensure that there is an understanding of the percentages of all major amputations and their outcomes rather than the current status of uncertainty as to the outcomes of all amputees.

3.1.3 With an improved understanding of the outcomes there will be a greater ability to provide appropriate resource application & development. It would remove the uncertainty as to whether all clients are being referred appropriately – whether to rehabilitation with a prosthesis or without. It would also help remove the current uncertainty around who is accessing services. Is everyone being given the appropriate information around services that are provided for amputees?

3.1.4 The database could be run through a web-based platform that would provide ease of access & assist with the national inputting of data and the collection of outcomes for amputees.

3.1.5 It would assist with the development of the ongoing collaborative research required to develop evidence based practise guidelines & clinically based research programs

3.1.6 For example: The Cliq – classification, currently being developed by the Netherlands, utilizes principles that will assist with the incorporation of electronic healthcare records. The classifications are based on functioning & participation for the individual.

3.1.7 Technological approaches that could assist with more empirical data for service provision could be implemented such as the introduction of Step watch type technologies with the inclusion of the Galileo System.

4 Plan for workforce development

4.1 There are currently significant career path issues for clinicians.

4.1.1 Inequality between pay rates provided to public service clinicians & hourly rates that are paid to private providers do not seem to match up with the government's

commitment to the "Competition Principles Agreement". It also limits the development opportunities for clinicians to experience different types of practise.

5 Provide mixture of both public and private service providers

5.1 Ensuring that with public private partnerships there are accurate cost structures in place and that the National Competition Principles are upheld.

5.1.1 The multidisciplinary team (MDT) approach to rehabilitation is well documented in its improved outcomes to clients. There is a need to be committed to the reduction of barriers to the "team without walls" approach for all amputee services. To be able to access services from a wide variety of service providers regardless of location.

5.1.2 There is often a misconception as to the funding and provision of service for prosthetic service provision. Generally people will speak of public & private service providers. IT would be better to see the comparison as the difference between medical officers & visiting medical officers in the hospital service. The majority of services are provided under the ALS' schemes around Australia – which are a capped priced or capped tendered system, being a "private" practitioner simply means that there are significant costs to services that have been shifted from the public to the small business owner.

5.1.3 The mixture of public & private service providers will give the client greater input into their treatment as they will have more options & choice.

6 **Review & Re-structuring of Compensation based payouts**

6.1 ***Ensure that life-long services are provided rather than lump sum payouts – with the ongoing developments in technology there can be no future security for clients who have payouts*****.**

6.1.1 National re-structuring of compensation payouts – similar to TIO in NT, or TAC in Victoria which are required to ensure that there is lifelong service provision to all clients. Currently, there is no realistic ability to predict the future changing needs of the individual or of technologies.

7 Prosthetic service provision be funded under a Medicare model.

7.1 Use of the Medicare levy for services

7.1.1 Currently amputee care does not come under the Medicare system

7.1.2 Consider the appropriateness of implementation of the ICD coding & cores sets as the basis for funding

7.1.3 Review Casemix funding for Amputations. It should get reviewed on a regular basis to accommodate changing practices.

7.2 Consider funding Amputee services from a proportion of the taxes raised from the sale of tobacco products.

7.2.1 A major, and growing, number of amputations are caused by circulation problems. A contributing factor to this condition is smoking. Obtaining a proportion of the taxes raised from the sale of tobacco products to assist in the funding of treatment of amputations would seem to be justified on health grounds. We would request the Commission to examine this issue.

Appendix A:

Glossary & Abbreviations:

"ADL's" Activities of Daily Living

"AMA" Australian Medical Association

"AOPA" Australian Orthotic & Prosthetic Association

"Artificial Limb Scheme" (ALS) is a Government Scheme that provides artificial limbs (prostheses) to eligible Australian residents.

"CLiq" (Classification with IQ) is derived from ISO 9999, providing more detailed categories than the original classification. It was developed in the Netherlands. To the original six-digit codes (3 pairs of two digits) of ISO 9999, a maximum of six extra digits (three pairs of two digits) are added. With these additional digits, the 'product related intended use' of the products can be described. 'Product related intended use' is a legal term that indicates what the user can and may expect of the assistive product. It encompasses the following characteristics:

- functionality: activities (indirect participation) for which the assistive product can be used (such as standing and work) and functions and structures supported by the product (such as respiration and a joint's range of motion)
- technical characteristics
- user friendliness
- external and cosmetic features (eg. color)
- other characteristics

It is important to match the wishes of the user with respect to the assistive product (human related intended use) (coded in ICF terms) to the characteristics of the products (product related intended use) (in Cliq codes).

Heerkens YF, Bougie T, de Kleijn-de Vrankrijker MW. 2010. **Classification and terminology of assistive products.** In: JH Stone, M Blouin, editors. International Encyclopedia of Rehabilitation. Available online: http://cirrie.buffalo.edu/encyclopedia/article.php?id=265&language=en

"Free Limb Scheme" (FLS) Nationally funded model of prosthetic service provision that was introduced in 1973, and administered by the Commonwealth under the Department of Veterans Affairs.

"Galileo System" Objective Patient Assessment System for Evidence Based Practice **http://orthocareinnovations.com/galileo/pdf/galileo.pdf**

"ICF" The International Classification of Functioning, Disability and Health, known more commonly as ICF, is a classification of health and health-related domains. These domains are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a

list of domains of activity and participation. Since an individual's functioning and disability occurs in a context, the ICF also includes a list of environmental factors. http://www.who.int/classifications/icf/en/

"ISO" The International Organization for Standardization (http://www.iso.org)

"K Classification"

These are descriptive functional levels from the American Orthotic and Prosthetic Association (AOPA) used by manufacturers in classifying components.

K0	Functional Level 0	The patient does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
K1	Functional Level 1	The patient has the ability or potential to use a prosthesis for transfer of ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
K2	Functional Level 2	The patient has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
K3	Functional Level 3	The patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic utilisation beyond simple locomotion.
K4	Functional Level 4	The patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress or energy levels. Typical of the prosthetic demands of the child, active adult or athlete.

Gailey, R., Roach, K., Brooks Applegate, E., Cho, B., Cunniffe, B., Licht, S., Maguire, M., Nash, M. (2002). **The Amputee Mobility Predictor: An Instrument to Assess Determinants of the Lower-Limb Amputee's Ability to Ambulate.** *Arch Phys Med Rehabil,* **83**, 613-627

"MDT" Multidisciplinary team - a group of health care workers who are members of different disciplines, each providing specific services to the patient.

"P&O" Prosthetist & Orthotist

"Removable Rigid Dressing" (RRD) A post surgical dressing that aids wound healing, assists with oedema reduction and provides protection to the residual limb.

"Step watch" Objective quantitative measures of physical function have become increasingly important throughout many areas of medical, rehabilitation, health maintenance, and behavioral research and practice. The StepWatch™ activity monitor provides a reliable, unobtrusive means for obtaining such data. This highly accurate instrument allows users to easily record the number of steps a person or large animal takes every minute in normal daily life for up to six continuous weeks per session.
http://www.nichd.nih.gov/about/org/ncmrr/prog_bsret/stepwatch/index.cfm

"team without walls" **"**Team members may be seeing the same patient at different locations in the same day, making direct communication more of a challenge.

This "team without walls" demands increased effort and attentiveness to continue to work toward the common goal of maximum recovery and rehabilitation after limb loss. It demands increased efforts for the various providers to communicate on behalf of the patient."
http://www.oandp.org/jpo/library/2004_03S_006.asp

References:

1. Industry Commission **Aids & Appliances for People with disabilities.** Report No.3; 18 July 1990 Australian Government Publishing Service, Canberra. ISBN 0 644 12955 7 pg 95

2. *Gayle E. Reiber, PhD, MPH; Douglas G . Smith, MD* **VA paradigm shift in care of veterans with limb loss.** *J Rehabilitation Res Dev. 2010; 47(4) Editorial*
http://www.rehab.research.va.gov/jour/10/474/pdf/reibervii.pdf

Resources:

KPMG Peat Marwick Management Consultants **Artificial Limbs Scheme - Commercial limb Manufacturers Hourly Rate Formula** - January 1991; ALS91/1501

Stewart J, McCarroll A, Cameron I & Wilson J. **Review of the New South Wales Artificial Limb Service. NSW Health Department's Final Report.** June 2004.

Appendix B:

Department of Veterans' Affairs

Review of the Commonwealth's Free Limbs Scheme

Final Report

September 1990

3.5 The possibility of a contribution has been considered on a number of occasions since the FLS was introduced. In 1977 the Department of the Prime Minister and the Department of Health opposed the imposition of a means test on the grounds that:

3.5.1 The existing Scheme was excellent and met a real need;

3.5.2 There was little possibility of abuse of the Scheme and the question of abuse had not arisen;

3.5.3 Savings would be insignificant; and

3.5.4 The community may see it as an extremely mean imposition. (2)

3.6 A Cabinet Submission of 15 June 1977 pointed out that:

3.6.1 50% of persons supplied with artificial limbs were aged 60 years or more;

3.6.2 45% were pensioners (Aged, Invalid or Repatriation); and

3.6.3 40% were hospital patients requiring first limbs.

3.7 The Submission noted the number of pensioners and argued that children and those exempt on income grounds from the Health Insurance Levy should be provided with free artificial limbs (which left almost no one else to charge). It also argued that, under the Hospitals Agreements, charges could be levied against the hospital on a cost sharing basis. Cabinet decided to continue the supply, free of charge, of artificial limbs to Australian residents who were in need of them in all cases except where the patient was considered compensable. (3)

3.8 In February 1978 a paper was prepared for the then Minister to reconsider the imposition of a moiety for the supply of artificial limbs. The Minister enquired as to the practicability of setting a limit on the number of replacement limbs which may be provided. He was advised that there was an effective limit on the number or replacements due to medical assessment of need by the prescribing clinician and that it would not be practicable to set limits on the frequency of replacement or the number of limbs. (4)

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(2) Philip Anderson, History of the Free Limb Scheme 1973-80 Part II, D.V.A., Canberra, August 1980, p.13.
(3) ibid., p. 14.
(4) ibid., p. 15.

Attachment E

highlight any obsolete items which might be deleted as well as proposing appropriate new items. The NLB approved componentry list should then be subject to continuous review.

5.6.2 The NULPO prepare a matrix and/or prescribing guidelines, for approval by the NLB, to be issued to all authorised prescribers/amputee clinics and manufacturers and then ensure these are regularly updated.

Supply of Non-Standard Componentry

5.6.3 Approval be granted for the free supply of non-standard items where there are compelling clinical and/or welfare reasons which satisfy the prevailing guidelines, but not solely or primarily for reasons of patient preference.

5.6.4 Where amputees choose non-standard componentry solely or primarily for reasons of personal preference, they continue to contribute the cost difference between the equivalent standard item and the total cost of the limb.

Cosmetic Limbs

5.12.1 Cosmetic limbs be made available under the FLS.

5.12.2 Rules for the supply of cosmetic limbs be incorporated by the NLB in its approved guidelines for prescribers.

Recreational Limbs

5.14.1 Recreational limbs continue to be made available under the FLS.

5.14.2 Rules for the supply of recreational limbs be incorporated by the NLB in its approved guidelines for prescribers.

Second or Spare Limbs

5.16.1 Second or spare limbs be made available on geographic or occupational grounds or because of an amputee's domestic circumstances.

5.16.2 Rules for supplying second or spare limbs be incorporated by the NLB in its approved guidelines for prescribers.

5.16.3 The incidence of prescribing second or spare limbs be closely monitored by the Secretariat (using its automated database) and regularly reported to the NLB.

Replacement Limbs

5.22.1 Rules for supplying replacement limbs be incorporated by the NLB in its approved guidelines for prescribers.

5.22.2 Expenditure on replacement limbs be closely monitored by the Secretariat (using its automated database) and regularly reported to the NLB.

Information Services

6.8.1 The NLB arrange the preparation of a range of multi-lingual material addressing at minimum the issues listed in paragraphs 6.2 and 6.3, and ensure such material is always readily available to amputees through public hospitals, amputee clinics, RALACs, commercial manufacturers and other appropriate sources.

6.8.2 The NLB, in cooperation with State and Territory health authorities, ensure that amputee rehabilitation teams and other appropriate health workers are fully versed in all aspects of the FLS.

6.11.1 The NLB arrange the ongoing distribution to prescribers, manufacturers and other interested parties of guidelines, technical bulletins, such information listed in paragraph 6.8 as seems appropriate, and other relevant material.

6.11.2 In particular, detailed but clear profiles periodically be sent to each approved amputee clinic showing prescribing patterns in their own and all other clinics.

Consumer Participation

6.21.1 The NLB seek ways to enable amputees and their families to become more involved in the FLS.

6.21.2 Selected amputees, chosen by the research team, participate in evaluating new componentry.