



AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

SUBMISSION ON THE FUNDING AND OPERATION OF THE CSTDA

Presented to the Senate Community Affairs References Committee

Prepared by the

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Authorised by

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INTRODUCTION

With regard to the CSTDA, APA members are primarily concerned about jurisdictional inconsistencies and arbitrary barriers to accessing services and equipment for people with disabilities. These inconsistencies and barriers are inefficient and lead to sub-optimal therapy outcomes. The CSTDAs have in no way addressed these concerns.

A comprehensive review of the inconsistencies and their impact is beyond the resources of the APA. This submission therefore presents examples of the problems physiotherapists and their clients face on a day to day basis and makes recommendations as to how these problems can be addressed. This submission does not address issues relating to the quantum of funding. While there is no doubt a need for additional funding, this submission argues for more effective use of existing funds.

The APA is also concerned that the CSTDA, despite its focus on linkages, has not addressed duplication or communication between programs.

This is a brief submission intended only to draw the attention of the committee to problems that stem from multiple funding sources and in effective cost containment measures. The APA would be pleased to appear before the Committee to elaborate on these examples and explore the issues in depth.

RECOMMENDATIONS

The APA supports the development of a national strategy for the provision of aids and equipment.

The APA contends that a national strategy should include:

- Responsive and timely provision of aids and equipment for all people with disabilities that meet both their short and long term needs;
- Strategies to build national purchasing power in the equipment market, while retaining local individualised clinical assessment and provision;
- More inclusive and nationally consistent eligibility criteria;
- An end to arbitrary access barriers such as age; and
- Equitable access for people waiting for, and accommodated in, residential aged care facilities; people living in rural and remote areas; people with hearing and/or visual impairment; and for Indigenous Australians.

Equipment provision under the strategy should be from a single funding source under the next CSTDA.

The APA contends that barriers to services based on age and place of residence do not contain cost and instead foster inequitable outcomes. Therefore, access to services should be determined on clinical and therapeutic need, as assessed by relevant clinical experts, not on age, setting or other form of entitlement.

To ameliorate the impact of the late effects of disability, every patient should have an appropriately skilled case manager, who is funded to work with the patient, their family and their GP to ensure that the patient is assessed at appropriate times and identified needs are addressed by a multi-disciplinary team.

AIDS AND EQUIPMENT

Aids and equipment are products that assist a person with a disability by improving their functioning. Aids and equipment include specialised aids for breathing, eating, drinking, bathing, toileting, mobility, positioning (lying, seating, standing) and sleeping; home modifications, hoists, augmentative communication devices and environment control units. Aids and equipment can provide comfort, pain relief, safety and support and can assist in the pursuit of education, training, employment and participation in community life.

In Australia nearly half of all people with disabilities use aids and equipment to enhance their independence and improve their quality of life (ACROD, 2004). The 1998 Survey of Disability, Ageing and Carers in Australia (AIHW, 2003) found that 48% of people with a disability used some form of aid, and of this group 40% were under the age of 65 years. The use of aids and equipment was more likely in older age groups and for those with more severe activity restrictions, for example the number of aids used increased from 1.2 for people with mild activity restrictions to 3.5 for people with profound activity restrictions.

Access to free or low cost equipment is available through a range of independently operating Commonwealth, State and Territory based schemes. In addition, a range of non-government organisations fund and implement aids and equipment schemes. However, there are inconsistencies between the various schemes and access is generally based on eligibility criteria that are often difficult to navigate. Significant gaps in the availability and range of equipment exist and current schemes fall short in meeting demand and timely provision of appropriate equipment.

The APA commissioned a consultant in Victoria to document the availability of equipment for children with disabilities. This was done because clinicians are unable to keep abreast of sources of equipment for their young patients. A bewildering array of public and private sources was identified – and this is only for equipment for children in Victoria.

Patients requiring aids and equipment experience difficulties when they move between states, with some equipment available in some jurisdictions but not others. Furthermore, additional confusion arises with arbitrary aged-based barriers to equipment programs and there are even difficulties for Department of Veterans' Affairs patients. For example, one patient with a permanent tracheostomy was declined DVA funding for suction equipment and was then denied home modifications to make way for his existing equipment because he has a DVA card. Most alternative public funding options will exclude access to those holding DVA cards, hence this patient had no alternative funding source.

The setting in which a patient resides also impacts on access to equipment. An example is outlined below.

“The Victorian Aids and Equipment Program (VAEP) is a Victorian Government program which aims to assist children and adults to access subsidised aids, equipment and home modifications to enhance their safety and independence, support their family and carers and prevent premature admission to institutional care or high cost services.

Unfortunately, if a client lives in any sort of supported accommodation (ie a Residential Aged Care Facility) they are not eligible for equipment through VAEP and supported accommodation funding does not cover equipment purchase.”

“Patients being discharged from hospital to nursing homes are not eligible for equipment. I have had two patients recently in their 50’s and needing high level care who need motorised wheel chairs or custom made chairs to re-enter the community. Both patients have the family and community support necessary to re-enter the community but they can’t do so because of lack of equipment. If they lived in the community they would be eligible for equipment.”

Recommendation:

The APA supports the development of a national strategy for the provision of aids and equipment.

The APA contends that a national strategy should include:

- Responsive and timely provision of aids and equipment for all people with disabilities that meet both their short and long term needs;
- Strategies to build national purchasing power in the equipment market, while retaining local individualised clinical assessment and provision;
- More inclusive and nationally consistent eligibility criteria;
- An end to arbitrary access barriers such as age; and
- Equitable access for people waiting for, and accommodated in, residential aged care facilities; people living in rural and remote areas; people with hearing and/or visual impairment; and for Indigenous Australians.

Equipment provision under the strategy should be from a single funding source under the next CSTDA.

ARBITRARY BOUNDARIES

APA members regularly report that patients with disabilities ‘fall through the gaps’ between services. This may be because of their age or income or even due to the nature of their disability. Many such barriers apply in respect of

provision of aids and equipment and the examples above could equally apply to this section.

Arbitrary barriers appear to be aimed at cost containment but usually lead to expenditure in another area. Sometimes that expenditure is the time spent by health professionals or service providers trawling through a myriad of schemes to try and find a way for the client to access the service they need.

“Many children miss out on government funded interventions because their condition is designated as ‘mild’. These are children who, with a little intervention, could achieve great results and be active contributors to society. Also by providing intervention at a young age or at appropriate times, co-morbidities are often avoided. Co-morbidities potentially result in even more costly interventions.”

Age cut offs are counterproductive to the therapeutic process:

I am writing from my experience of more than 25 years working with patients with head injuries and five years specialising in the late effects of disability in patients with acquired brain injury. A young person who has not completed growing needs to be able to access physiotherapy services as required until such time as they stop growing. This access is usually available but young people often need further therapy to achieve their potential as they transition from child to adult services and funding for this often cuts off at 18 years of age. What they need is short bursts of physiotherapy periodically to ensure that they have maintained their skills. Without this they can easily decline and become more dependant.”

Late effects of disability refers to patients who have a congenital disability, such as cerebral palsy or spina bifida or who acquired a disability in early life, but do not have degenerative conditions such as multiple sclerosis. These patients continue to have care needs throughout their lives and many of these needs are unmet.

Patients experience poor transition from children’s to adult services and there is often a failure to recognise the effects of ageing on mobility. Programs generally are not transferable between supported facilities and the home environment and carers rarely have the opportunity to learn skills from therapists to assist the patient when away from supported facilities. In general, there is a lack of care coordination and insufficient support for therapy services to assist both patients and families.

Arbitrary boundaries impact on the whole family:

“I saw a patient today who is significantly impaired and has reached four years of age. In Queensland up until this age, children (who do not have a definite diagnosis) are cared for by Disability Services Queensland. She is now in limbo as she is awaiting treatment via the Cerebral Palsy league of Queensland. Last year she was funded in a

severe impairment banding and has now been “reclassified” into a moderate banding which has resulted in at least a \$12000 decrease in funding for the financial year. The child needs a lot of equipment as she has grown and the mother is now no longer able to distribute funding for respite. This means that she cannot go to work or support her other children at school and extracurricular events as her child with a disability is unwell and has high needs.”

Recommendations:

The APA contends that barriers to services based on age and place of residence do not contain cost and instead foster inequitable outcomes. Therefore, access to services should be determined on clinical and therapeutic need, as assessed by relevant clinical experts, not on age, setting or other form of entitlement.

To ameliorate the impact of the late effects of disability, every patient should have an appropriately skilled case manager, who is funded to work with the patient, their family and their GP to ensure that the patient is assessed at appropriate times and identified needs are addressed by a multi-disciplinary team.

INEFFICIENCY

The 2003-04 CSTDA Annual Report¹ describes progress toward making linkages with other programs, such as Home and Community Care, but a good deal of administrative duplication remains. For example, the minimum data sets for each programs overlap significantly, leading to duplication of administration for many providers. It would be useful to cut back on administrative red tape and duplication of reporting the two data sets.

The CSTDA aims to strengthen relationships; this is a laudable aim. To achieve this aim more attention is required to linkages and partnerships. A national strategy for the provision of aids and equipment, the removal or arbitrary barriers to accessing services and reduced duplication of administrative function will go a long way to achieving the aim and to improving services for people with disabilities.

¹ Accessed 8 August 2006:
[http://www.facs.gov.au/internet/facsinternet.nsf/vIA/cstda/\\$File/cstda_annual_report_0304.pdf](http://www.facs.gov.au/internet/facsinternet.nsf/vIA/cstda/$File/cstda_annual_report_0304.pdf)

REFERENCES

ACROD (National Industry Association for Disability Services) 2004. Newsletter.

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide. Version 1.0. Disability Series. AIHW Cat. No. DIS 33. Canberra: AIHW.