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Australian Orthotic Prosthetic Association

Submission Relating To Orthotic Services for People with Physical Disabilities

Dear Sirs,

Thank you for the opportunity to contribute to the Productivity Commission's review of Disability Care and Support. The Australian Orthotic Prosthetic Association (AOPA) is Australia's peak representative body for prosthetists (clinicians who provide artificial limbs) and orthotists (clinicians who provide braces & supports). It represents approximately 300 members across Australia from a workforce of approximately 400 nationwide. This submission to the Productivity Commission seeks to comment upon orthotic service funding systems and the care of people who have a wide range of physical disabilities and who rely upon these services.

This submission is an initial attempt to outline the current platform of care across the states and territories of Australia, and provide some broad recommendations for a more successful model in the future.

We subsequently humbly request that the Productivity Commission permit further contributions from AOPA following this initial submission.

There is no disputing that the current systems that fund the provision of orthotic services are heavily flawed, varying widely across the nation in terms of access and regulation. Independent workforce analysis shows Australia has far fewer orthotists than are required to meet the ongoing and growing demands to provide services for people with physical disabilities. Long-term sustainability of service provision is under threat and requires a well considered plan to ensure long-term capacity meets the community's needs. We hope our initial and further future submissions may shed some light on how an equitable and efficient system based on world's best practice may be constructed and implemented.

Terminology and scope of practice

An **Orthotist** is an allied health professional and clinician who practices in public hospitals or the private sector. The Orthotist's role is to assess, prescribe, apply and provide education regarding the use and care of an

appropriate orthosis that serves the individual's requirements. Orthotists care for a large and diverse group of Australians. An **orthosis** is the true term for a brace or appliance that is designed and fitted to the body to achieve one or more of the following goals:

- Control biomechanical alignment
- Protect and support a healing injury
- Assist rehabilitation
- Reduce pain
- Increase mobility
- Increase independence

Several professions may fit a smattering of orthoses and splints in the course of their work (physiotherapists, chiropractors, podiatrists), however there are very few professionals who are qualified and trained to fabricate and fit **custom-made orthoses**. These professions include podiatrists (custom fabricating foot orthoses), occupational therapists (custom fabricating hand orthoses) and orthotists (custom fabricating orthoses for all parts of the body). Only orthotists are specifically trained in the fabrication, design and fitting of a vast array of custom orthoses.

People with physical disabilities most often require custom-made orthoses that are designed to last for a long period of time. Most often, only orthotists have the training and skills to provide such orthoses.

Benefits of orthotic services

Benefits to people with physical disabilities

Examples of orthotic assistance that are utilized by people with chronic or permanent physical disabilities :

Arthritis - With degenerative changes to lower limb joints in the Osteo or Rheumatoid arthritic patient, the role of the orthotist is often two fold. Firstly to reduce symptoms of chronic pain by providing foot orthoses that distribute pressure evenly, unloading the painful prominent joint or bony projections often found in this foot type. The second role of orthoses is to assist in prevention of further deformity. Foot orthoses are often utilised but more advanced deformities require Ankle Foot Orthoses (AFOs) or Knee Orthoses (KOs) to control the ankle as well.

Cerebral Palsy - Many children with cerebral palsy (CP) have to manage the complications of either hypertonicity (spasticity) or hypotonicity (weakness). Both types of CP patients often require orthoses such as AFOs to maintain the foot and ankle in a functional position to enable them to walk. Without AFOs walking or transferring would be less efficient or in some cases impossible. Unchecked spasticity often is followed by muscle shortening or contractures that severely affects the individual's ability to function or requires corrective surgery. Often orthoses are responsible for reducing or delaying the need for tendon lengthening surgical procedures. AFOs are also utilised following surgical procedures or Botox therapy.

Diabetes - Foot orthoses and Medical grade footwear are essential for maintaining the high risk foot from injury or trauma. Complications and costs of ulceration in the neuropathic foot to the health care system are substantial. Treating a neuropathic ulcer requires a multidisciplinary team to heal the ulcer and return the patient to their previous status. Ulcers can take months to heal and if infection in the bone (Osteomyelitis) occurs amputation often follows. Prosthetists then provide the relevant prosthesis.

A destructive condition called the Charcot Foot can occur in the *diabetic* or *neuropathic* foot or ankle. Orthotists are directly involved in applying serial plaster casts to prevent further deformity of the weakened bony structures, often for 4-6 months or until this foot is diagnosed as being past the acute stage. A protective removable AFO called a Charcot Restraint Orthotic Walker (CROW) is then custom-made to maintain the foot and ankle positioning often for 6-9 months. Following the removal of the CROW, foot orthoses and suitable medical depth and width footwear are required to maintain the foot in good health and reduce the likelihood of the return of this condition.

Polio - The assessment and prescription of Knee Ankle Foot Orthoses (KAFOs) by orthotists often mean the difference of an individual being an active community walker or not. Without KAFOs these patients would be dependent on wheelchairs for mobility and require carers for transfers and limited standing. Paralysis associated with lower motor neurone disease means the lower limbs cannot support the individuals own body weight. KAFOs control this weakness and often correct deformities or prevent further deformity from occurring.

Stroke - Many individuals who have had upper motor neurone disorders like stroke patients are dependent on AFOs for their everyday mobility. The AFOs allow these people with paralysis, spasticity or both, to continue to walk and perform activities of daily living. Stroke patients with foot drop and without AFOs often cannot walk and are a high falls risk.

Cost benefit of orthotic intervention

Independently determined benchmarks suggest resources and funding for prosthetic and orthotic services are equally deficient. Studies have shown the provision of well planned prosthetic and orthotic services greatly reduce total health budgetary costs. These cost reductions can be measured through a range of outcomes including a significant decrease in hospital bed stay, through to more rapid re-integration of the individual back into their community, and increased re-employment prospects.

Issues relating to the current disparate range of funding systems

Funding of orthotic and prosthetic services

Each state health department has developed its own model of care and funding, with a generally adversarial position taken with service providers. An initially under-resourced situation has further deteriorated in most states . There are now extreme differences in the standards and models of care provided to people with physical disabilities across Australia. Policy development, and subsequent ongoing service development has stagnated and in some states regressed.

The continued real term decline in resources dedicated to this area, and the lack of ongoing quality improvement and development of best practice care pathways has encouraged orthotists to move to differing careers, outside of clinical care. AOPA statistics show 60% of graduates leave the profession within 7 years of qualifying. Because the sole tertiary training facility is based in Melbourne, and remuneration rates in most other states often being well below that of Victoria, it is difficult to attract practitioners to areas outside of Victoria. This has dire consequences for the sustainability of services in most parts of Australia.

In most states, community patients, who are born with or who develop or acquire a physical disability, cannot access services and orthoses to the standard that compensable people with disabilities can (those who have become disabled as a result of road or occupational trauma). This imbalance is not equitable and requires

addressing. In most states of Australia, people who acquire their disability as a result of road or work trauma are ultimately provided with a payout of their insurance claim, and are made responsible for financially managing their lifetime orthotic care. This lump sum settlement in many instances is used not for ongoing lifetime orthotic care. Often clients mismanage these funds and then become reliant upon the government and community programs for their long-term care. Victoria and NT have systems by which settlements do not include major lump sum payments for lifetime care, but instead provide ongoing lifetime care, support and funding. This model appears to make a great deal of sense.

The majority of funding for prosthetic and orthotic treatment is provided by state governments under a range of diverse programs. The provision of services in hospital settings are generally funded by the hospital. However long-term rehabilitation programs and ongoing life-long care are generally not funded. Funding varies greatly from state to state, with some states able to provide funding for worlds best practice care, whilst other states are comparatively poorly resourced, resulting in the development of services that may be considered as falling short of international benchmarks.

Unfortunately only a limited number of private health insurance funds subsidise orthotic services and none of these insurers subsidise prosthetic services. Government resources provided through varied programs have been in decline in real-terms over the past decade. A coordinated approach to funding and service provision at local, state and federal levels is required to ensure successful outcomes.

Equipment Schemes

Equipment schemes that operate completely separately and with different guidelines and funding levels in each State, commonly provide some funding assistance, such that people with physical disabilities may access partial funding of necessary orthotic services.

- Some schemes fund pre-fabricated orthoses, whilst others only fund custom-fabricated orthoses
- The degree to which different schemes contribute to the funding of orthotic services varies markedly
- Some schemes do not fund orthotic services at all
- On the whole, schemes typically only fund a small portion of required funding for any given orthosis
- Often people with disabilities choose a cheaper, less effective option or choose not to have any orthotic management (even though they may require it), solely because they are unable to make the required co-payments (as some schemes only rebate a small portion of some items)
- Wait lists for funding vary markedly between states and even between area health services
- Other more expensive services (such as the provision of wheelchairs) often exhaust available funds and a long wait often exists for clients

DVA Funding of Orthotic Services

- Funding of orthotic services for eligible veterans vary between states
- Although orthotists are tertiary qualified, the DVA chooses to only employ podiatrists to assess applications for orthotic funding (which is particularly limiting, when anything above the ankle is required to be provided)

Immediate needs

In most states, well integrated and seamless services spanning acute, rehabilitation and long-term care does not exist and services are relatively uncoordinated. The most pressing need is to ensure a platform is established to deliver best practice and seamless pathways of care throughout the amputee's journey, irrespective of which

part of Australia the amputee is from. Funding for acute best practice inpatient services and good rehabilitation programs and systems is a prerequisite. Built into this must be a clear understanding of the different needs of metropolitan and rural/remote amputees.

The prescription of appropriate and modern technologies is vital to good outcomes, and a stagnation of funding for modern technologies over the past two decades in most states of Australia has greatly restricted the functional output and lives of most non-compensable clients. This must be addressed by collective review by independent experts.

To ensure replenishment of professional numbers and a sustainability of services today, a clearly defined national strategy is urgently required. The standardization of remuneration across the nation is a priority, as is the provision of incentives to encourage potential clinicians from all states to complete undergraduate qualifications at the National Centre for Prosthetics and Orthotics at La Trobe University in Melbourne.

Independent and expert economic and clinical analysis is urgently required, and benchmarks from nations who have best practice models in place need to be set in Australia. Unless realistic and independent analysis can be performed, we cannot move from the current adversarial position which exists between state health department funding bodies, people with disabilities, and service providers.

Future needs

We need to be able to benchmark services across the country and determine where we are succeeding and where we are failing. This benchmarking should encompass all components of care delivery including outcome measures, economic measures, efficiency measures, quality of life measures, etc,.

A national information system should be constructed and rolled out to ensure thorough and standardized data collection occurs across the nation. This data collection is a missing platform required for ongoing analysis and service development.

Equitable and transparent funding models for all states and service providers (whether public or private) in line with competitive neutrality legislation, will provide a sustainable environment for all services across the country. The AOPA agree with Physical Disability Australia's statement that there is a need for equity across the system nationally, in addition to more choice rather than random distribution of disability equipment.

Equitable and consistent care provision to all people with physical disabilities is required, irrespective of whether they become disabled in a motor vehicle accident and thereby have sufficient insurance coverage or whether their disability is of an uncompensable aetiology. The current system penalizes community patients who are not compensable.

There should be an end to third party compensation pay outs, and the adoption of TIO/TAC model of lifetime funding for compensable road trauma and work trauma amputees.

A workforce planning team should be established, to determine future personnel requirements, and develop a national strategy to ensure broad geographical and sustainable service provision.

Closing statement

Australian prosthetic and orthotic professionals are considered amongst the most highly trained and capable globally. We are seen as tremendously innovative and carry an international reputation for being committed to the delivery of world leading standards of care. We continue to strive to improve the lives of all Australians requiring prosthetic and orthotic care.

AOPA would like to thank the commission for the opportunity to contribute to this most important of tasks. We aim to continue to provide further submissions as greater feedback is received from our membership and from the wider industry. We offer our support and also offer our openness and willingness to discuss all issues with the Productivity Commission over the coming 18-months.

Yours respectfully,

AOPA National Council