



RISK ADVISORY SERVICES

Department of Human Services

**Final Report of the Review of the
Aids and Equipment Program**

GOVERNMENT

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Disclaimer

This report has been prepared using financial and performance information provided to KPMG by the Victorian Department of Human Services (DHS). KPMG has relied on that information being accurate. KPMG has not undertaken any audit or other forms of testing to verify the accuracy, completeness, or reasonableness of financial and performance information provided. This work constitutes neither an audit nor a comprehensive review of operations. Accordingly, KPMG can accept no responsibility for any errors or omissions in the information shown in this report where it is based upon that information provided. KPMG is under no obligation in any circumstances to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

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List of acronyms

A&EP	Aids and Equipment Program
CACP	Community Aged Care Package
CAEP	Community Aids and Equipment Program
CASS	Continence Aids Assistance Scheme
CES	Community Equipment Scheme
CPI	Cost Price Index
CSS	Continence Support Services
DHS	Department of Human Services
DSD	Disability Services Division
DVA	Department of Veterans Affairs
EACH	Extended Aged Care at Home
ECIS	Early Childhood Intervention Service
GST	Goods and Services Tax
HACC	Home and Community Care
HARP	Hospital Admission Risk Program
HPV	Health Purchasing Victoria
ILEP	Independent Living Equipment Program
IT	Information Technology
LGA	Local Government Area
MASS	Medical Aids Subsidy Scheme
MHACS	Metropolitan Health and Aged Care Services
PADP	Program of Aids for Disabled People
RAP	Rehabilitation Appliances Program
SACS	Sub-acute Ambulatory Care Services
TAC	Transport Accident Commission
TIME	Territory Independent and Mobility Equipment
VWA	Victorian Workcover Authority

Introduction

1 Introduction

This section provides an overview of the approach taken in conducting this Review.

1.1 Objectives of the Review

In January 2006, KPMG were engaged by the Department of Human Services (DHS) Disability Services Division (DSD) to undertake a review of the Aids and Equipment Program (A&EP). The aims of this Review were to¹:

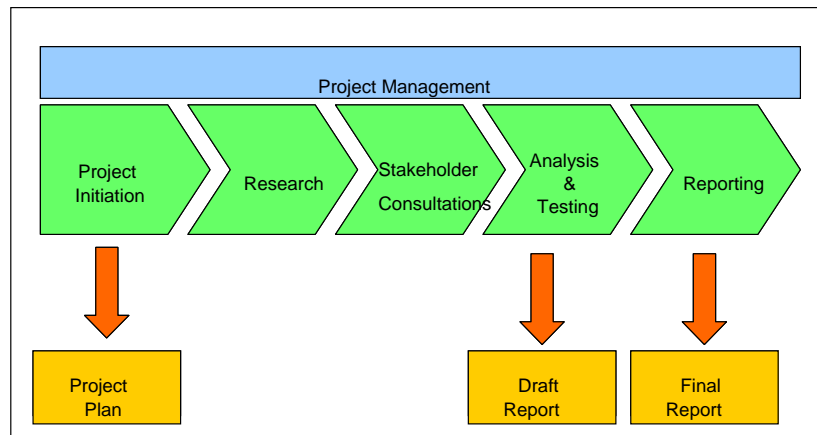
- conduct an analysis of the sustainability of the current A&EP, both from an administrative perspective and a demand perspective;
- consider the extent to which A&EP is meeting its stated objectives, especially in relation to specific client groups such as complex clients, children and the aged;
- identify and cost demand drivers and model projected funding requirements for aids and equipment from 2006 to 2011;
- identify the key elements required in an effective and efficient aids and equipment system;
- identify best practice A&EP models and examine their feasibility within the Victorian context;
- recommend a preferred model for Victoria; and
- recommend an implementation strategy from the current arrangements to the preferred model/s.

1.2 The approach

The Review was conducted using a five-stage approach, as shown in Figure 1 below. Further detail about the approach is contained at Appendix A.

¹ Department of Human Services, Disability Services Division, Request for Quote Aids and Equipment Program Review, September 2005, 7.

Figure 1 Approach to the A&EP Review



1.3 Governance

Governance for this project occurred through the:

A&EP Review Advisory Group – who provided advice to the KPMG Project Team and the Department. The principle functions of the Review Advisory Group were to:

- provide advice regarding processes and methodology for undertaking the Review;
- provide guidance on the most effective way to consult with the broad range of stakeholders, including people accessing A&EP and their families/carers, service providers and DHS staff;
- ensure the A&EP Review was aligned with the goals of the State Disability Plan 2002-2012;
- provide specialist knowledge on particular aspects of the A&EP as they related directly to the project, including accessibility, flexibility, viability, and quality; and
- respond to key themes and trends identified through the Review process and consider proposed opportunities to improve the way A&EP responds to people with a disability and the frail aged.

Management and support of the A&EP Review Advisory Group was provided by the Department. The Project Advisory Group meetings were held at:

- project initiation – 2 March 2006;
- completion of the consultation stage – 3 May 2006;
- completion of the interim report – 13 June 2006; and
- presentation of the draft final report for consideration of the findings – 13 October 2006.

The Terms of Reference and membership of the A&EP Review Advisory Group are provided at Appendix B.

A&EP Review Project Control Board – who provided Departmental project management and received the key deliverables. Discussions with representatives from this group were held at key milestones of the Review. Project Control Board meetings were held at:

- project initiation – 20 February 2006;
- completion of the consultation stage – 30 March 2006;
- completion of the draft interim report – 3 May 2006;
- consideration of options – 24 May 2006; and
- presentation of the draft final report for consideration of key findings – 13 October 2006.

The membership of the Project Control Board is provided at Appendix B.

1.4 The structure of the report

The report has been structured as follows:

- Section 1 provides an introduction to the review and the report;
- Section 2 outlines the current A&EP, its objectives, method of service delivery and current financial and performance trends;
- Section 3 describes the views of stakeholders regarding the strengths of the A&EP and opportunities for reform;
- Section 4 details the current government wide and program policy contexts that have a direct impact on the provision of aids and equipment to each of the key target groups;
- Section 5 explores the management of aids and equipment programs across Australia and internationally, highlighting key issues for the Victorian A&EP;
- Section 6 analyses the implications of the current arrangements, performance trends, linkages with the wider policy context and stakeholder experiences of the A&EP in meeting its stated objectives;
- Section 7 details the principles for change to guide service improvements and to ensure that the A&EP is more closely linked to contemporary policy objectives; and
- Section 8 provides key recommendations for improving the A&EP in light of the Review's objectives.

The Aids and Equipment Program in Victoria

2 The Aids and Equipment Program in Victoria

The purpose of this section is to describe the A&EP as it currently operates, and to examine the current trends in A&EP provision.

2.1 Background

The Australian Government established the Program of Aids for Disabled People (PADP) in 1981, the International Year of the Disabled. In 1987 the Australian Government transferred funding and program administration responsibility for the PADP to the States and Territories.

Since the initial transfer, the PADP has expanded significantly and become the key platform for the provision of aids, equipment and home modification services in Victoria. Recurrent funding for the program has grown from approximately \$1 million to \$21 million over that time.

In June 2001, PADP changed its name to the Victorian Aids and Equipment Program (A&EP) to better reflect the target population.

The DSD administers the A&EP on behalf of DHS.

In 2005-06 the A&EP provided subsidised aids, equipment and home modifications to 26,619 people.

2.2 Program aims and objectives

The provision of aids, equipment and home modifications to people with disabilities and the frail aged plays a critical role in supporting them to live as independently as possible. The A&EP aims to provide people with permanent or long term disabilities with subsidised aids, equipment and home modifications to enhance their safety and independence, reduce their reliance on carers and prevent premature admission to institutional care or high cost services.

The objectives of the A&EP, as outlined in the A&EP Guidelines², are to:

1. Provide efficiently administered aids and equipment services which are targeted to people most in need and promote equity of access throughout Victoria for people with permanent or long term disabilities.
2. Identify and provide subsidised aids, equipment and home modifications, which are appropriate and cost effective to meet the identified needs of clients.
3. Ensure that people with disabilities and the frail aged are provided with aids, equipment and home modifications that facilitate the achievement of outcomes such as increased independence, enhanced quality of life and maximum participation within the community.
4. Provide aids, equipment and home modifications to support people with disabilities and the frail aged to remain living in their own home and enhance the carers' capacity to maintain the care arrangements.

² Department of Human Services, Victorian Aids and equipment Guidelines, June 2002, p.5

5. Facilitate the provision of advice, training and ongoing monitoring regarding the appropriateness of aids, equipment and home modifications to current and potential clients of the A&EP.

2.3 Program structure

Funding for the A&EP is directed through the eight DHS regions to 29 Issuing Centres including four specialist statewide services and 26 localised services (one service conducts both roles). A listing of A&EP service providers is included in Appendix D.

The majority of the Issuing Centres provide geographically targeted services based on Local Government Areas (LGAs). However, there are four statewide Issuing Centres:

- the Royal Children's Hospital provides a statewide Issuing Centre for children who require aids and equipment;
- the Yooralla Brooklyn Electronic Communication Devices Scheme provides assessments and electronic communication devices for people of all ages with complex communication needs;
- the Mercy Lymphedema Clinic provides Lymphedema compression garments for people who have been medically assessed as having either primary or secondary Lymphedema and meet the eligibility criteria for the A&EP and are currently receiving a pension or have been assessed as being a low income earner; and
- the Breast Prosthesis Subsidy Program was established in 2004 to reduce waiting times for breast prostheses. Southern Health operates this program at Monash Medical Centre.

In 2000-2001 DHS agreed to fund a further statewide service on a non-recurrent basis at the Motor Neurone Disease Association. This service provides an aids and equipment loan program for people with Motor Neurone Disease, and is funded in recognition of the inability for the current A&EP to meeting the often rapidly changing needs of this client group.

2.4 Budget and funding

The A&EP budget is structured in two components. The first comprises a series of items, listed in Table 1, that have been 'quarantined' within the budget. These include domiciliary oxygen, which is based on actual demand, and allocations for the statewide services.³

³ Statewide services receive annual funding based on the previous years funding level.

Table 1: Quarantined components of A&EP budget 2005

Service funded	Approximate funding allocation (\$)
Oxygen	4,300,000
Oxygen Reserve Funds	200,000
Royal Children's Hospital	1,100,000
Yooralla - ECDS	1,150,000
Yooralla - DEIS	21,000
Mercy Hospital - LCGP	208,000
TADVIC	33,000
Supported Accommodation Equipment Assistance Scheme	943,000
Regional staff - DHS	110,000
Breast Prostheses Statewide Program	180,000
Motor Neurone Disease Equipment Loan Scheme	108,000
A&EP Database - Dermart	31,000
DHS Consultant Respiratory Physician	12,000
Client Satisfaction Survey	27,000
TOTAL	8,423,000

The second component of the A&EP budget, that which remains after quarantined elements have been funded, is allocated to DHS Regions based on population estimates of disability prevalence within LGAs. This funding is then distributed to service providers.

Funds allocated to service providers include administration costs and an allowance for staff training, which total 12.65 per cent of the allocated budget. The remainder of the funding is used to provide subsidised aids and equipment to eligible individuals.

Subsidies for aids and equipment are granted either on a wait-listed basis, for the majority of items, or on a "no wait" basis. There are four "no wait" items:

- oxygen – in 2005 oxygen accounted for approximately half of the quarantined budget;
- breast prostheses – with the establishment of the Breast Prosthesis Subsidy Scheme in 2004, breast prostheses became a "no wait" item. Additional funding was granted in 2004–05 and 2005–06 to continue breast prostheses as a "no wait" item;
- wheelchair repairs – funded from the second component of A&EP funding, rather than being allocated funding based on levels of demand; and
- on-going supply of continence aids – funded in the same way as wheelchair repairs.

Demand for "no wait" items has increased and is likely to continue to increase. This places increasing pressure on the budget for provision of wait listed items, significantly impacting on the capacity of the program to respond to applications for items that are not on the "no wait" list.

Expenditure

Table 2 below provides an overview of the A&EP budget for the period 2001–2005. A significant level of non-recurrent funding is provided annually to respond to the level of unmet demand within the program. This is often allocated late in the financial year and expended the following financial year.

Table 2: Expenditure and budget 2001-2005

Year	Recurrent Budget*	Non-recurrent Budget*	Total Budget*
	\$	\$	\$
2001	15,990,000	1,800,000	17,790,000
2002	16,377,000	4,500,000	20,877,000
2003	16,603,000	Nil	16,603,000
2004	16,883,000	2,250,000****	19,133,000
2005	17,174,000	5,000,000***	22,174,000

* Includes administration component of 12.5 per cent

** Includes oxygen

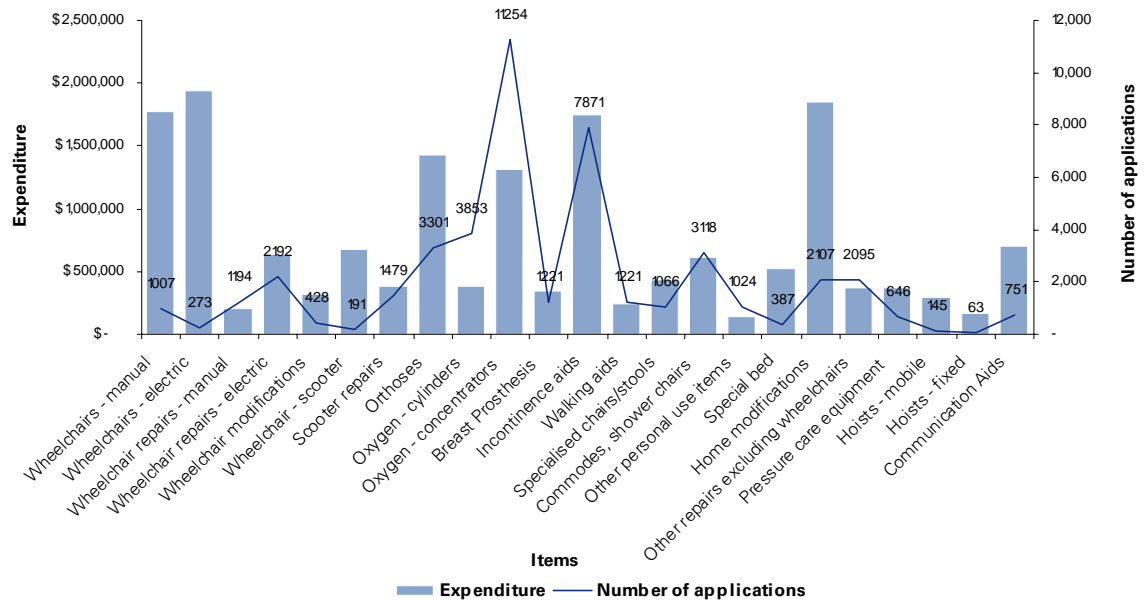
*** Victorian Government 2004-05 budget

**** \$1 m of this came from "Maintaining Independence at Home" strategy announced by the Minister for Aged Care.

Based on the information above, over the last three years non-recurrent funding allocated to the program to address unmet demand has averaged \$3.3 million annually. This may be underestimated due to allocations made directly to service providers by regional offices of the Department.

Figure 2 provides a snapshot of the numbers of applications received and expenditure on A&EP subsidised items in 2005. Only items where total expenditure exceeded \$60,000 in the year are shown, although the program provides or subsidises a much larger range of items, as detailed in Appendix C.

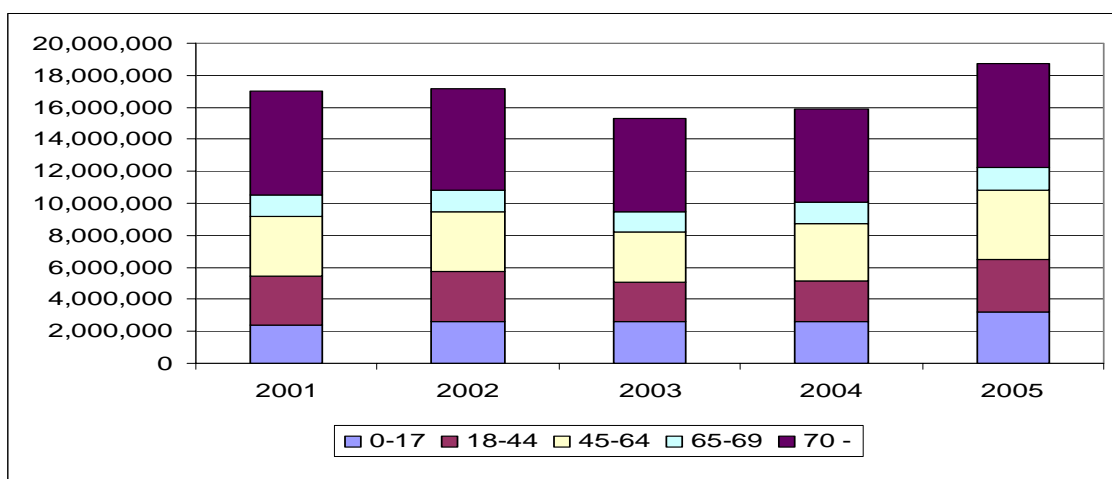
Figure 2 : Funded applications and expenditure by item in 2005



As can be seen the items of highest demand (as indicated by the number of funded applications) are oxygen and continence aids, which are both “no wait” items according to the A&EP prioritisation criteria.

A breakdown of expenditure by age groups for the years 2001 to 2005 shows that the greatest proportion of the A&EP budget is expended on the provision of items to people aged 70 and above (\$31 million or 37 percent). This was followed by expenditure for adults aged 45-64 years (\$18.6 million or 22 percent). Children and young people (0 to 17 years) consistently represented the smallest component of the program’s expenditure (\$13.5 million or 16 percent).

Figure 3: Expenditure by age cohort



Overall, the proportion of expenditure by age groups has remained relatively stable since 2001.

2.5 What does the A&EP subsidise?

The A&EP supports people by providing subsidies for a broad range of equipment and aids including items such as:

- walking aids, wheelchairs, commodes, beds and hoists;
- personal use items such as continence aids, orthoses, shoes, wigs, and breast prostheses;
- customised equipment such as specialised wheelchairs;
- communication aids such as voices prostheses and electronic communication devices;
- domiciliary oxygen; and
- home modifications.

Subsidies provided range from a maximum of \$4,400 (including GST) for a home modification to \$90 for a shower chair/stool.

The list of items subsidised is historical and diverse. The summary list of available maximum subsidies for items available through the A&EP is provided at Appendix E.

2.6 What items are not subsidised through the A&EP?

The A&EP does not subsidise:⁴

- aids or equipment specifically for use at work or in educational settings;
- aids and equipment that are standard household or personal items (i.e. washing machines, beds, clothing etc) and generally regarded as a community norm for the person or their family to purchase;
- items associated with medical treatment or surgical interventions; and
- the provision of short-term aids and equipment.

2.7 Target population

A&EP provides aids, equipment and home modification subsidies for people who:

- are a permanent resident of Victoria and holder of a Medicare card;
- have a permanent or long term disability and/or are frail aged; and
- need aids and equipment from the A&EP summary list of available aids on a permanent or long-term basis.

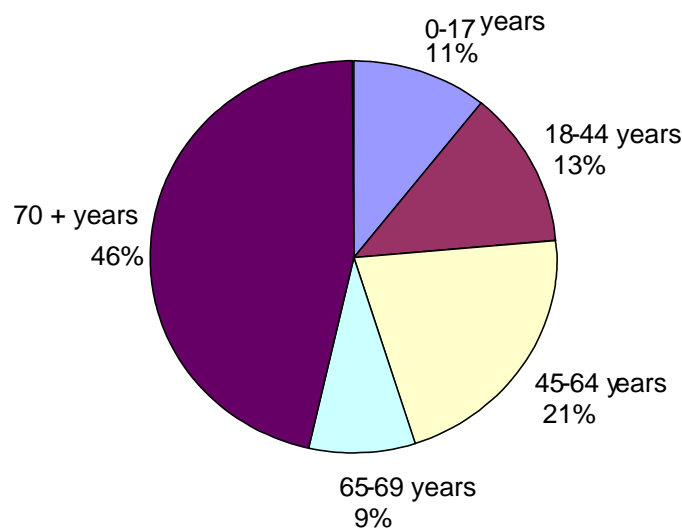
⁴ Department of Human Services, "Victorian Aids and Equipment Program (A&EP) Guidelines", July 2002, Page 7-8.

The A&EP Guidelines establish that a person becomes ineligible for assistance through the A&EP if they are eligible for assistance from other government-funded aids and equipment programs or if they are entitled to some form of compensation relating to their disabilities. Ineligible individuals include:⁵

- those who have access to the Supported Accommodation Equipment Assistance Scheme (SAEAS);
- Department of Veterans Affairs (DVA) Gold Card holders (except scooters and powered wheelchairs for those without a DVA approved disability);
- residents of government funded Residential Care Facilities or people in receipt of an Australian Government funded care package (Community Aged Care Package [CACAP] or Extended Aged Care at Home [EACH]);
- people who have access to compensation through the Transport Accident Commission (TAC) or Victorian Workcover Authority (VWA);
- in-patients of a public or private hospital; and
- out-patients within thirty days post discharge from a public hospital or extended care centre where the provision of aids, equipment or home modifications required is related to the hospital admission. The hospital or extended care facility is responsible for providing the required items during this period.

The figure below shows the proportion of clients receiving assistance from the A&EP in 2005 by age group.

Figure 4 : A&EP clients by age group for 2004-05



⁵ Department of Human Services, "Victorian Aids and Equipment Program (A&EP) Guidelines", July 2002, Page 6.

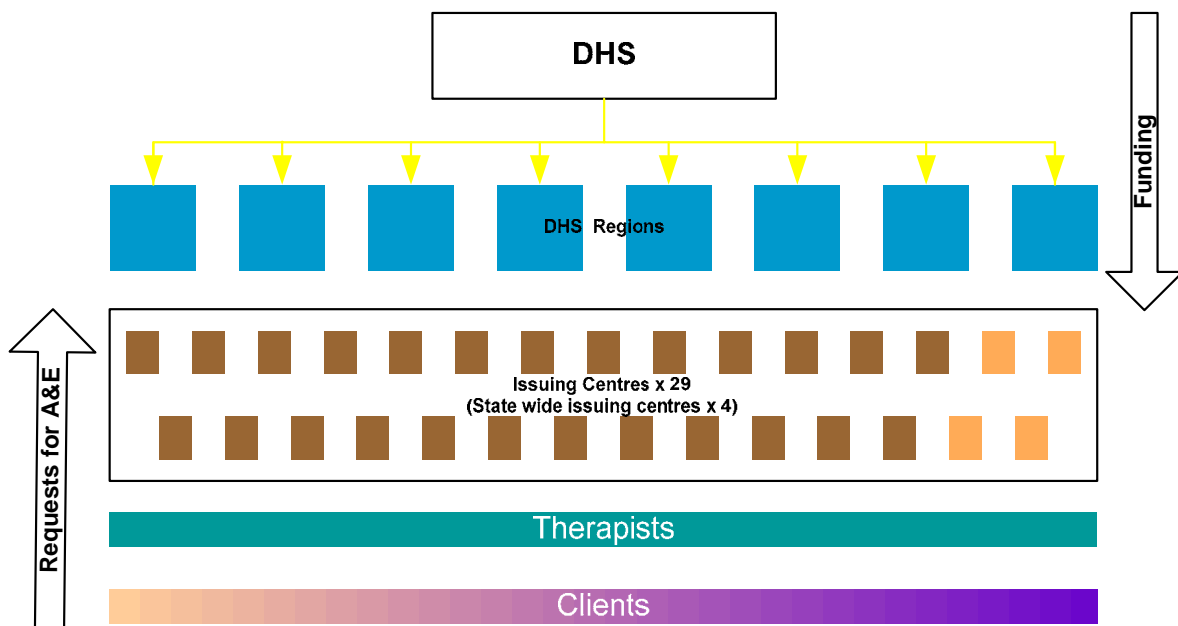
2.8 Accessing A&EP

To access the A&EP a therapist or other specialist assessor must assess the person to determine which aid, equipment or home modification is most appropriate to meet the clients' needs. The prescribing therapist then submits an application to the A&EP Issuing Centre detailing the recommendations, the basis for the recommendations, the recommended supplier and any customisation that is required. The completed A&EP application form also provides confirmation of disability by the treating medical professional.

Staff at the Issuing Centres establish the client's eligibility for the program, evaluate the application and prioritise the provision of the aids or equipment according to the A&EP Guidelines. Where an item is classified as a no-wait item under the Guidelines (such as oxygen or wheelchair repairs) or a suitable reissue item is available, the item is supplied immediately. In the case of other items, if funds are not immediately available and there is no item available for reissue, the application is placed on a wait list and the prioritisation of the application will determine how quickly the item is supplied. Funding availability and prioritisation can vary between Issuing Centres.

The relationships between the components of the A&EP are represented in Figure 5 below.

Figure 5 The components of the A&EP



2.8.1 Prioritisation

A&EP Issuing Centres are responsible for managing waiting lists and prioritising client applications. Prioritisation for service is based on assessed needs and urgency of applications

as per the prioritisation criteria specified in the A&EP Guidelines. These criteria are detailed in Table 3 below.

Table 3: Prioritisation criteria

Prioritisation Categories	
No Waiting	<p>Aids and equipment will be issued immediately following the processing and approval of the application.</p> <p>Criteria:</p> <ul style="list-style-type: none"> • Clients who meet the clinical eligibility criteria of the Oxygen program. • Wheelchair repairs. • Ongoing supply of continence aids. • Availability of re-issue aids and equipment.
High Urgency	<p>Aids and equipment will be issued as soon as funds are available or appropriate re-issued equipment has been identified.</p> <p>Criteria (not in priority of order) :</p> <ul style="list-style-type: none"> • The provision of aids and equipment is critical to the safety of the client or injury prevention in daily living activities; • The non-availability of aids and equipment will lead to a deterioration of the clients health or functioning abilities which may result in premature admission to institutional care, hospitalisation or dependence on more costly services; and • The non-availability of the aids and equipment will place excessive demand on carers in caring for the person who has a Disability or frail aged and seriously jeopardise the current care/ living arrangements.
Low Urgency	<p>Aids and equipment will be issued subject to availability of funds and priority order of the requests considering.</p> <p>Criteria (not in priority order):</p> <ul style="list-style-type: none"> • Clinical factors as indicated by prescribing therapist • Length of waiting period.

2.9 Gap funding

The program provides a specified maximum subsidy for each of the items. Where there is a difference between the total cost of the item and the maximum specified subsidy, the difference or "gap" is funded by the client personally or by the client through an alternative funding source.

This subsidy level has remained unchanged for a number of years, despite increases in the cost of aids and equipment. For many clients, this increasing gap between the subsidy and the full cost of the item is impacting on their capacity to afford necessary items.

To access an alternative funding source a client, their case manager or the prescribing therapist may be required to submit an application to another government funded program, a community service organisation, a charitable organisation or a trust fund, or secure funding from a private source. These processes can cause significant delays in provision of equipment.

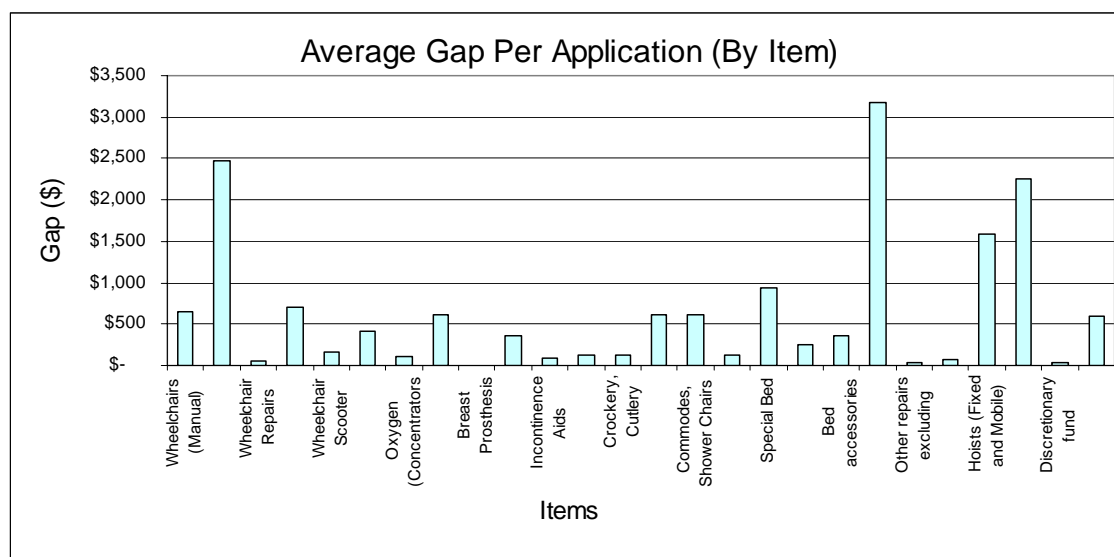
This process adds significantly to the workload of the case manager or prescribing therapist, who made need to take on the role of securing additional funding if the client is unable to do so themselves. Delays in securing this funding may also lead to the need to reassess the client, as

their circumstances may have changed over time such that the original item prescribed is no longer suitable.

Anecdotal evidence suggests that a significant number of Community Health Centres have waiting lists for assessments, and that the additional workload generated by the requirement to source gap funding contributes to delays experienced by potential A&EP applicants seeking their initial assessment.

The average gap across all items was approximately \$500 per person in 2004–05. However, Figure 6 shows that the gap is significantly higher for the more expensive items such as wheelchairs and home modifications. For such items it can be a number of months before the gap funding is either saved by the client or alternatively sourced. Smaller items, such as breast prostheses, may on average have no gap at all, with A&EP usually funding the full cost of the item.

Figure 6: Average gap per application by item in 2004-2005.



It is anticipated that the average gap will continue to increase as subsidy levels specified in the A&EP Guidelines are not indexed annually and therefore do not adjust to offset inflation.

Snapshot data provided by A&EP Issuing Centres during the Review process indicated that approximately half the gap required was provided by the client. The remainder was provided through alternative sources. These sources of gap funding included other Victorian Government programs such as the HomeFirst and Support and Choice programs within DSD. Other sources included programs funded by the Office for Children and Sub-Acute Ambulatory Services. This drain on other programs impacts on their effectiveness and masks the true magnitude of the gap funding issue.

The A&EP is the primary source of aids and equipment for children from birth to school entry. Feedback from service providers indicates that a considerable percentage of applications for the Early Childhood Intervention Service (ECIS) Flexible Support Packages have been for aids and equipment because of the long waiting lists to access the A&EP. The program was not designed for this purpose. Further, the ECIS Flexible Support Package Guidelines specifically exclude support for children with high medical support needs, so these children are not eligible for this alternative source of aids and equipment funding.

2.10 Ownership

Items of equipment issued under the A&EP are provided on a long-term loan basis except in the case of home modifications (which become the property of the owner of the premises) and personal use items (which the client retains).

The A&EP retains ownership of reusable equipment when it has contributed more than 50 per cent towards the cost of the item. If the client contribution towards the cost of the item is more than 50 per cent, the client can:

- retain ownership and therefore be responsible for the cost of ongoing maintenance and repairs; or
- transfer ownership of the item to the A&EP and the A&EP will cover the cost of ongoing repairs.

Should the item no longer be required it is to be returned to the program for reissue.

As there is currently no consistent statewide approach to the recovery, repair or write-off of the aids or equipment owned by the A&EP,⁶ each Issuing Centre manages this process individually. Some centres have put in place an annual process to contact all people who have received items over recent years, to ensure the item is still required and in good repair. This process also enables accurate tracking of the items supplied. Other Issuing Centres have not developed such practices and do not track equipment regularly once it is supplied.

2.11 Demand for the A&EP

Demand for the A&EP has continued to rise and outstrip growth in the program's budget, with significant waiting lists developing in almost all A&EP Issuing Centres. Currently the main demand drivers for aids and equipment in Victoria are:

- an ageing population;
- increasing disability/frailty of people living at home;
- increasing incidence of chronic disabling conditions in the community;
- changing expectations of people with a functional limitation about the nature and type of support they desire (that is, non-institutional and least restrictive alternatives);
- active participation of people with disabilities in their communities;
- impact of changing technology; and
- the increasing cost of equipment⁷.

During the period 2001-05, people aged 70 years and over accounted for the majority of applications (33,662) followed by the 45-64 cohort making a total of 12,898 applications.

⁶ As there is no consistent program to repair the equipment it places the DHS at risk of an adverse event occurring in terms of common law obligations around the maintenance of the equipment.

⁷ Department of Human Services, Review of the Aids and Equipment Program Request for Quote, 2005.

Children and young people (aged 0-17 years) made 5,038 applications, while the 65-69 age cohort made 6,468 applications. The numbers of applications by age cohort is shown below in Figure 7.

The number of applications does not represent the number of clients in the program as an individual may apply for multiple aids and/or equipment in a financial period. However, the figure shows clearly that there is a growing demand for items through the A&EP.

Figure 7 Applications by age cohort

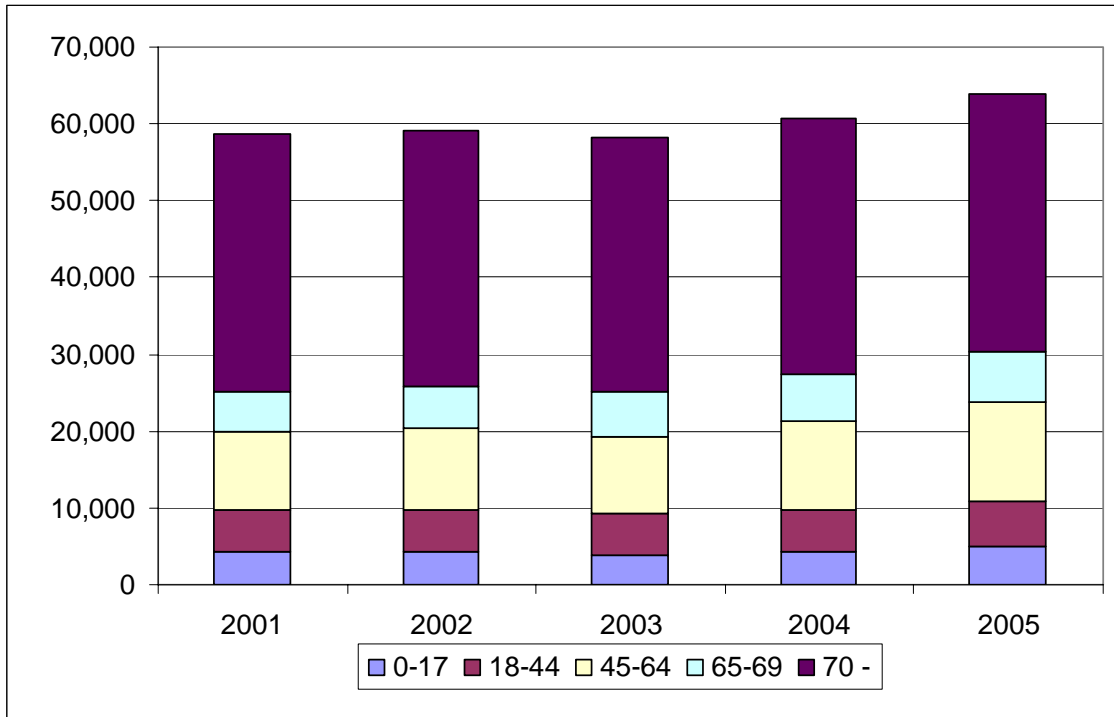
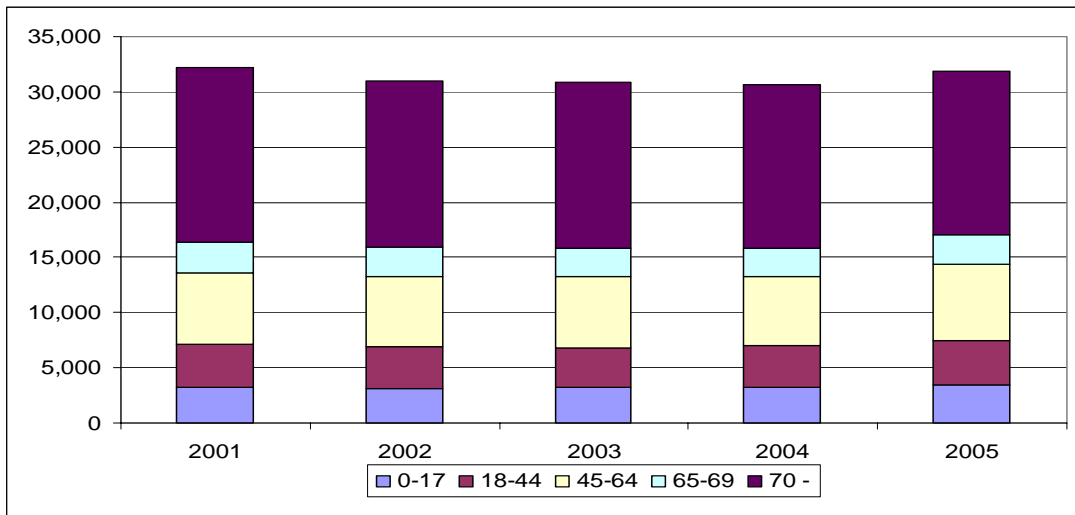


Figure 8 below provides a breakdown of the number of clients by five age cohorts: 0-17 years, 18-44 years, 45-64 years, 65-69 years and over 70 years for the 2001-05 period.

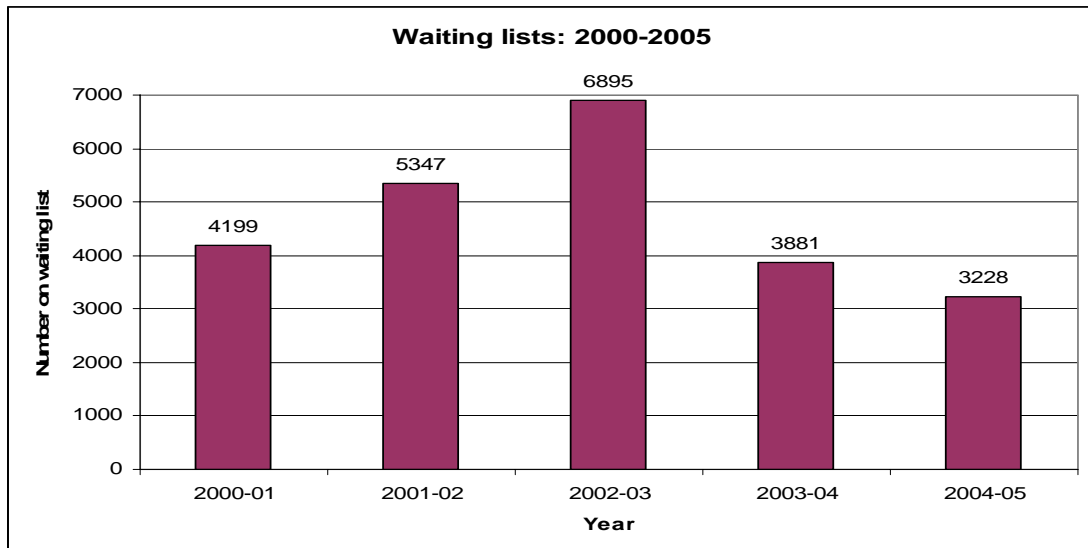
Figure 8 Clients applying for A&EP by age cohort



The greatest number of clients of the A&EP are aged 70 years and over. Additionally, there have been increases in the 45-64 years and 65-69 years age cohorts.

While Figure 8 shows the total number of clients applying for Aids and Equipment per annum, Figure 9 shows that each year there are a large number of clients whose applications for assistance from the A&EP are unable to be met within the recurrent budget. This has led to the additional non-recurrent allocation discussed earlier.

Figure 9 : Clients on waiting lists



While the above data is provided on a statewide basis, each individual Issuing Centre manages its own separate budget and waiting list. This means that waiting times at A&EP Issuing Centres can vary across Victoria, generating inequities in access to the program. For example, a client whose application is given a high priority at one Issuing Centre may wait over 12 months

for an item, while at another Issuing Centre it could be supplied in less than 6 months. The following table provides an indication of the variability in waiting times across Issuing Centres.⁸

Table 4: Comparison of waiting time across Issuing Centres

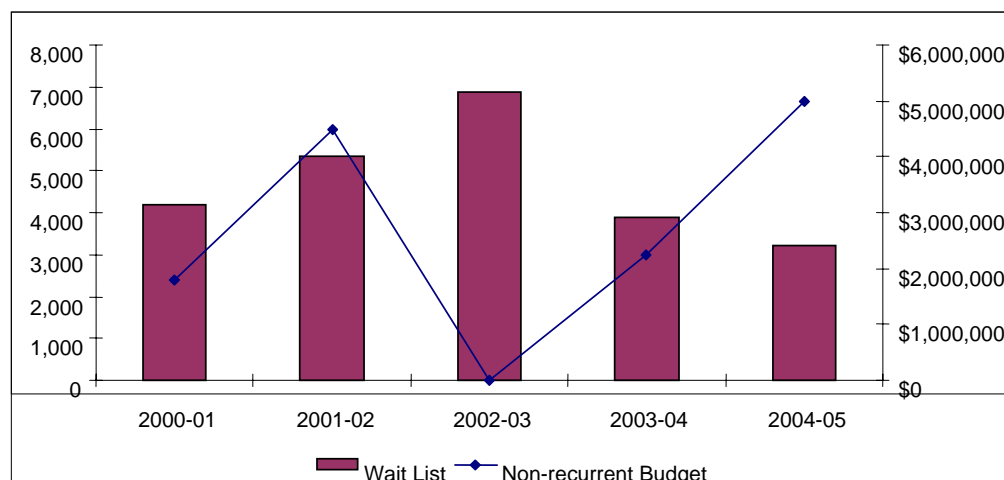
Issuing Centre (unidentified)	Average of wait period in days	Max of wait period in days
A	12	48
B	20	39
C	21	52
D	34	170
E	48	392
F	60	249
G	70	355
H	73	915
I	84	524
J	95	250
K	124	454
L	124	358
M	127	873
N	133	1,097
O	141	531
P	141	651
Q	142	1,207
R	144	847
S	145	538
T	161	345
U	197	578
V	211	883
W	245	1,154
X	278	1,127
Y	280	783
Z	344	5,079
AA	404	630

According to the above table the average number of days that clients wait for “wait items” ranges between 12 and 404 days across the various Issuing Centres. It is important to note that the waiting list data detailed in the above table is only for those clients on the waiting list (and does not represent the typical waiting period for all clients as many will receive 'no wait items' including reissued items).

Figure 10 below demonstrates the relationship between the allocation of additional non-recurrent funding and the number of clients on the waiting list. As the figure shows, the waiting list reached approximately 7,000 people in the 2002-03 when no non-recurrent funding was allocated to the program. Non-recurrent allocations in subsequent years significantly reduced this figure.

⁸ The data in this table was provided from databases held at Issuing centres and has not been validated by DHS or KPMG.

Figure 10: Clients on waiting lists and non-recurrent funding allocations



The growing pressure on the A&EP budget, alongside the need to more effectively and efficiently supply aids and equipment to the target population, is the chief impetus for this Review.

2.12 Summary of key performance trends

The analysis of the data for the period 2001-05 shows that the number of applications for aids, equipment and home modifications is increasing, with the greatest rise in the number of applications occurring in the 45-65 years and 65-69 year old age groups. However, the greatest increase in the overall number of applications for the program is associated with the 70 years and over cohort.

The most frequently requested items are oxygen and continence aids, and the continued growth in requests for these items is contributing to the overall budgetary pressure on the A&EP. Individuals seeking access to wait items are increasingly experiencing difficulty in having their needs met due to the demand pressures and the financial impact of "no wait" items on the program.

There is pressing need to rebalance the availability of aids, equipment and home modifications in light of the demand for 'no wait' items and associated budget pressures on the A&EP. There is need to ensure that the growth in demand in respect to these does not diminish the capacity of the program to concurrently meet demands for other items in response to the needs of adults and children with disabilities and older people.

In addition to these trends, if the program were to continue under the current A&EP funding arrangements, the gap between the average total cost and expenditure on items would continue to increase. This in turn, would result in a continued growth in the gap between the available subsidy and cost of items placing further significant financial burden on many clients who are currently struggling to afford these services.

Critically, the major driver of cost going forward is the growing demand for high volume, uncapped and/or "no wait" items such as oxygen, continence aids and repairs.

Further details on the key performance trends of the A&EP are located in Appendix C.

2.13 Post script

Since completion of the *Review of the Aids and Equipment Program*, an additional study regarding access to aids and equipment in Victoria was completed.

In 2006 Scope (Vic)⁹, a not-for-profit organisation providing disability services throughout Victoria to over 5,000 children and adults with physical and multiple disabilities, undertook a study titled *Too little too late: Wait times and cost burden for people with a disability in seeking equipment funding in Victoria*¹⁰. The purpose of the study was to:

- commence the establishment of a public evidence base to document the barriers to meeting the equipment needs of people with a disability in Victoria; and
- ascertain the costs and waiting times experienced by Scope clients, as they relate to the process of application, approval, through to delivery and use of equipment.

The study utilised a file audit approach to collect data about the experience of 57 clients with a range of high, medium and low support needs in relation to obtaining aids and equipment.

The Scope study looked at only a sample of the population examined in the Review. However, a number of the key findings are of interest. For example:

- the average wait time between assessment of need by a therapist and delivery of equipment is between two hundred and eight (208) and two hundred and thirty-eight (238) days (i.e. seven to eight months) with a typical maximum being up to three hundred and six (306) days of wait. In many cases, a further one or two months' wait occurs whilst modifications, fitting and training are undertaken;
- there is significant wait time between the approval of A&EP funds and the delivery of equipment, with an average wait time of between one hundred and three (103) and one hundred and thirty-three (133) days;
- a second significant wait period occurs between application to A&EP and approval of A&EP funds, with this period averaging between seventy-nine (79) and one hundred and nine (109) days;
- nine percent of clients accessed loaned equipment whilst awaiting equipment funding and delivery. The remaining ninety-one percent (91 percent) did not borrow equipment during this period;
- ninety-one percent (91percent) of clients were required to self fund or source top up funding to meet the gap between A&EP funding and the total cost of equipment;
- the A&EP provided an average allocation of sixty percent (60%) of the total equipment cost requested;
- clients were required to find an average of forty percent (40 percent) of the total equipment cost. In general, clients could expect to require a maximum amount of top up funds of between \$3,000 and \$7,000 per equipment request (though one client required \$16,415);

⁹ Scope – About us. Viewed at <http://www.scopevic.org.au/about.html> on 21 December 2006.

¹⁰ Scope (2006). *Too little too late: Wait times and cost burden for people with a disability in seeking equipment funding in Victoria*. Melbourne: Scope (Vic).

- sixty-two percent (62 percent) of applications for top up funding were made to non government sources, including a client or family's own sources of personal finance; and
- thirty-eight percent (38 percent) of applications for top up funds are made to government sources and seventy-one percent (71 percent) of these are made to DHS.

The Scope study concluded that there are a range of actions that would greatly improve access to equipment for people with a disability in Victoria. These are:

- 1 increase equipment funding ceilings on most items and the overall level of funds in the A&EP budget;
- 2 review AE&P application assessment processes in order to radically decrease the amount of time A&EP assessment takes to a standard of no more than thirty (30) days.
- 3 initiate an immediate review of school aged equipment funding, access and eligibility of government sources. Establish an information and support strategy directed at school aged clients and their families to ensure they are well informed about funding opportunities for equipment.
- 4 investigate barriers to the loan of equipment and develop a resource plan for the further implementation of an effective loans program. This should occur within the context of additional funding to A&EP in order to reduce wait times overall.

These recommendations are consistent in their intent with the recommendations of the Review. That is, reforms are required to ensure that aids and equipment are more affordable, that the program is more accessible and that waiting times are reduced.

**Stakeholder perspectives on
the A&EP**

3 Stakeholder perspectives on the A&EP

This section describes feedback received during the Review, from two key sources:

- consumer feedback provided as part of the DHS client satisfaction surveys; and
- consultation undertaken with clients, carers, service providers, administrators and other key stakeholders as part of this Review.

3.1 Consumer feedback on A&EP

Since 1998 the Department has undertaken research via a client satisfaction study to measure the degree to which the A&EP meets the needs of its diverse client base. The 2005 survey was conducted by ResearchWise, independent research consultants. The study takes the form of a mail survey targeting current clients of the program drawn from data provided from each Issuing Centre. ResearchWise had access to client demographics but not personal information, to ensure confidentiality for clients who responded. A total of 902 surveys were distributed, representing 10 per cent of the total client database. Of the 902 surveys, 340 (or 38 per cent) were returned completed.

Overall, the results of the survey demonstrate high levels of satisfaction with the A&EP, with individuals identifying a range of positive benefits.

In 2005 14 per cent of the sample were children, with 96 per cent per cent of these surveys answered by the carer or parent. Compared to adults this group appeared to be less satisfied with the application process than adults clients (41percent satisfied compared to 63percent), although they reported receiving more information. In relation to assessment and equipment options overall satisfaction was 80 per cent, with children and adults reporting similar levels of satisfaction. Child clients were however less satisfied with staff performance and the application process.

In relation to subsidy levels, children reported a gap between the cost of the equipment and funding provided through A&EP more often than adults. They also tended to wait for equipment more often and experience more problems and equipment repairs than adults.

Satisfaction rates are generally lower when a financial contribution towards the equipment was required. According to survey respondents, the strengths of the A&EP are its quality of staff, ease of use of equipment and the personal benefits derived from the program.

Response rates from the 2006 survey to a selection of statements focussing on the personal benefits of the program are presented in Table 5 below.

Table 5: Client Satisfaction Survey 2006

Question	Score		
	1	3	4
	Total satisfied %	Neutral %	Total Dissatisfied %
I feel more secure with the aid or equipment.	89	8	3
I am more independent with the aid or equipment.	86	9	5
The aid or equipment has helped me to stay living at home.	82	11	7
The aid or equipment has helped my carer to support me at home.	87	5	8
The aid or equipment has made it easier for me to keep in touch with people.	78	15	7
The aid or equipment has made it easier for me to go out.	82	10	7
My life is better now that I have the aid or equipment.	89	7	4
Without the aid or equipment, I would be unable to continue living at home.	48	23	29

As indicated above, the A&EP plays a significant role in supporting carers, with 87 per cent of respondents stating the aid or equipment helped their carer to support them at home.

The data also shows that 48 per cent of respondents believe they would be unable to stay living at home without the aid or equipment. This demonstrates that the A&EP is achieving its aim of preventing premature admission to institutional care or high cost services and that the program provides significant benefit for Government by reducing demand for these services.

3.2 The consultation feedback

As an important component of this Review, consultations were held with:

- clients and their carers;
- external stakeholders which include prescribing therapists, advocacy groups, suppliers and other interested persons;
- service providers, staff and managers of the Issuing Centres; and
- program administrators within the DSD and representatives from DHS regional offices.

Stakeholders also contributed to the Review via a 1800 number and via written submission during the Review period. Over 60 written submissions were received either by mail or email.

Feedback was received about the strengths of the program, as well as areas for improvement and suggestions for change. A more detailed discussion of the feedback received is contained at Appendix F.

3.2.1 Strengths of the A&EP

Clients, their carers and families strongly agreed that the cost of purchasing necessary aids and equipment is high and without the program most clients and their families or carers would be unable to afford the aids and equipment required.

Clients also reported that the aids and equipment accessible through the program enable independence and are therefore important to their quality of life and well-being. Many families also reported that without the program, they would be unable to continue to care for the person with a disability, especially as ageing carers find themselves less physically able to assist people with the key activities of daily living.

Many clients and their families and carers indicated that the lack of means testing was a strength of the program, although conversely, a number of people indicated that the program would better assist those in the greatest need if it were means tested.

Feedback received from external stakeholders focused on the benefits to clients and their carers and on positive aspects of the operation of the program. These included the access to maintenance of equipment available through the program, which means that clients can have their aids and equipment repaired in a timely manner and the reduction in waiting times that can result from the re-issuing of equipment. The cooperation and responsiveness of individual staff at many of the Issuing Centres was also identified by some prescribing therapists and case managers as a strength of the program.

The staff operating the Issuing Centres identified many strengths of the current program, primarily in relation to its actual operation. Most agreed that the major strength is the localised nature of the program and the majority would like to see this practice continued. Other strengths identified included the experience of Issuing Centre staff, the level of support received through the network of Issuing Centre staff and from DHS administrators and the location of Issuing Centres in hospitals because of the capacity to utilise the hospital's infrastructure such as IT support.

3.2.2 Opportunities for reform

Specifically, the feedback indicated that reform is needed to:

Reduce waiting times

Feedback about waiting times was substantial, with all groups consulted identifying this as a significant issue. According to feedback received, waiting times can be for a year or even longer, and many clients highlighted the personal hardships that arose while waiting for aids or equipment, including use of old equipment that was no longer appropriate or safe. These delays in receiving the required aids, equipment or home modifications can pose risks to both clients and carers. Overall there was a strong consensus among stakeholders that waiting times must be addressed if the program is to effectively meet the need of clients.

The following case studies provided by DHS exemplify the difficulties that can arise from delays in obtaining necessary aids, equipment or home modifications.

3.2.2.1 Case Study 1

Mrs J is 84 years old. She had been living independently in her own home until she was admitted to hospital with a broken wrist that resulted from a fall.

On discharge she was experiencing unresolved delirium and confusion as a result of the administration of morphine. She was therefore unable to return to own home and instead went to live with her daughter and son-in-law.

Due to Mrs J's care needs, her daughter has had to give up her job to become a full-time carer for Mrs J. This loss of income is placing additional financial pressure on the family.

To enable Mrs J to be cared for by her daughter, a number of pieces of equipment are required: a hoist, electric bed, suitable seating, pressure mattress, wheelchair, and a mobile commode.

Mrs J' daughter has applied to obtain these items through the A&EP, and has been placed on a waiting list. While she waits for assistance, Mrs J' daughter is hiring the necessary items at a cost of \$140.00 per week.

As a result of the waiting times for some of these high-level care items, the daughter will have almost paid for equipment in hire fees before the items are supplied through the A&EP. For this reason the daughter is considering purchasing the required items such as the pressure mattress, wheelchair, and specialized seating. The daughter advises that the Issuing Centre is unable to inform her when the equipment will be available through A&EP. The prescribing therapist is therefore unable to recommend whether it would be more advisable to purchase or wait for A&EP assistance.

The second case study, below, highlights not only the personal cost of delays in receiving necessary aids and equipment, but also the impact that this can have on prescribing therapists and other services.

3.2.2.2 Case Study 2

Ms S is a 41 year old single woman with a progressive neurological condition that renders her dependent on a manual wheelchair for mobility. A major feature of this condition is progressive spinal and pelvic changes that demand specialized seating and postural support. Ms S lives alone with support from external carers that attend daily to assist with personal care tasks. She is independent in her transfers.

An Occupational Therapy (OT) assessment was conducted in early January 2006. Ms S reported severe and debilitating low back pain which was directly attributable to her wheelchair and poor postural support. A review of her wheelchair and seating revealed the following issues: overall frame size too small, back support too small/worn and providing little support, and transfers in/out of bed increasingly difficult due to inappropriate floor to seat height.

Ms S urgently required prescription and provision of a new wheelchair and seating system. Her back pain was getting so severe that she was at risk of losing her independence in transfers and was spending increasing time in bed. Her independence and quality of life were being significantly compromised. A new wheelchair prescription was completed and a new seating and back support system was trialled and recommended in January 2006.

An urgent submission was made to the relevant Aids and Equipment Programme (A&EP) coordinator on 12 January 2006. The OT then made regular follow up phone calls to ascertain the status of the application. Ms S's back pain continued to increase to the point where she was referred for outpatient rehabilitation in order to assist in pain control and maintaining independence while waiting for the new wheelchair. She commenced taking anti-inflammatory medication and remains on this medication to manage her back pain.

A&EP funding was approved in late May 2006. Ms S was not in the financial position to pay for the difference in funding (approximately \$1100) between the actual cost of the wheelchair and the A&EP subsidy. An application was made to the Department of Human Services for top up funding in early June 2006. (NB: This application could not be made until AEP approval was received). Given the time that had elapsed since the initial prescription, a further OT assessment was completed to ensure the prescription was still valid.

Approval for gap funding was granted by DHS in late August 2006. The A&EP coordinator was on leave at the time so the order was not placed until early September 2006. The wheelchair took 10 weeks to manufacture so delivery of the wheelchair was not until late November 2006.

The delay of approval for funding for this wheelchair caused significant strain on other services including extra care required when her back pain was particularly severe, attendance at outpatient allied health services and repeated attendance at local doctor for pharmacological management of pain. Ms S's independence and quality of life were also reduced during this period.

Increase the level of recurrent funding available to the program

Comments about funding levels pertained to both the total amount of funding for the program, and the individual subsidies for each item in the program. Stakeholders indicated that more funding would mean that more people would be able to get assistance and that each person would get more assistance. It would also mean that people could access equipment when they needed it rather than being restricted to the timeframes in the Guidelines.

The lack of available funding for other costs such as transport to and from fitting appointments or to take equipment for repairs, the costs of trialling equipment, and travel to specialist assessment clinics was also raised as problematic for many clients.

Improve consistency in the way the service is administered and delivered

A number of the stakeholders consulted also provided feedback about the current administrative practices within the A&EP. These included relationships between prescribers, Issuing Centres and suppliers, and issues of performance and reporting.

Clients and prescribing therapists commented on the apparent inflexibility of the existing A&EP Guidelines, while also noting that there seemed to be significant variation across Issuing Centres in how funding and Guidelines were applied. It was suggested that decision-making is often locally driven rather than in accordance with the statewide Program Guidelines.

Staff of Issuing Centres also indicated that better tools were required to improve program administration. A number of these staff indicated that PADMIN (the A&EP data collection program) is not as easy to use or as effective as it should be.

Ensure there is greater equity of access to the program

Appropriateness of eligibility criteria, timely access to prescribing therapists and aids, equipment and home modifications, and geographical access to assessment clinics were the main concerns raised by stakeholders in respect to equity of access.

For example, stakeholders indicated that the eligibility criteria are out of date and do not appear to be consistent with contemporary approaches to service delivery. They need to be updated to better align with current thinking about service responses for people with a disability, older people and people with ongoing health conditions that result in functional limitations.

The most common comment in relation to the A&EP's eligibility criteria was in respect to the exclusion of people receiving Australian Government funded Community Aged Care Packages (CACPs). Access to aids and equipment through this program is limited, and yet clients and families who receive services such as case management and personal care through this scheme often need aids and equipment if they are to remain living in their own homes.

Clients, carers and prescribing therapists also reported that the lack of support to access statewide assessment centres, especially for clients outside of Melbourne, was problematic and contributed to inequities within the program.

Clarify prioritisation criteria and link these to client outcomes

Concerns were raised by clients about the lack of transparency of decision-making with regard to prioritisation, the lack of consistency in applying prioritisation guidelines between Issuing Centres, and the lack of communication with clients about their priority and the expected wait for items.

There was also some concern expressed by stakeholders that people who require aids and equipment to prevent admission or readmission to hospital or an aged care facility were receiving priority over people who require aids and equipment to improve their capacity for independence and community participation. A number of stakeholders expressed the view that the criteria for prioritisation should be expanded to include quality of life and improved community participation, and should also give greater consideration to carers' needs.

Clients also indicated there is a need for improved communication regarding their priority of access and the implication for waiting times for allocation of equipment in responding to their presenting needs.

Improve targeting of resources to ensure they are directed to those most in need

Stakeholders indicated that greater targeting of resources to those most in need is required, and that greater equity could be achieved by linking subsidy levels to an individual's capacity to pay. Complementing such an approach is the need to ensure that consideration is given to the need by some individuals for multiple items at key transition points, and the potential financial burden that can arise from the need to regularly replace aids and equipment in response to such changing needs.

There was also concern about the impact on clients with complex needs who require a number of items. The Program Guidelines need to recognise the financial burden this can place on these clients and their families. This is also the case for people with deteriorating conditions such as Motor Neurone Disease, and children, who may also require access to aids and equipment to meet their rapidly changing needs.

Means testing received some support as a way of ensuring that the available funds are directed toward the most financially disadvantaged. However, other stakeholders held views that everybody should be entitled to support through the A&EP and should not be 'disadvantaged' because they are working or have alternative means of paying for equipment.

Improve re-issuing rates

Clients were concerned that re-issuing is not being managed well within the program. They indicated they would be happy to accept re-issued equipment if it met their needs and meant reduced waiting times. However clients expressed concern regarding the current program requirements about returning equipment for re-issue. They noted that they could contribute thousands of dollars toward an expensive item such as an electric wheelchair or motorised scooter, and yet this contribution is non-refundable. Therefore, there is little incentive to return equipment once it is no longer needed.

Prescribing therapists and program managers noted that the increasing tendency toward customising items such as wheelchairs is reducing the capacity of the program to reissue these items.

The capacity to reissue is also hampered by the lack of a statewide database of client applications and items available for re-issue. As a result, Issuing Centre staff reported that

re-issuing tends to occur at the local level, and there is limited capacity to match available items to client needs across the state. It was also noted that it could be costly to transport items to meet the needs of clients in other locations.

Link the types of aids and equipment available and the replacement of items to peoples' needs

Clients want to remove the current restrictions about when equipment can be replaced to enable a more needs based approach to requesting and replacing equipment. For example, many clients indicated that wheelchairs do not last seven years when used daily. The replacement of equipment needs to be balanced with a need to ensure the item has been appropriately maintained

Stakeholders particularly referred to the need to review restrictions on replacement of items for children who are outgrowing equipment sooner than they are permitted to request replacements.

A further issue raised by both external stakeholders and clients is the restriction to one set of home modifications in a lifetime. This limitation does not recognise the needs of children whose parents may not live together, nor does it support people with a disability to leave the family home once they reach adulthood. If the family had modifications to the home to meet the needs of a child with a disability, that child cannot request home modifications as an adult.

Some suggested a person-centred approach to the provision of aids and equipment. Rather than adding items to a list of approved equipment following a periodic review, the provision of equipment should respond to assessed requirements.

Increase program funding to ensure that subsidies are able to increase in line with costs of items

Stakeholders were concerned that the A&EP subsidies have not been increased to take account of the rising costs of items, with the result that the gap between the subsidy and the full cost of equipment is increasing, making it more difficult for many clients to fund the difference.

Therapists also reported spending an increasing amount of time assisting clients to source additional funds. This activity diverts the prescribing therapist from their core role in assessment and provision of treatment to clients and leads to further delays in the assessment process.

It was suggested that the A&EP should be better able to respond to the needs of some individuals for multiple items at key transition points, and the potential financial burden that can arise from the need to regularly replace aids and equipment in response to such changing needs.

Reposition outside of hospitals to reinforce its role in promoting community participation and quality of life

The Program Guidelines state that the program aims to assist people to achieve greater independence and participation in the community. However, the feedback received revealed that the program is highly medicalised, with the majority of prescribing therapists who provided feedback using language such as "clinical outcomes" for "patients" to describe the desired goals of the program. Many therapists and Issuing Centre staff also identified a client's capacity to benefit in terms of clinical outcomes as a key consideration in

determining the client's priority for assistance through the A&EP. This is inconsistent with the A&EP's stated objectives.

Some clients also expressed the view that hospital outpatients are being given priority over community clients. This view was supported by program administrators who reported that if the centre is located in a hospital the focus is on preventing re-admission of clients to hospital and trying to ensure they are moved through the health system, and on improving clinical outcomes. Whereas if the centre sits in a community health centre the focus tends to be more on social inclusion and personal outcomes for the client. These perceptions and experiences suggest that the policy objectives for the A&EP have become disconnected from the way the program is operationalised.

Explore alternative purchasing and supply arrangements

A number of concerns were received about the current purchasing arrangements. Specifically, the requirement to obtain three quotes for an item was viewed by prescribing therapists as onerous, particularly where there is a limited number of suppliers available.

Clients were also concerned about the influence that suppliers can have on prescribing therapists, and about the apparent monopolies that can occur, particularly in rural areas where the number of suppliers is limited.

Generally, there was recognition that the program is not using its buying power to best advantage. Some suggested that other options should be explored, such as establishing contracted suppliers and exploring avenues such as direct payments to enable clients to purchase items directly.

3.3 Conclusion

The provision of aids, equipment and home modifications is a significant component of the services and supports that are available to assist Victorians with a disability or chronic disease or those who are older and frail. The program assists with the financial burden associated with obtaining the items that people need to increase their functional capacity and independence and to enable them to participate in the community.

Stakeholder feedback indicates that a number of fundamental improvements are required to strengthen the program and its capacity to effectively deliver a quality service now and into the future. The current service is not meeting the needs of the target population or their carers and needs to be repositioned to achieve its aim both now and into the future, when the program faces further increases in demand.

Current Policy Context

4 Current policy context

The purpose of this section is to describe the contemporary policy context in which the provision of aids, equipment and home modifications occurs in Victoria. It outlines the broad Victorian policy frameworks *Growing Victoria Together* and *A Fairer Victoria* and describes the policy contexts for the delivery of services to people with a disability, older people, people whose functional capacity is limited as a result of chronic disease or ongoing health issues, and those requiring accessible housing.

4.1 Growing Victoria Together and A Fairer Victoria

In 2001 the Victorian Government released *Growing Victoria Together* outlining the Government's vision for Victoria to the year 2010. The goals it identifies include:¹¹

- high quality, accessible health and community services;
- building friendly, confident and safe communities; and
- a fairer society that reduces disadvantage and respects diversity.

When *Growing Victoria Together* was revised, updated and republished in 2005 its purpose was to describe the Government's vision of a stronger, more caring and innovative state. It contained ten revised goals for Victoria's future.

Of these goals, the provision of high quality, accessible health and community services, building friendly, confident and safe communities, and reducing disadvantage, provide the context for the planning and delivery of services and supports to assist people with a disability or ongoing health needs that result in functional limitation and people who are older and frail.

A Fairer Victoria, launched in April 2005, outlines the Victorian Government's plan to address disadvantage within Victoria by creating opportunities and reducing barriers to full participation in daily life experienced by those who are disadvantaged.¹² The strategies and actions outlined include giving children the best start in life, helping older Victorians stay independent and creating new opportunities for people with a disability.

4.2 The Department of Human Services

The mission of DHS is to enhance and protect the health and wellbeing of all Victorians, emphasising vulnerable groups and those most in need. The objectives of the Department focus on a number of key areas including:

- strengthening the capacity of individuals, families and communities;
- building sustainable, efficient and well managed human services;

¹¹ Department of Premier and Cabinet (2005). *A vision for Victoria to 2011 and beyond – growing Victoria together*. State of Victoria, Victoria.

¹² Department of Premier and Cabinet (2005). *A Fairer Victoria – creating opportunity and addressing disadvantage*. State of Victoria, Victoria.

- providing timely and accessible human services;
- improving human service safety and quality; and
- reducing inequalities in health and wellbeing.

Within DHS, DSD is responsible for the provision and funding of a range of services for people with intellectual, physical, sensory and neurological disabilities and acquired brain injury. The demand for disability supports is increasing due to a range of factors, including:

- population growth;
- a reduction in the availability of informal care as carers age;
- the changing role and structures of families; and
- a service use cohort effect that is driven by changing expectations of people requiring a service and the likelihood that the need for additional services will intensify as current service recipients age.

Demand for disability services is characterised by:

- growth in demand of approximately five per cent per annum;
- the long term dependency of clients once they enter the support system;
- the weighting of current service responses towards more intensive, accommodation-based options and day programs; and
- the forecast decline in the availability of informal carers as they age and as community attitudes change.

DSD aims to manage and respond to the rate of growth in demand for supports by redesigning service delivery approaches through individualised planning and the provision of supports into a more developed and inclusive community.

Access to aids and equipment can significantly enhance functioning in the community for people with a disability, and are an integral part of the Government's objectives for improving outcomes for people with a disability and for managing unmet need. Aids and equipment assist people to remain living at home, to access the community and general service system, and to enhance the longer-term capacity of carers.

4.3 The Victorian State Disability Plan 2002-2012

The *Victorian State Disability Plan 2002 – 2011* was released in September 2002 and outlines a vision for the Victorian community in 2012:

By 2012, Victoria will be a stronger and more inclusive community – a place where diversity is embraced and celebrated, and where everyone has the same opportunities to participate in the life of the community, and the same responsibilities towards society as all other citizens in Victoria.

Key to achieving this vision are a number of priority strategies including:

- reorientating disability supports so they are more focused on the individual as an equal partner rather than a recipient of services;
- developing a strong foundation for disability support provision that is based in the community supporting individuals in their pursuit of lifestyles of choice; and
- promoting and protecting the rights of individuals so they have access to the same opportunities and can participate fully in community life.

For many people with a disability, pursuing the lifestyle of their choice and participating in the community requires access to a range of supports and services. Among these are the essential aids and equipment that are required to increase their functional capacity and independence.

4.4 Disability Act 2006

The *Disability Act 2006* was passed in May 2006. Sections 1 and 2 of the Disability Act, which outline the purpose and commencement of the Act, have already come into effect. The rest of the Disability Act is expected to come into operation on 1 July 2007 and provides the framework for a whole-of-government and whole-of-community approach to enabling people with a disability to actively participate in community life. It also provides for a fairer and more coherent approach to the provision of services for people with a disability in Victoria. The Act is guided by the principles of human rights and citizenship and provides substantial reform to the law for people with a disability in Victoria.¹³

4.5 Improving care for older people: a policy for Health Services

In 2003, the Victorian government published *Improving care for older people: a policy for Health Services*.¹⁴ This policy describes the forward direction for the provision of care to older people based on a number of principles, which are intended to encourage health services to adopt a person centred approach to service provision, better understand the complexity of older people's health care needs and improve integration with community based health services programs and broader community services.

This policy recognises the importance of community based programs in enabling people to live independently, preventing functional decline and supporting carers. It also recognises the role played by community based programs in preventing hospitalisation and readmission, and improving health outcomes by ensuring that adequate supports are available to enable people to reach their optimal level of functional independence.

¹³ Department of Human Services. Disability Act 2006. viewed at ncs719.dhs.vic.gov.au/ds/disabilitysite 9 November 2006

¹⁴ Department of Human Services. *Improving care for older people: a policy for Health Services*. 2003.

A significant initiative arising from the implementation of this policy has been the creation of Centres Promoting Health Independence. These centres aim to provide integrated treatment and care services in the community by bringing together a number of programs that support the independence of older people and people of all ages who need access to sub-acute care and assessment, diagnostic and therapeutic services. Centres for Health Independence provide access to sub-acute community based services including centre-based and home-based services, cognitive, dementia and memory services, continence clinics, falls and mobility clinics and outreach services.

4.6 Care in your community: a planning framework for integrated ambulatory health care

Care in your community: a planning framework for integrated ambulatory health care (2006)¹⁵ provides a framework for the delivery of integrated, community based health care, for the provision of health services that do not involve an overnight or multi-day stay in hospital. It applies to a range of health services including sub-acute home and community based services and Home and Community Care (HACC) services.

Care in your community articulates a vision for health care in Victoria that:

The Victorian health care system will increasingly deliver person and family centred health care in community based settings, reducing the need for inpatient care and improving health outcomes of Victorians.

According to *Care in your community*, there will be an increasing focus on health promotion, prevention, early intervention and self-management that will enable health services to respond to people's health needs in the community before they become seriously ill.

Within this broad policy context, Sub-acute Ambulatory Care Services (SACS) provide services and supports to people of all ages who have limited function as a consequence of disease, injury, impairment and/or disorder. The aim of these services is to:

- improve, restore and/or maintain a person's functional capacity to achieve the highest possible level of independence physically, psychologically, socially and economically; and
- provide a coordinated and integrated service that delivers the appropriate care, in a timely manner, in the most appropriate setting.

Together, *Improving care for older people: a policy for Health Services* and the policy context for the delivery of SACS to older people represent a clear shift away from a perception of older people being in a constant state of functional decline, and a focus on providing services that will act to reduce hospitalisation or delay their admission to residential aged care. The current philosophy underpinning the policy directions is that older people should be provided with supports to maintain or improve their functional capacity and thus their level of independence.

¹⁵ Department of Human Services. *Care in your community: a planning framework for integrated ambulatory health care*. 2006

4.7 Recognising and supporting care relationships for older Victorians

The Victorian Government acknowledges the efforts of people in care relationships as they seek to maintain dignity, quality of life, comfort, purpose and happiness. In August 2006 the Ministers for Aged Care, Health and Disability jointly launched a whole of DHS policy framework for recognising and supporting care relationships, with associated action plans for mental health, disability and older Victorians.

As detailed in *Recognising and supporting care relationships for older Victorians*, the A&EP Review is an opportunity to improve services for people with a disability, including older people and their carers.

4.8 Every child every chance

The Victorian Government believes that every child has the right to live a full and productive life in an environment that builds confidence, friendship, security and happiness, irrespective of their family circumstances and background.

The *Every child every chance* reforms focus on enabling earlier intervention, reducing abuse and working cooperatively with other service providers.

Within this context, the A&EP plays an important role in supporting children with a developmental delay or disability and their families by providing access to subsidised aids and equipment that promote the child's capacity to participate in family and community life.

4.9 Summary

Delivery of services to the A&EP target group is underpinned by a range of policy documents that, while focused on individual groups, are similar in their aims of maintaining or improving functional independence, increasing community participation and maintaining people in their community. The A&EP plays a key role in the implementation and effectiveness of these policy goals and should be linked into all related program areas within DHS.

4.10 Intersections with other programs

The A&EP intersects with a range of other program areas within the Department. These are:

- other programs within DSD (including HomeFirst and Support and Choice);
- Aged Care;
- Sub-acute Ambulatory Care Services, including community rehabilitation services and continence clinics (Programs Branch, MHACS)
- Hospital Admission Risk Program Chronic Disease Management (HARP-CDM) services (Programs Branch, MHACS)
- the Office of Housing Home Renovation Scheme;

- Primary Health (Community Health Centres);
- HACC Home Modifications;
- Cancer and Palliative Care Services Breast Prosthesis Subsidy Program;
- Office for Children
- Early Childhood Intervention Services (ECIS); and
- Flexible Support Packages.

Each of these is discussed in more detail in the following sections.

4.10.1 Other Disability Services programs

It is common for people with a disability to access a range of services from DHS as well as the A&EP. For example, the A&EP may provide the powered wheelchair for a client who is then provided with personal support through either the HomeFirst or Support and Choice programs. Similarly, clients of other programs such as Flexible Support may access the A&EP as part of the suite of services and supports that are identified as necessary to meeting their needs.

As waiting lists for the A&EP and the cost of the gap between the subsidy level and the total cost of the item grows, pressure builds on these other programs to assist with either partial or full funding of the item. This impacts on the resources available for direct client support, reducing their effectiveness.

The time spent sourcing gap funding is also a drain on staff resources provided through other DSD funded organisations such as case management services.

This process also generates administrative difficulties as the transfer of ownership of the items is usually then negotiated with the local A&EP service provider so that A&EP will fund repairs. However there may be no administrative funding passed on to the A&EP service provider to fund these future costs.

DSD also provides Continence Support Services (CSS) for children with a disability aged 5-15 years. The service provides access to continence assessments, interventions and continence aids. Children accessing a CSS can also access the A&EP. However, only the CSS will subsidise disposable continence aids.

4.10.2 Aged Care

The Aged Care Branch of the Rural and Regional Health and Aged Care Services, including Office of Senior Victorians, has broad policy responsibilities for the older population who are generally healthy and active as well as for those who require support services. The Branch has a dual focus on broad population ageing issues within the Whole of Victorian Government context and on the delivery of aged care services. The role of the Branch is to set policy directions, plan, fund and monitor certain services for older people and the families/ carers of both target groups. The Government's agenda for senior Victorians is focused on addressing their special needs and ensuring policies and programs recognise and reflect the diversity of older peoples' lives. This includes:

- enabling older people to live active lives in the community;
- encouraging the community to have a more positive balanced view of ageing;
- encouraging participation of older people in making decisions about policies and programs that affect them; and
- providing access to good quality, appropriate services when they are needed, including services that enable older people to remain independently in their own homes.¹⁶

By providing access to subsidised aids and equipment, the A&EP plays a significant role in assisting to achieve these outcomes for older Victorians.

4.10.3 Health Independence Programs, Programs Branch MHACS

4.10.3.1 Sub-acute Ambulatory Care Services

SACS deliver an interdisciplinary clinical service that provides assessment, diagnosis, evaluation, treatment, education and support for people of all ages who have limited function as a consequence of disease, injury, impairment and/or disorder.¹⁷ SACS provide community rehabilitation services, both centre-based and home-based, and a comprehensive suite of specialist assessment and management services.

The SACS target group includes people who have on-going health needs impacting on their functional independence who require access to rehabilitation services. The target group also includes people with incontinence that require assessment and management through the continence clinics.

In addition to the above services SACS is also responsible for Continence Clinics. A Continence Clinic is a multidisciplinary clinical service specialising in incontinence and other bladder and/or bowel function difficulties. It provides assessment, diagnosis, management, education and support to improve continence for clients. The service also provides consultancy, education and support to carers, relatives and professional services providers. However, the service does not provide continence aids. Clients requiring continence aids can be referred to the A&EP.

Continence clinics also provide assessments and interventions to children aged 5-15 years who are eligible for assistance through the Continence Support Scheme (see 4.10.1).

The SACS program also funds prescribing therapists through community rehabilitation services.

4.10.3.2 Hospital Admission Risk Program- Chronic Disease Management (HARP CDM)

Established in 2001-02, HARP aims to develop preventive models of care involving hospitals and community agencies which focuses on people with chronic and complex conditions and gives priority to high volume and/or frequent users of the acute public hospital system.¹⁸

¹⁶ Department of Human Services Disability Services Division Request for Quote for Aids and Equipment Program review September 2005, p.2

¹⁷ Department of Human Services Continuing Care and Clinical Service Development Programs Branch. Draft Philosophy of SACS. Provided by DHS.

¹⁸ Department of Human Services. Hospital Admission Risk Program – Chronic Disease Management. Viewed at <http://www.health.vic.gov.au/harp-cdm/> on 9 November 2006.

However, HARP's focus is changing, and in future the program will focus on continuing to improve the management of people with defined chronic diseases and complex needs who frequently use hospitals or who are at risk of hospitalisation. The HARP Chronic Disease Management (HARP CDM) mission includes facilitating access to mainstream community programs by this group, with the aim of supporting them within the community and preventing hospitalisation. The target group includes:

- people with chronic heart disease;
- people with chronic respiratory disease;
- older people with complex needs; and
- people with complex psychosocial needs.

HARP-CDM services manage people with chronic respiratory diseases who require domiciliary oxygen.

4.10.4 Office for Children

4.10.4.1 Early Childhood Intervention Services (ECIS)

Through ECIS the Victorian Government provides support to children with a disability or developmental delay from birth to school entry and their families. ECIS provide a range of services with the overall goal of providing parents and families with the knowledge, skills and support to meet the needs of their child and to optimise the child's development and ability to participate in family and community life.

4.10.4.2 Flexible Support Packages

Support available through the Office for Children includes Flexible Support packages. Feedback from service providers indicates that a considerable percentage of applications for the ECIS Flexible Support Packages have been for aids and equipment due to the long waiting lists to access the A&EP.

4.10.5 Office of Housing Home Renovations Scheme

Through its Home Renovations Service, the Office of Housing provides advice and assistance to older people and people with a disability who require home modifications or minor renovations to enable them to continue living in their own homes.¹⁹ The scheme can provide assistance and advice for health and safety modifications, personal safety, internal maintenance and general maintenance.

Through the Home Renovation Service, free home inspections are available to homeowners or private renters who hold a current Commonwealth Health Care Card or a Commonwealth Pensioner Concession Card, and:

¹⁹ Department of Human services Office of Housing, Home Renovations Scheme Brochure.

- are aged 60 or over; or
- have a disability; or
- are permanently caring for someone with a disability.

The Office for Housing also administers Home Renovations Loans that provide financial assistance to undertake necessary renovations. Some recipients of the A&EP subsidy for home modifications are also eligible for and use this scheme to close any gap between the total cost of a home modification and the subsidy available through the A&EP. Other therapists report a lack of information regarding the Home Renovation Loans or that their client is unwilling to consider a loan late in their life.

4.10.6 Primary Health

Primary Health, an area within the Rural and Regional Health and Aged Care Services Division, is responsible for policy related to Community Health Centres. These centres receive a range of funding from the Department including funding for therapists. A significant role of these centres is to provide assessments and prescribe equipment as required. The majority of applications to the A&EP relate to assessments made by the local Community Health Centre.

The therapist at the Community Health Centre will often complete the majority of the paperwork relating to an A&EP application and will be the first contact point for the A&EP service provider for any follow-up required. As waiting lists at A&EP Issuing Centres grow, the original assessments may no longer be valid, and the client may need to be re-assessed if their condition may have degenerated. This increases the workload of the prescribing therapist and impacts on waiting times for assessments at the Community Health Centre.

4.10.7 HACC Home Modifications

HACC provides services to assist people who are older and frail or younger people with a disability to continue to live in their own homes and avoid early admission to residential care. Among the services provided are Property Maintenance and Minor Modifications, which provide assistance with maintenance and repair of an eligible client's home, garden or yard to maintain the home in a safe and habitable condition.

Examples of home modifications available through the HACC program include the installation of grab rails, ramps, shower rails or special taps. The home modification service is provided following an assessment by an Occupational Therapist and the client is expected to pay for the materials used. Alternatively the client can be assisted through the Office of Housing's Home Renovation Service and/or the A&EP.

4.10.8 Breast Prosthesis Subsidy Program

When the A&EP was established, one of the items available on the list of approved items was breast prostheses for women who have undergone mastectomies. The A&EP Guidelines allowed for the provision of a subsidy for one prosthesis per mastectomy, and the A&EP prioritisation criteria applied.

To improve the delivery of breast prosthesis subsidies to women in Victoria, a new strategy was developed in 2004. The strategy involved streamlining the service provision from 29 Issuing Centres to a single statewide A&EP service provider. This was intended to provide a more equitable service by eliminating difficulties in prioritising these items within a program that focuses on safety and independence of people with disabilities.

Following an invited submission process, Southern Health was selected as the provider of the statewide Breast Prosthesis Subsidy Program. The service commenced in August 2004 at Monash Medical Centre and is jointly funded by Disability Services and MHCAS.

Additional funding was allocated to the service when it was established in the expectation that it would be a no-wait service. However, demand has grown and the service has approached DHS in both 2004-05 and 2005-06 to advise that it would soon be forced to assign applications to a waiting list. On these occasions the Department has allocated additional non-recurrent resources to enable the program to meet demand and avoid the need to implement a waiting list.²⁰

The growth in client numbers and the amount of additional non-recurrent funding that has been allocated to the Breast Prosthesis Program since 2004 is shown in Table 6.²¹

Table 6: Breast prosthesis subsidy

Year	Est. clients	Actual clients	Recurrent funding (\$)	Non recurrent funding (\$)	Actual Total funding (\$)	Non recurrent DSD component (\$)	Non recurrent MHACS (\$)
2004-05	990	1245 ²²	340,000	68,000	408,000	34,000	34,000
2005-06		1597	340,000 8,500 ²³	130,000 60,000	538,500	60,500 ²⁴	130,000 ²⁵
2006-07		1684 (Est.)	348,500		626 222 (Est.)	138,861	138,861 (Est.)

4.11 Summary of intersections with other programs

This section shows that the needs of the individuals serviced by the A&EP are diverse, and are served by a range of program and policy areas governed by DHS.

Until recently, this breadth of responsibility has not been well recognised in the day-to-day operations of the program, resulting in limited opportunity for policy and program guidance from the key policy areas. The only exception to this is the Breast Prostheses Subsidy Program,

²⁰ DHS email correspondence. 31 July 2006.

²¹ Source: Department of Human Services

²² 46 week period full year effect estimated at 1418

²³ Indexation

²⁴ \$30,500 + \$30,000

²⁵ \$99,500 + \$30,500

which is jointly funded by the A&EP and MHACS and which operates under the A&EP Guidelines.

There is a need to redress this imbalance of policy guidance and resourcing to more accurately reflect the nature and needs of the full range of individuals who access the A&EP. This will ensure the A&EP remains aligned with contemporary practice and government policy directions and priorities.

One of the key priorities of the Victorian Government is to reduce disadvantage and maximise the health, independence and opportunities for participation of people with a disability, including children, the aged, and people with chronic and/or complex health conditions. The A&EP plays an important role in the implementation of this policy agenda, by providing the aids, equipment and home modifications required to maximise functional independence in the home and maintain children and adults with a disability and the frail aged in the community. The A&EP also provides clear benefits to carers by supporting them in their role.

To achieve this strategic priority, the capacity of the program to deliver aids and equipment in an equitable and timely way needs to be strengthened.

Other aids and equipment programs

5 Other aids and equipment programs

This chapter provides a comparative summary of aids and equipment programs across international and Australian jurisdictions. The programs examined included:

- The Community Equipment Services program in England;
- Various programs operating within thirteen of Canada's provinces and territories;
- New Zealand's Environmental Support Service;
- Rehabilitation Appliances Program (Australian Government Department of Veterans' Affairs);
- Office of Hearing Services ((Australian Government Department of Health and Ageing);
- Continence Aids Assistance Scheme ((Australian Government Department of Health and Ageing);
- Workplace Modifications Scheme ((Australian Government Department of Employment and Workplace Relations);
- Program of Appliances for Disabled People (NSW);
- Medical Aids and Subsidy Scheme (Qld);
- Community Aids and Equipment Program (WA);
- Independent Living Equipment Program (SA);
- Community Equipment Scheme (Tasmania);
- ACT Equipment Scheme; and
- Territory Independence Mobility and Equipment Scheme (NT).

Excluded from this Review were the:

- Commonwealth Rehabilitation Service (CRS), which is vocationally focussed;
- State/Territory Limb Services; and
- The ACT Oxygen Scheme.

Various aspects of service provision in aids and equipment programs were examined including:

- program aims;
- eligibility criteria;
- prioritisation;
- payment arrangements; and
- ownership.

5.1 International aids and equipment programs

This section examines the following programs operating internationally:

- the Community Equipment Services program in England;
- various programs operating within thirteen of Canada's provinces and territories; and
- New Zealand's Environmental Support Service.

Table 7 summarises the key features of programs providing aids and equipment to people with a disability and to those who are frail and ageing in England, Canada and New Zealand. Given that the policy direction in each country is unique, it is therefore not surprising that there is no single approach to the provision of aids and equipment across these jurisdictions.

Table 7: Characteristics of international aids and equipment programs

	SUMMARY OF KEY CHARACTERISTICS – INTERNATIONAL PROGRAMS		
Characteristic	England ²⁶	Canada ²⁷	New Zealand ²⁸
Aims	Community Equipment Services enable children and adults who require assistance to perform essential activities of daily life to maintain their health and autonomy and to live as full a life as possible.	All jurisdictions aim to assist people maximise their independence and maintain their health through access to aids and equipment.	The Environmental Support Service assists people with disabilities to access essential equipment, housing modifications, vehicles and vehicle modifications.
Eligibility	Determined by local councils but should be established in line with the Department of Health policy <i>Fair Access to Care Services 2003</i> .	In all jurisdictions the client must have a disability as defined by the program, have a professional assessment, be a resident of the jurisdiction, have a health care card (although not in all cases) and be able to share the costs of equipment.	Eligible applicants must have a disability, be a New Zealand resident (or qualify under a reciprocal funding agreement) and have been assessed by a Specialist Assessor with the outcome that the equipment, home modification or vehicle meet the essential criteria. These essential criteria relate to equipment that is essential for mobility, remaining in the home, undertaking employment, study, training or voluntary work, communicating and acting as a primary carer.
Prioritisation	As above, however it is expected that equipment will be delivered within seven days of request.	Prioritisation criteria are not specified.	Prioritisation is based on the principle that those who have the greatest exposure to risk will have their needs met first.
Provision	Equipment is free to people who are eligible and have an established needs as determined by a health professional.	Equipment is provided under a cost sharing arrangement. Contributions by the client vary and can be based on a percentage of the cost or an income test.	Full funding is provided for equipment recommended under the program. The only exception is low cost equipment (under \$37), which clients fully fund themselves unless they are residents of an aged care facility, are unable to pay, are under 16 years or are in receipt of a special benefit from Work and Income New Zealand. Funding limitations and income and assets tests apply in relation to home modifications and vehicles/vehicle modifications.
Purchasing arrangements	Managed by the individual councils involved.	Not specified. It is likely arrangements vary between jurisdictions.	Preferred tendering processes are in place for the purchase of some basic equipment. For more complex work (eg. home modifications) quotes are sought.
Ownership	Item usually owned by the program. The principles of provision indicate a direct payment option should be introduced, with the implications regarding ownership and maintenance explained.	Options utilised include purchase by the individual, rental and ownership by the aids and equipment program.	All equipment (excluding consumables) is owned by the Ministry of Health and must be returned for reissue if no longer required. Vehicles are the property of the client.

²⁶ UK Department of Health. *Community equipment services: guidance and background information, 2002*, viewed at <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/CommunityEquipmentServices/> 1 February 2006.

²⁷ Government of Canada: Federal Disability Report; *Advancing the Inclusion of Persons with Disabilities, 2005*.

²⁸ Disability Funding Information: about Ministry of Health funding for people with disabilities, viewed on 14 February 2006, <http://www.disabilityfunding.co.nz/>

5.2 Summary of the key characteristics of international programs

In general the international programs reviewed are all aimed at enabling people with a disability to maintain their health and independence and in some cases take this objective further in aiming to achieve a greater quality of life. Assisting people to remain living in the community is a desired outcome.

The programs offer full or partial assistance to meet the costs of aids and equipment. A person must have a long term disability or functional limitation to access the programs and residency, age and special criteria for certain items of equipment are also requirements in various programs. The types of equipment provided by these programs are most often concerned with personal care, personal mobility and ensuring households are appropriately modified for the client.

Prioritisation criteria are not specified in England or in the Canadian programs, but New Zealand has prescribed a set of criteria that enable assessors to identify those people with the highest and most urgent disability related needs. The guiding principle behind the criteria is that those who are at the greatest risk will have their needs addressed first.

The arrangements regarding payment for aids and equipment also vary between programs. Programs in Canada tend to be funded through cost sharing arrangements where clients are expected to meet a portion of the equipment cost. There is an upper limit on the amount that either clients or the programs must contribute and this varies between programs.

The arrangements in New Zealand vary according to each program and may involve a mixture of cost sharing, partial subsidisation and full subsidisation. In England, the program covers the full cost of equipment for eligible clients for items that are required to meet an assessed need. England also offers a system of direct payments from local councils to consumers who need to buy aids and equipment

Items may be loaned to clients or the program may provide a subsidy to assist individuals to purchase the item required. The client is usually responsible for all costs associated with maintenance and replacement (lifecycle costs) when they have assumed ownership through a purchase agreement. Otherwise the program may cover the extra costs associated with the equipment's lifecycle costs. An expectation that re-usable equipment will be returned for reissue is common to many of the programs reviewed.

In the UK Auditor General's report into potential improvements to the provision of aids and equipment in England titled *Fully Equipped (2002)*, the biggest single savings opportunity identified was recycling community equipment.²⁹ The Audit Office found that low collection and recycling rates were strongly associated with higher than average expenditure on new equipment and with higher levels of stock.³⁰ The Audit Office recommended the target for reissue should be around 70 per cent of reusable items. Currently the reissue target in Victoria is set at 10 per cent.

29 Audit Commission. *Fully Equipped 2002*, <http://www.audit-commission.gov.uk/reports/AC-REPORT.asp?CatID=&ProdID=2103ACC1-7512-46a0-B74C-3D28724588FE> viewed 14 February

2006

30 *ibid*

5.3 Programs around Australia

According to the *Survey of Disability, Ageing and Carers* (ABS, 2003)³¹ there were 1,890,800 Australians using aids and equipment to assist with activities of daily living, which is equivalent to approximately 10 per cent of the Australian population. A further 395,700 Australians living in private dwellings had made modifications to their home to enable them to cope with restrictions to their activity levels or to continue to live in their homes rather than move into more supported environments such as residential aged care facilities.

Schemes to assist people who have a disability or who are older and frail to access aids and equipment are operated by both the Australian Government as well as by each of the states and territories.

For the purpose of this Review, the following Australian Government programs were considered:

- the Rehabilitation Appliances Program (Department of Veterans' Affairs);
- Office of Hearing Services (Department of Health and Ageing);
- the Continence Aids Assistance Scheme (Department of Health and Ageing); and
- Workplace Modifications Scheme (Department of Employment and Workplace Relations).

State and territory programs reviewed include:

- the Program of Appliances for Disabled People (NSW);
- the Medical Aids and Subsidy Scheme (Qld);
- the Community Aids and Equipment Program (WA);
- the Independent Living Equipment Program (SA);
- the Community Equipment Scheme (Tasmania);
- the ACT Equipment Scheme; and
- the Territory Independence Mobility and Equipment Scheme (NT).

Excluded from this Review were the:

- Commonwealth Rehabilitation Service (CRS), which is vocationally focussed;
- State/Territory Limb Services; and
- the ACT Oxygen Scheme.

31 Australian Bureau of Statistics *Survey of Disability, Ageing and Carers 2003*. ABS Cat. No. 44300. viewed 22 June 2006

Also excluded were services funded and provided by non-government organisations.
A summary of the characteristics of the Australian programs is provided in Table 8.

Table 8: Characteristics of Australian aids and equipment programs

SUMMARY OF KEY CHARACTERISTICS – OTHER AUSTRALIAN PROGRAMS – STATE FUNDED			
Characteristic	New South Wales ³²	Queensland ³³	Western Australia ³⁴
Aims	The Program of Appliances for Disabled People (PADP) aims to provide appropriate equipment, aids and appliances to assist eligible residents of NSW who have a permanent or long term disability to live and participate in their community.	The Medical Aids Subsidy Scheme (MASS) assists residents of Queensland with permanent and stable conditions or disabilities with access to aids and equipment. The Program aims to assist individuals at home and to avoid preventable or unnecessary admission to hospital or residential aged care.	The Community Aids and Equipment Program (CAEP) funds the purchase of basic and essential aids and equipment to assist people with disabilities to manage at home.
Eligibility	The target population is individuals living in the community who have a permanent or long term disability, are a permanent resident of the Area Health Service providing PADP and have not received related compensation. Residents of state government funded group homes are also eligible.	To be eligible for MASS the person must be a permanent resident of Queensland, have a permanent and stabilised condition or disability and hold one of the following cards: Centrelink Pensioner Concession Card, Veteran's Affairs Pensioner Concession Card, Centrelink Health Care Card, Queensland Government Seniors Card and Centrelink Confirmation of Concession Card Entitlement Form.	To be eligible for CAEP a person must have a permanent disability, be a holder of a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Card, be living independently in the community and be eligible for services offered by the Disability Services Commission.
Prioritisation	Access to PADP is means tested for adults while access for children with a disability is universal. Level of need is considered in prioritising access. In addition people in lower income groups have priority over people in higher income groups.	MASS gives priority to applicants with greater need.	Not specified.
Provision	Co-payments apply. Excluding the highest income grouping, all other people (both adults and children) are charged a single co-payment of \$100 in any given financial year. People in the highest income grouping are charged 20 per cent of the retail cost of high cost items.	Co-payments apply.	Joint funding arrangements apply.
Purchasing arrangements	Managed by individual Area Health Services.	Some items are procured using three-year contract arrangements, eg. continence aids.	Not specified.
Ownership	Appliances issued through PADP remain the property of the Health Services. Clients are asked to return appliances issued through PADP should they no longer be required.	MASS retains ownership of the aids and equipment where it has contributed more than 50 per cent of the cost. Otherwise the applicant can chose to own the item and be responsible for repairs and maintenance.	CAEP retains ownership of reissuable items except where the client has contributed more than 50 per cent.

³² NSW Health. *Program of Appliances for Disabled People (PADP) – NSW Health Policy*. Sydney, 2005.

³³ Queensland Health Medical Aids Subsidy Scheme QH 2006a Viewed at <http://www.health.qld.gov.au/mass/default.asp> on 8 February 2006

³⁴ Disability Services Commission. *Community Aids & Equipment Program*. DSC 2006 Viewed at http://www.dsc.wa.gov.au/cproot/869/2/CAEP_brochure.pdf on 9 February 2006

SUMMARY OF KEY CHARACTERISTICS – OTHER AUSTRALIAN PROGRAMS – STATE FUNDED			
Characteristic	South Australia ³⁵	Tasmania ³⁶	Australian Capital Territory ³⁷
Aims	The Independent Living Equipment Program (ILEP) provides equipment to assist individuals with disabilities to remain living safely and independently within their homes and the community.	The Community Equipment Scheme (CES) provides a range of equipment and continence supplies to eligible Tasmanians to facilitate discharge from hospital, enable people with a temporary or permanent disability to live at home, prevent premature admission to an institution and assist the integration of people with a permanent disability back into the community.	The ACT Equipment Scheme offers funding to assist people with long term disabilities to obtain and maintain equipment to live at home in the community.
Eligibility	Those who are eligible are clients of Options Coordination, living in community accommodation such as their own home or a group home and do not require the equipment specifically and only for work, study or recreation. To be eligible for Options Coordination the person must be a resident of SA, be aged under 65 years, have a permanent or long term disability and have a need for a disability service.	The scheme is available to Tasmania residents (generally of three months or longer) living in the community who have a disability of a long term or indefinite duration or require equipment as part of discharge from hospital or residential care and are: ineligible to receive equipment from other government funded programs, have not received compensation in respect of the injury and are the recipient of either a Health Care Card, Pensioner Concession Card, Health Benefit Card or Interim Concession Card Entitlement.	Residents of the ACT are eligible if they have a permanent disability of at least 2 years duration, are ineligible to receive assistance from other government funded schemes, private health schemes or injury compensation and meet the financial criteria or receive a child disability allowance.
Prioritisation	If suitable equipment is not available for reissue, the applicant is allocated a priority rating based on their level of need.	Applications are prioritised using a rating scale, which considers the extent to which a client meets program objectives.	Not specified.
Provision	In most cases the total cost of the equipment and modification is funded by ILEP.	Eligible clients pay the following costs for equipment; \$50 per year loan fee, \$50 per year maintenance fee when maintenance of the equipment is required and the cost of materials for home modifications. Ineligible clients can hire equipment for a fee of \$20 per month. Continence supplies of up to \$1,000 per year are available, with clients paying half the cost of supplies received.	A client contribution is required, with the amount depending on the cost of the item.
Purchasing arrangements	Quotes are obtained from suppliers by the prescriber.	Not specified.	Not specified.
Ownership	ILEP retains ownership of all equipment purchased by the program, including equipment to which the person has made payments, irrespective of whether the payment exceeds 50 per cent of the total cost.	Equipment is provided on a loan basis, excepting consumables and items relating to home modifications.	All reissuable items obtained through the program must be returned to the program once no longer required. For equipment maintenance the client contribution is one third of the total cost.

35 Government of South Australia Independent Living Equipment Program Policy Manual. 2003, p. 20 Viewed at http://www.iic.asn.au/files/ilep_policy_july2003.pdf on 9 February 2006

36 Tasmanian Service Directory – viewed 10 February 2006, <http://www.dhhs.tas.gov.au/services/view.php?id=352>

37 Australian Capital Territory Health. The ACT Equipment Scheme. Viewed at <http://www.health.act.gov.au/c/health?a=sp&pid=1059610195> on 9 February 2006.

SUMMARY OF KEY CHARACTERISTICS – OTHER AUSTRALIAN PROGRAMS – STATE FUNDED	
Characteristic	Northern Territory ³⁸
Aims	The Territory Independence and Mobility Equipment (TIME) Scheme aims to provide access to appropriate equipment and appliances to meet assessed needs, assist in maintaining and improving an individual's capacity to remain in the community and to participate in the family and community activities, support continuity of care, support efficient administration (with effective management of existing resources), provide consistency and equity in priority of access (targeting those most in need) and support flexibility and responsiveness in individual needs.
Eligibility	Applicants must have a disability of a permanent or long term duration, be a Northern Territory resident, be living or returning to the community, require approved TIME Scheme equipment on a permanent or long term basis, not be eligible to receive compensation in relation to the disability for which the equipment has been prescribed, not be eligible to receive equipment under any other program/fund, not be a High Care resident of a residential aged care facility and be a beneficiary of a Centrelink Aged Pension, Centrelink Disability Support Pension or a person aged under 16 years for whom a family member is in receipt of a Centrelink Carer Allowance or Carer Payment, or are a child in the care of the Minister or have been approved as eligible on the basis of Financial Hardship.
Prioritisation	The prescriber explains the clinical need and assigns the priority based on this need.
Provision	A maximum cost applies to basic items supplied, with the maximum established based on the cost of supply and reviewed annually. The TIME Scheme will fund to the maximum level with the client responsible for finding funding for the balance required. Where the item is a basic piece of equipment required to meet the assessed need, the TIME Scheme Committee and/or delegated authority has the ability to purchase above the maximum cost. An authorised prescriber can prescribe an item not on the TIME Scheme equipment list for consideration on the basis that the equipment is the most essential and basic aid which will meet the client's needs.
Purchasing arrangements	A single written quote is required for equipment up to a value of \$3,000 and three written quotes are required for equipment valued from \$3,000 to \$10,000.
Ownership	In general, reissuable items are provided on a long term loan basis and remain the property of the TIME Scheme unless the client contributes over 50 per cent of the total cost or the item is customised.

³⁸ Department of Health and Community Services, Territory Independence and Mobility Equipment (TIME) Scheme: Policy and Procedure Manual (version 2), Northern Territory Government, 2002.

SUMMARY OF KEY CHARACTERISTICS – OTHER AUSTRALIAN PROGRAMS – AUSTRALIAN GOVERNMENT FUNDED			
Characteristic	Rehabilitation Appliances Program (RAP) ³⁹	Office of Hearing Services ⁴⁰	Continence Aids Assistance Scheme (CAAS) ⁴¹
Aims	The RAP is administered by the Department of Veterans' Affairs (DVA) and provides items for self-help and rehabilitation to assist eligible veterans, war widows and widowers and their dependents to be as independent and self-reliant as possible.	The OHS is administered by the Department of Health and Ageing and acts as a government purchaser and regulator. It provides contestable hearing services for eligible adult clients through a voucher system, hearing services (provided by Australian Hearing Services and private providers) and research and other community education services (delivered by the National Acoustic Laboratories).	The CAAS provides assistance to clients with permanent and ongoing incontinence as a result of a neurological condition or severe intellectual impairment. Its aim is to help eligible clients meet the cost of continence aids.
Eligibility	Eligible veterans can access the program based on assessed clinical need.	Clients eligible for the voucher system include pensioner concession cardholders, DVA Gold and White Repatriation cardholders, Sickness Allowees, certain Commonwealth Rehabilitation Services clients and Defence Force personnel. Clients funded to access hearing services include all young Australians under 21 years, eligible Aboriginal and Torres Strait Islander clients, eligible adult clients with complex hearing rehabilitation needs and eligible adult clients who live in remote areas.	Eligibility requirements are: permanent loss of bladder and/or bowel function, aged at least 16 years but not yet 65 years or 65 years and working at least eight hours in paid employment, currently eligible for the Disability Support Pension and eligible for Mobility Allowance or in receipt of the equivalent GST exemption on a vehicle. Certain exclusions also apply, including incontinence as a result of surgery.
Prioritisation	Prioritisation does not apply, as there is no waiting period.	Not specified.	Not specified.
Provision	Items are fully funded.	Hearing devices provided through the program are designed to meet the basic assessed clinical needs of clients. Eligible clients may also choose to pay the difference between the cost of the free-to-client hearing devices and the actual cost for more expensive items.	CAAS provides a subsidy of up to \$470 per person per financial year on aids ordered from Intouch.

39 Australian Government Department of Veterans Affairs. Rehabilitation Appliances Program. Viewed at <http://www.dva.gov.au/factsheets/default.htm> on 7 February 2006/

40 Australian Government Hearing Services Program Guidelines (2001), viewed, <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-hear-prog.htm> on 10 February 2006

41 Australian Government Department of Health and Ageing, Continence Aids Assistance Scheme, DoHA Canberra n.d., viewed at <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/continence-caas.htm> on 9 February 2006

SUMMARY OF KEY CHARACTERISTICS – OTHER AUSTRALIAN PROGRAMS – AUSTRALIAN GOVERNMENT FUNDED	
Characteristic	Australian Government Workplace Modifications Scheme⁴²
Aims	The objective of the Workplace Modification Scheme (WMS) is to encourage employers to provide employment opportunities for new workers with disabilities or existing workers with disabilities whose job may be in jeopardy. The program is administered by the Department of Employment and Workplace Relations.
Eligibility	Companies must employ the individual at least eight hours per week in a job that is expected to last for a minimum of at least three months. The eligibility of each individual is examined on a case by case basis regardless of whether they are in open employment or eligible business service, or have an approved Slow Worker, Aged and Infirm or other under-rate permit.
Prioritisation	Not currently required.
Provision	Items include: disability specialist IT software, adapting workplace tools and workspaces and providing specialist equipment for people with physical disabilities. A \$5,000 cap generally applies for each new worker, although this amount may be exceeded in special circumstances.
Purchasing arrangements	Not specified.
Ownership	Negotiated at time of approval and agreed between all parties in writing.

⁴² Australian Government Department of Employment and Workplace Relations Job Able Workplace Modifications Scheme (WMS) Guidelines. DEWR 2006 Viewed at http://www.jobable.gov.au/openemploymentproviders/WMS_Guidelines.asp on 9 February 2006

5.4 Summary of aids and equipment programs in Australia

Australian based aids and equipment programs tend to be either generic in their focus or alternatively provide assistance for particular special needs or population groups.⁴³ Most of the state and territory schemes are aimed at promoting community inclusion, improving quality of life and supporting people with a disability to remain living in their homes. In contrast, Australian Government administered schemes tend to cater to specific population groups or to address particular types of disability.

Applicants, in general, must demonstrate that their disability is ongoing and, in some cases, the result of a specific medical condition. Applicants may also need to be in receipt of health care or pension card and be permanent residents in the state or territory where the application is being made. Some programs also exclude clients from consideration where the person is eligible for assistance under another aids and equipment program.

Programs differ in terms of prioritising applicants for access to aids and equipment. In New South Wales, prioritisation considers level of need and level of income.⁴⁴ In the Northern Territory, prioritisation is clear, with applications for "equipment required to meet a client's essential needs in their daily living skills and functioning" prioritised over other applications.⁴⁵ In Tasmania, applications for equipment are prioritised using a rating scale which considers the extent to which clients meet program objectives. A waiting list exists for some items of equipment, including both standard and non-standard items.⁴⁶

Other programs including Queensland's MASS and South Australia's ILEP, suggest that higher needs clients should receive priority, but unlike the Northern Territory do not provide a list of needs that should form the basis of the prioritisation.⁴⁷

Similar to international jurisdictions, the Australian jurisdictions broadly offer a common range of aids and equipment. The Australian Government Rehabilitation Appliances Program, the NSW PADP, Queensland's MASS and Northern Territory's TIME Scheme are the only programs in Australia, other than Victoria, to provide oxygen as part of the aids and equipment program.

Procurement and purchasing of equipment arrangements differ significantly between programs. Some state and territory programs ask that either the prescriber or program manager obtain at least one written quote for equipment supply. In other cases, such as the Queensland MASS continence program, items are procured by the program using three-year competitive contract arrangements.

Many of the Australian Government programs operate under more streamlined procurement arrangements. For example, DVA has recently put in place new supply arrangements that involve national contracts with preferred tenderers and the Department of Health and Ageing has sub-contracted the administration of CAAS to a private company.⁴⁸

43 Walker, L. (2005), *Research and Development in Australia and New Zealand* presentation www.novitatech.org.au/ viewed 13 February 2006

44 *ibid*

45 Department of Health and Community Services, *Territory Independence and Mobility Equipment (TIME) Scheme: Policy and Procedure Manual (version 2)*, Northern Territory Government, 2002.

46 *Tasmanian Estimates Committee – Hansard*, Thursday 2 June 2005.

47 South Australia Government *Independent Living Equipment* Website. ILEP 2006 <http://www.ilep.asn.au/ilep/> viewed 13 February 2006.

48 Australian Government Department of Health and Ageing, *Continence Aids Assistance Scheme*, DoHA Canberra n.d.,

<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/continence-caas.htm> viewed 10 February 2006

Ownership of equipment under most programs is clear. In NSW, SA, Tasmania, ACT and NT, ownership of equipment remains with the program regardless of the level, if any, of client contribution. Therefore clients are required to return the equipment when it is no longer needed, unless the item was disposable or customised for personal use and not suitable for re-issue.

In Queensland and WA ownership depends on the level of the shared contribution arrangement. For example, in cases where the program subsidises less than 50 per cent of the cost, the item is consumable or is a home modification, then ownership may be assumed by the client. However, these programs require items that are reusable to be returned for re-issue. The A&EP also requires that reusable items that are provided to clients on a long term basis, including those cases where clients have made a financial contribution but have chosen not to assume ownership of the item, be returned to the program when no longer required.⁴⁹

5.5 Summary and implications for Victoria

The review of the literature demonstrates there is no consistent approach to the provision of aids and equipment internationally or across Australia. However, there are a number of lessons that can be considered for application in the Victorian context.

5.5.1 Program aims

The aims of aids and equipment are generally linked to the government's broader strategic policy objectives for the target groups, whether they are people with a disability, people with functional limitations, or older people. In this sense, the provision of aids and equipment is seen as a component of the government's systems of supports and services that are provided to achieve the wider policy objectives for each target group.

For Victoria, this would mean defining the target groups for the program and aligning the program objectives for the delivery of aids, equipment and home modifications to the broader policy objectives for these groups. The Victorian policy context is discussed further in the following section.

5.5.2 Eligibility criteria

Eligibility for programs is effectively determined by the programs' objectives and then in accordance with the outcomes desired under the governments' strategic policy directions. Most programs, both in Australia and internationally, exclude persons from particular aids and equipment programs if the person is eligible to receive a similar service under another program.

For example, recipients of Australian Government EACH packages are able to receive a range of aids and equipment through this package. Therefore they are not eligible for assistance through the A&EP.

For Victoria, eligibility should be linked to the program objectives and the broader policy objectives for the individual target groups.

⁴⁹ Department of Human Services, Victorian Aids and equipment Guidelines, June 2002, p.13

As is the case with most of the programs reviewed, the A&EP excludes people who are eligible for aids and equipment through other government programs such as the VWA or the TAC.

5.5.3 Prioritisation

Where programs have published prioritisation criteria, these are generally associated with ensuring people with the greatest need or at greatest risk receive the highest priority. Programs may also consider financial capacity as part of the prioritisation process.

For Victoria this suggests there is a need to redevelop the prioritisation criteria to ensure they incorporate consideration of a person's needs (consistent with the relevant broader policy objectives) and the risk to the person if they are not able to access the required aids and equipment. Consideration should also be given to a person's capacity to pay for required items, ensuring that the resources of the program are indeed targeted to those most in need of assistance.

5.5.4 Payment arrangements

A number of different approaches were described in the literature, including programs that pay the full cost of items and provide them to clients on a long term loan basis or simply provide them to clients with no expectation of recovering the item, and programs that require a co-payment from clients. In many cases, the client's contribution is capped on an annual basis and/or linked to the client's capacity to pay.

England has also introduced a direct payment approach whereby clients who have the capacity are provided with funds that can be used to purchase or repair aids and equipment directly.

Victoria should therefore consider reviewing its payment arrangements to link the client contribution to capacity to pay and consider introducing direct payments to enable clients who have the capacity to purchase their aids and equipment themselves.

5.5.5 Ownership

Ownership of equipment is generally linked to the payment approach operating within programs. For example, when the program purchases aids or equipment, it is usually provided on a long term basis. The program is responsible for maintenance and repairs and the client is expected to return the item when it is no longer required. The exceptions to this are personal use and disposable items.

Retention of ownership of equipment enables a program to recover and reissue the item for further use. This has the advantage of increasing the amount of stock available to meet demand, and improves the efficiency of the program.

When clients contribute to the purchase of an item, ownership is generally determined according to whether the client or the program has the larger financial interest in the item. This is the current practice in Victoria, with responsibility for maintenance dependent upon whether the program or the client has retained ownership of the item. In addition clients can choose to have A&EP assume ownership of an item to which they have contributed 50 per cent or more.

5.5.6 Purchasing arrangements

Competitive tendering arrangements are used in many programs. This means that items for the program are supplied under contract, eliminating the need to obtain quotes for each purchase and ensuring that the program's buying power is maximised.

Currently in Victoria, the A&EP does not use contracted suppliers. In moving to this approach, the A&EP could not only reduce the cost of items as suppliers compete for contracts, but it would eliminate the need for therapists to source quotes for prescribed items and thereby decrease the time they spend away from their core role.

5.5.7 Conclusion

While there is no best practice model of service delivery for aids and equipment, the review of other programs did reveal there are alternative approaches to many of the policy and operational aspects of aids and equipment services that could strengthen the Victorian A&EP. Key opportunities for improvement included:

- aligning program objectives with broader policy objectives for the target groups;
- linking eligibility to program and broader policy objectives for the target groups;
- ensuring that prioritisation criteria take account of a person's needs and the risks of not accessing aids and equipment, as well as targeting resources to those people with the greater needs;
- considering introducing alternative payment arrangements including direct payments to clients;
- clarifying ownership arrangements and responsibility for repairs and maintenance; and
- introducing alternative purchasing arrangements.

The lessons from these other programs have been considered as part of the overall findings of this Review and have informed the final recommendations for the future direction of the A&EP.

Implications

6 Implications

The purpose of this section is to summarise the key findings of the Review and describe their implications for the future directions of the A&EP.

Drawing on the information obtained through the analysis of the current program, the literature review and the contributions of the many stakeholders who participated in the consultation process, this Review has identified a number of issues that indicate there is a need to reform the A&EP to ensure it is effectively meeting the needs of Victorians who need assistance to maintain or improve their functional ability.

The key issues and their implications are described under the following headings:

- policy context;
- administrative efficiency and capacity;
- access;
- interaction between therapists, hospitals, community centres and referral sources;
- purchasing processes;
- re-issuing of items;
- ownership of equipment;
- subsidy levels; and
- types of equipment available.

Many of the implications described here have budget implications, some involving potential savings, others potentially involving additional costs to the program.

6.1 Policy context

At present the program is driven by the Program Guidelines and not by the needs of people who require aids, equipment or home modifications to assist them to maintain or improve their functional ability and participate more fully in the community.

There are a number of groups of people who require assistance to access the supports available through the A&EP:

- children and adults with a disability;
- people who are older and frail and who require supports to maintain or improve their functional ability to enable them to continue living in their own homes and preventing admission to a residential aged care facility;

- people with ongoing health needs that impact on their functional capacity and independence including those who require oxygen and continence aids; and
- people who require home modifications to live independently in the community.

The Victorian Government has established a priority policy objective of reducing disadvantage and maximising the health, independence and opportunities for participation of people with a disability, including children, the aged and people with chronic and/or complex health conditions. The provision of aids and equipment therefore needs to align with the contemporary policy objectives for these populations.

This overarching policy direction is reflected in the specific policy frameworks that guide service provision to the various groups who access the A&EP. As such, they all aim to promote independence and maximise participation in the community. However, the different policy frameworks have slightly different emphases on desired outcomes for clients.

For people with a disability and older people, the provision of aids and equipment should promote their independence, enable community participation and improve their quality of life.

For children with development delay or a disability, the provision of aids and equipment should aim to maximise their ability to participate in family and community life.

People living in the community with ongoing health needs require aids and equipment to improve functioning and independence. For people with chronic respiratory disease, this includes access to oxygen and for others it includes access to continence aids.

Home modifications should be provided to people who require more accessible housing to facilitate their independence.

In recognising the range of client groups who require access to aids and equipment, the provision of aids and equipment should be aligned to the policy contexts that shape the delivery of services and supports for each of the target groups. This also requires redeveloping the governance structure. This will allow the relevant policy area within DHS to drive change and seek additional resources for their client group in line with the overarching policy objectives, while always operating in a collaborative approach with other internal stakeholders.

Implications

The provision of aids and equipment for the target groups should reflect the Government's overarching policy objectives for these groups.

The governance structure for the A&EP should be broadened to include representatives from all relevant policy areas.

6.2 Administrative efficiency and capacity

Despite the additional funding allocated to the A&EP since its transfer from the Australian Government to Victoria in 1987, demand continues to increase and is outstripping the capacity of the program. This is evidenced by the increasing number of clients being assigned to waiting lists. A range of program reforms are needed to increase the capacity of the program and thereby increase the number of people who are provided with aids and equipment in a timely manner.

6.2.1 Consolidation of the A&EP Issuing Centres

One way to increase the administrative capacity of the program is to rationalise the number of Issuing Centres. The majority of the 29 Issuing Centres have a geographical focus, while five Issuing Centres provide statewide services to particular target groups. However, as clients do not access Issuing Centres directly, there is limited benefit for clients in operating this many centres.

Each Issuing Centre is allocated 12.5 per cent of the annual budget to cover administrative expenditure. However, there is no definition in the Program Guidelines as to what administration includes and the Review identified significant variation in how this being treated across the Issuing Centres. In some cases, the auspicing service providers are charging the program for office rent and other corporate costs at a level far exceeding the administration limit. It is also understood that there may be some cross-subsidisation of the A&EP through access to hospitals patient appliance programs, oxygen and access to stock for trial, however this has not been quantified.

Moving to a single statewide Aids and Equipment Centre therefore represents potential administrative savings to the program, which would enable greater expenditure on the supply of aids and equipment. However, the lack of transparency in current expenditure on administration means the potential scale of these savings cannot be stated with any certainty.

The establishment of a single Issuing Centre would, however, reduce the inconsistencies in program administration that currently exist and improve the capacity to meet the needs of clients with re-issued equipment, regardless of where the client or the item is located. A consistent approach to the recovery, repair and write-off of the aids and equipment owned by the A&EP would also be facilitated through this approach.

Another key benefit of a single Issuing Centre would be the reduction in inequities due to variable waiting times at individual Issuing Centres. Currently the A&EP is not meeting its objective in relation to promoting equity of access throughout Victoria, as people wait for different lengths of time simply because the funding is split between many service providers and managed separately in each service's catchment area. A single Issuing Centre would remove the need to allocate resources out to catchment areas and allow a single prioritised waiting list to be implemented across the State.

A number of Issuing Centre staff reported that there is growing pressure on the program to provide aids and equipment to prevent admission to hospital, supported accommodation or residential aged care facilities. Clients who require aids and equipment to support or improve their capacity to participate in the community, but who are not at immediate risk of hospitalisation or entry into more supported accommodation, are reportedly being assigned a lower priority in the A&EP. Establishing the program outside health care settings would assist in addressing this issue.

The core functions of the statewide Aids and Equipment Centre would include:

- receiving and assessing applications to determine eligibility and prioritisation according to the relevant policy framework;
- providing advice about current and emerging technology in meeting the needs of individuals seeking assistance from the A&EP;

- allocating and managing budgets and resources;
- managing the procurement and delivery of items, the recycling/re-issuing of items and the repair and maintenance of items;
- monitoring and performance review;
- data management; and
- quality assurance.

Implication

The current distribution of Issuing Centres should be rationalised to increase operational efficiency and to improve consistency in decision making across the program.

6.2.2 IT platform

Another issue to consider is the capacity of the program to collect, manage and use data to improve planning and budgeting processes. There is currently little capacity for forward planning and budget forecasting based on projected client needs, other than planning for “no wait” items based on demand in previous years. Although future demand for assistance can often be predicted based on a person's age, condition and the expected life of items of equipment, this data is not collected and there is no planning framework to support budget allocations to meet predicted need.

Forecasting demand and therefore projecting budget requirements is also not possible at present because of the lack of robust data about expenditure patterns and unmet need. Issuing Centre coordinators recommended that the PADMIN data collection tool be reviewed and a more robust system for budget management and data collection and reporting be developed.

The literature review revealed that other similar programs have also recognised the need to address this need for effective tools to manage the program and a number of them have recently developed and implemented new systems. For example, the findings of the Audit Office report into aids and equipment services in the UK found that improved performance measures and information management were needed, particularly in respect to current client numbers, profiles and disabilities; numbers of people on waiting lists, equipment requested, value of equipment, and time spent waiting; expenditure on items; and administrative expenditure.

Implication

More effective data collection tools and processes should be developed to improve reporting, enable better planning and equitable distribution of resources and ensure there is maximum efficiency within the program and minimum waste.

6.2.3 Purchasing processes

The A&EP requires that quotes be obtained for items prior to the request being forwarded to the Issuing Centre. This function, generally undertaken by the prescribing therapists, is time consuming and diverts them from performing therapeutic assessments and interventions.

This practice is also time consuming and administratively expensive. In some cases, too, the available pool of suppliers is so limited that suppliers hold almost a monopoly on the market and there is thus little opportunity to affect cost savings through a competitive purchasing approach. Where there is only a single supplier of an aid or equipment available in a location, as was reported to be the case in some rural areas, the requirement to obtain quotes was seen as administratively burdensome and of little benefit in terms of ensuring that the best price for an item was obtained.

The feedback from clients indicated that there were often difficulties obtaining equipment locally, especially in rural areas. This, in turn has the potential, once an item is provided, to affect a client's capacity to afford maintenance and repairs of an item where they are responsible for the cost. In relation to home modifications clients in rural areas also reported a lack of builders prepared to provide home modifications in rural areas. Some builders would not travel the distance to undertake small jobs such as those funded by the program

Alternative purchasing arrangements should be explored. There are numerous examples of similar programs using contracted suppliers for high volume items, enabling them to gain better prices for clients, and pre-approved suppliers for more expensive, individualised items. Within Victoria, Health Purchasing Victoria (HPV) is responsible for procurement for public hospitals and health services. HPV procures a number of aids and equipment via a competitive tendering process. The types of aids and equipment purchased through this process are largely the same as those provided to clients of the A&EP and consideration should be given to investigating the potential benefits of this process.

The UK Auditor General's report identified benefits to clients resulting from the use of a voucher system for pre-approved expenditure. In other programs the need for quotes only applies to items of a particular value or greater. These processes can offer administrative savings to the program as well as greater choice and personal control for clients.

The Review also identified benefits to clients when equipment is sourced through local providers, especially in terms of access to repairs. However, some caution should also be exercised to ensure this does not result in suppliers achieving a monopoly in the local market. This can result in inflated prices as the usual market forces that affect pricing have failed.

Implication

Alternative purchasing arrangements, including contracted suppliers, direct payments to clients and vouchers, should be explored to increase choice for clients and to improve opportunities for securing increased value for money in the purchase of aids and equipment.

6.2.4 Re-issuing of items

Re-issuing aids and equipment can reduce waiting times for clients and increase the number of clients who can be assisted through reducing unnecessary purchase of new equipment.

However, there is a growing tendency for therapists to prescribe customised equipment for clients. This is not only costly but reduces the amount of stock that is suitable for re-issue. A contributing factor may be a lack of familiarity by prescribing therapists with the range of items available and their application, leading to a higher level of customisation which may not be necessary.

Issuing Centres aim to achieve a 10 per cent rate of reissue per annum. Issuing Centre staff, however, provided feedback that the program does not provide funding to pay for the administrative time and other costs involved in recovering, repairing and re-issuing equipment. They also indicated that the increasing trend toward customisation of equipment is diminishing the number of items suitable for re-issue.

Feedback from clients indicated they were happy to receive re-issued equipment, as long as it is appropriate to their need and in good repair. However items are re-issued only if they are safe and in good state of repair. Also, the age of the wheelchair for replacement purposes is counted from the date of initial purchase and not from the date of being re-issued to another person.

Implication

Prescribing therapists and clients should be encouraged to consider the appropriateness of standard or re-issued equipment rather than customised equipment, to increase the volume of equipment available for re-issue. This may require providing additional training to therapists to improve their understanding of the range and use of available items.

Consideration should also be given to determining an appropriate re-issue target (currently 10%).

6.2.5 Maintenance and repairs

Ownership arrangements and the related responsibility for maintenance and repairs varies in state administered aids and equipment programs depending on whether and to what extent the client has contributed to the purchase and whether the item is for personal use only or could be reused.

At present the A&EP does not have effective processes for tracking the equipment in which it does have an ownership interest and the current systems do not incorporate this functionality. Issuing Centre staff and A&EP program managers expressed concern given the potential risk arising from a legal liability should faulty equipment result in an injury to a client or carer.

In other similar programs there is a trend toward ownership resting with the client, particularly for low cost and personal items. Many similar programs purchase more expensive items and offer them to clients under long term loan arrangements, with clients generally paying a contribution or rental fee.

Stakeholders who have equipment that belongs to the program also identified a need to improve processes for obtaining authorisation for repairs, especially in emergency situations.

In the case of an item owned by the program requiring repairs, the client must obtain authorisation to proceed with the repair. The Program Guidelines say that a client who arranges repairs prior to obtaining authorisation will not be reimbursed for any costs incurred. Some Issuing Centres leave a mobile number or have a recorded message stating what do if authorisation for emergency repairs is required after hours, However, this is not the case at all

Issuing Centres. The A&EP will also not authorise repairs outside the state. Given the essential nature of some equipment and aids, this requirement has the potential to cause a client undue hardship and may even place the client at risk.

Apart from the financial burden that can result from the cost of repairing equipment, a key issue that was raised was the lack of loan equipment available while items were being repaired. It was noted that this is becoming more problematic as equipment such as wheelchairs become increasingly customised.

Implication

Improved tools and processes for tracking stock should be developed to facilitate improved levels of recovery of equipment and increase the overall availability of stock to meet clients' needs in a more cost effective manner.

Where ownership resides with a client, recognition of maintenance and repair requirements should be built into the resourcing available to individuals.

Statewide procurement contracts should include a requirement for a maintenance component regardless of ownership of items.

6.3 Access

The A&EP is an important element in the system of supports available to people with a disability, people with ongoing health needs that limit their functional capacity, people who are older and frail and their carers. Without access to appropriate aids, equipment and home modifications many would be unable to continue to live in their own homes and participate in the community.

6.3.1 Priority of access

Prioritisation practices vary between Issuing Centres resulting in inequity of access for clients. Prioritisation needs to consider personal outcomes for clients and overall potential improvements to a person's quality of life, as well as the risks of not receiving the items.

6.3.2 Waiting lists

As detailed earlier, there are a large number of clients whose applications for assistance from the A&EP are unable to be met within the recurrent budget.

Stakeholders indicated that waiting times for aids and equipment through the program cause significant hardship for clients and their carers. For those unable to manage without the equipment and who do not have the financial resources to hire the items required, it may become difficult for the client to remain in their home, particularly if they are reliant on an aged carer.

Children are also being placed on wait lists which is particularly concerning given that access to aids and equipment can be a significant component of an early intervention strategy. The ECIS Flexible Support Package, a new initiative in 2005-06, was developed to provide additional support for children birth to school entry and their families to address behavioural, social and emotional issues. Support for families includes respite in relation for those families with children with autism and complex behavioural issues. Feedback from service providers

indicates that a considerable percentage of applications for the ECIS Flexible Support Package have been for aids and equipment due to the long waiting lists to access the A&EP. The program was not designed for this purpose. The ECIS Flexible Support Package Guidelines specifically exclude support for children with high medical support needs.

The growth in the number of older people accessing services to stay at home (such as those funded by the HACC program) has placed increasing pressure on the program. The need to ensure that basic Occupational Health and Safety requirements are met prior to receiving home based service provision creates a "Catch 22" for some individuals. Without access to the necessary equipment, these individuals are often unable to access other services such as personal care, which in turn is required to enable them to continue to live in the community. Having to wait for the required equipment further exacerbates the individual's physical status and functional independence and often leads to an increase in their needs.

It is important to note that waiting lists are a conservative indicator of the level of unmet demand as they only reflect those individuals who have outstanding applications. They do not include those individuals who have chosen not to approach the program due to lengthy waits for assistance or the restrictions on the items it will subsidise.

Without additional funding, it is anticipated that the number of people on the waiting list will grow significantly and the program's capacity to assist people to remain in their homes, maintain caring arrangements and reduce demand for high cost services will therefore be significantly reduced.

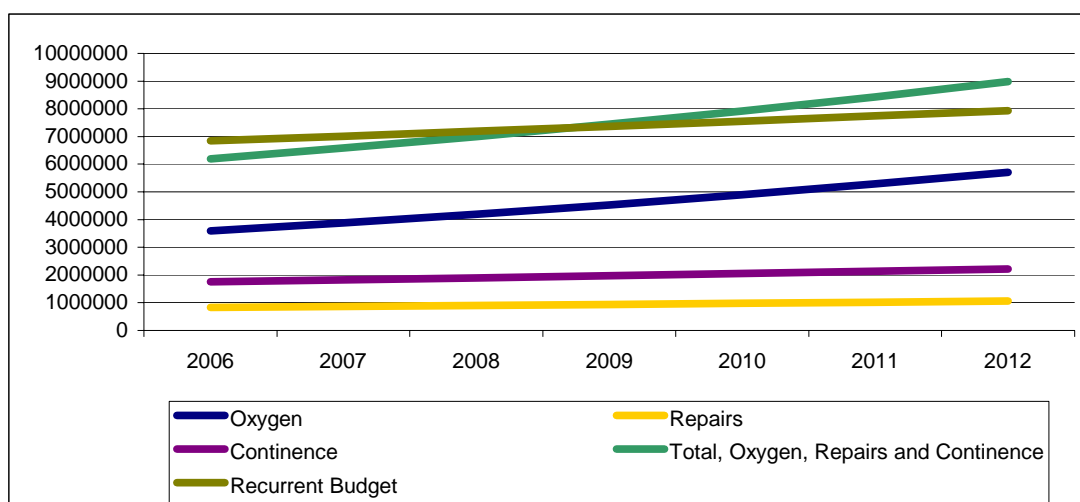
6.3.3 Impact of "no wait" items

As set out in the A&EP Guidelines, the following items are considered "no wait" and consequently must be funded immediately:

- domiciliary oxygen;
- wheelchair repairs; and
- the ongoing supply of continence aids.

As demand for "no wait" items increases, a greater proportion of the A&EP budget is expended on these items, and the capacity of the program to meet requests for subsidisation of other items is diminishing rapidly. That is, without access to additional one off funding provided annually, individuals seeking items that can be waitlisted would experience a significant reduction in the capacity of the program to respond to their requirements.

Figure 11: Projected expenditure on “no-wait” items



In addition to the “no wait” items listed above, the Breast Prosthesis Subsidy program has been operating as a “no wait” program. Redirection of resources by DSD to the Breast Prosthesis Subsidy Program has resulted in a direct reduction in funding for the general A&EP, reducing the number of clients that can receive subsidies for other items. While this program is only a relatively small component of the A&EP, the rate of growth in demand and related expenditure in this area is a significant concern for the program.

It is also important to consider the implications of this growth in demand when considering the A&EP more generally. For example, it would appear that people who had previously been funding the items themselves are now accessing the program, as there is no waiting period and the A&EP does not restrict access based on a person’s capacity to pay. Data collected by the program administrators indicates that approximately 30 per cent of the clients serviced do not receive a pension.

Implication

A standardised holistic assessment and referral format that considers the client’s need for aids and equipment in the context of their social and environmental needs would assist in determining priority.

Prioritisation criteria should be redeveloped to ensure they incorporate consideration of an individual’s needs (consistent with the broader policy objectives) and the risk to the person if they are not able to access the required aids and equipment.

6.3.4 Waiting time for therapist assessments

Many stakeholders reported that significant delays can be experienced while awaiting an assessment for appropriate aids and equipment from a therapist, placing both clients and carers at unnecessary risk. This waiting period is in addition to the time that many clients then wait to be issued an item of equipment once they have been assessed and their application submitted to an Issuing Centre. In some cases, the wait for an assessment may be months.

The Scope report (2006)⁵⁰ also found that waiting times for aids and equipment can be overly long. Amongst its reported findings were:

- the average wait time between assessment of need by a therapist and delivery of equipment is between two hundred and eight (208) and two hundred and thirty-eight (238) days (i.e. seven to eight months) with a typical maximum being up to three hundred and six (306) days of wait. In many cases, a further one or two months' wait occurs whilst modifications, fitting and training are undertaken;
- there is significant wait time between the approval of A&EP funds and the delivery of equipment, with an average wait time of between one hundred and three (103) and one hundred and thirty-three (133) days;
- a second significant wait period occurs between application to A&EP and approval of A&EP funds, with this period averaging between seventy-nine (79) and one hundred and nine (109) days.

Implication

Consideration should be given to improving access to therapists to streamline the assessment processes for clients requiring access to the A&EP.

6.3.5 Improving resource targeting

The program aims to support those most in need. However, there is no process for determining who has the greater need, since the program does not include income or means testing. Many similar programs operating in Australian jurisdictions and overseas do include means testing in one form or another, with funding targeted to the most financially disadvantaged.

In Victoria, the fee structure for the HACC program, which provides services to the same target group as the A&EP, is linked to the individual's capacity to pay. To ensure that the A&EP is effectively targeted to supporting those with the greatest need and to improve affordability, the person's capacity to pay should inform the prioritisation process.

A standard approach to assessing a client's level of need, including capacity to pay, and their subsequent priority for access to the program would provide a more transparent and consistent approach.

Clients who are able to pay may still benefit by having access to the program's purchasing arrangements, either through purchasing at the price available through the program, or potentially through rental options if this strategy was available.

Implication

Prioritisation criteria should include consideration of a person's capacity to pay for required items, thus ensuring that program resources are indeed targeted to those most in need of assistance.

⁵⁰ Scope (2006). Too little too late: Wait times and cost burden for people with a disability in seeking equipment funding in Victoria. Melbourne: Scope (Vic).

6.3.6 Recognising changing needs

Program restrictions (including what equipment can be obtained, levels of subsidisation and timeframes for equipment replacement) limit opportunities for the target population to gain access to aids, equipment or home modifications that would facilitate their independence, community participation and quality of life. They also fail to take into account the rapidly changing needs of children or people with deteriorating conditions such as Multiple Sclerosis.

Not only are children and their families disadvantaged because of limitations regarding replacement items, the Review also found that families can experience particular financial hardship at key transition points when additional aids and equipment may be required. These transition points include commencing and leaving school.

Implications

Restrictions on the replacement of equipment should be reviewed to ensure that replacement is linked to the needs and potential outcome/benefits for clients.

Individuals who have the capacity to pay for aids and equipment should do so and recognition should be given to the financial burdens placed on individuals who have complex and multiple needs and/or changing needs, e.g. children.

An annual cap for the total contribution an individual or family is expected to make and a means for recognising changing needs and lifetime requirements for aids and equipment should be established.

For example, stakeholders expressed a strong view that the restriction of home modification subsidies to a maximum of \$4,400 (including GST) per person per lifetime is inappropriate and fails to recognise the transition of children from home to living independently as well as new needs generated through the ageing process.

Implication

The limit of one home modification per lifetime should be removed as people with a disability and older people, like other members of the community, may move home as their needs change and require access to home modifications when they do so. However, a limit to the number of home modifications that will be subsidised may need to be established.

6.3.7 Expansion to include additional client groups

There are two key areas of concern in relation to people being excluded from the A&EP. The first relates to CACP recipients who are specifically excluded from the program in the A&EP Guidelines.

CACPs aim to enable frail older people to continue to live in their home through the provision of support services. Although this aim is consistent with the objectives of the A&EP, CACP recipients are unable to access the A&EP. As CACPs only support access to limited amounts of aids and equipment, there was considerable concern expressed throughout this Review that individuals in receipt of these packages are being disadvantaged under the current program arrangements.

The second key area relates to people who require disposable continence pads. While continence aids are available through the A&EP, disposable continence pads are not subsidised

through the program. This effectively means that those who need disposable continence pads are unable to access the program.

The Australian Government provides a subsidy towards such items through the CAAS, however the eligibility requirements for this program mean that a significant group of people, predominantly those aged over 65 years who are not working, are unable to access a subsidy for these items through either program.

Further work needs to be undertaken in conjunction with the Australian Government to address these service gaps.

Implication

The Victorian and Australian Governments should work together to develop an appropriate service response for people who fall through gaps in the system including those in receipt of a CACP and those who require disposable continence aids.

6.4 Subsidy levels

The A&EP Guidelines currently prescribe subsidy ceilings for each item available. However, subsidy levels have not been indexed annually and the gap between the full cost of items and the subsidy level is increasing. Clients report experiencing increasing difficulty meeting the gap.

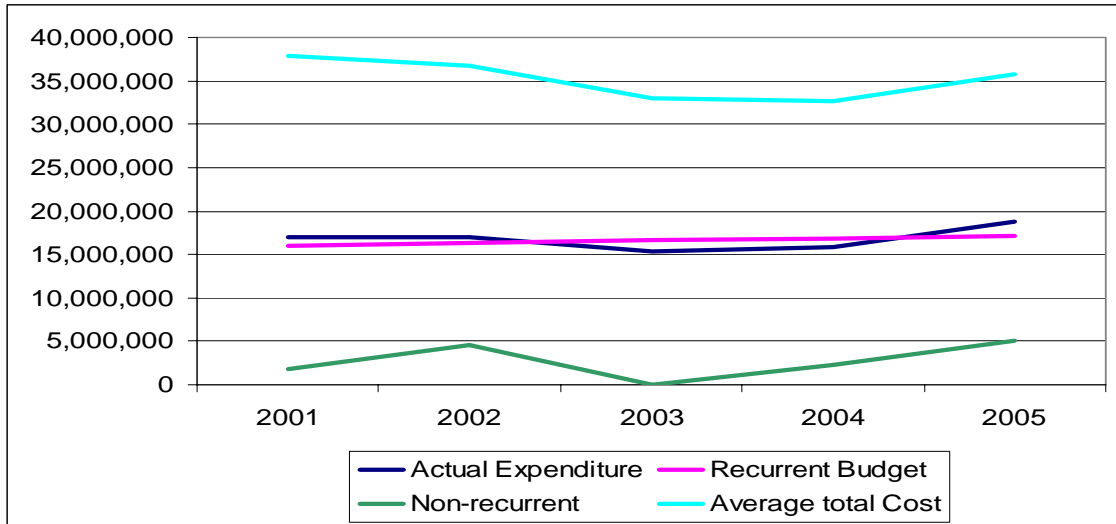
Feedback was received from all groups of stakeholders about the additional burden this is placing on clients, especially those who are least able to pay. The result is a decrease in the program's overall effectiveness in meeting the needs of people with a disability, older people who are frail and their carers.

Additionally, clients are looking to other funding sources to meet the gap. As a result, funds from other initiatives such as flexible support packages across DHS are being diverted to fund the gap. This redirection of support funding is not sustainable as it impacts upon the ability of other programs to deliver appropriate support to their target populations

Therapists also reported spending significant time assisting clients to source alternative funds to meet the gap between the full cost of an item and the subsidy. This diverts them from performing their roles as therapists.

Figure 12 shows the gap between the total amount of funding provided by the A&EP (actual expenditure) and the full cost of aids, equipment and home modifications (average total cost). This gap is steadily widening, meaning that for some items, the cost to the client is increasing, making the items less affordable for clients.

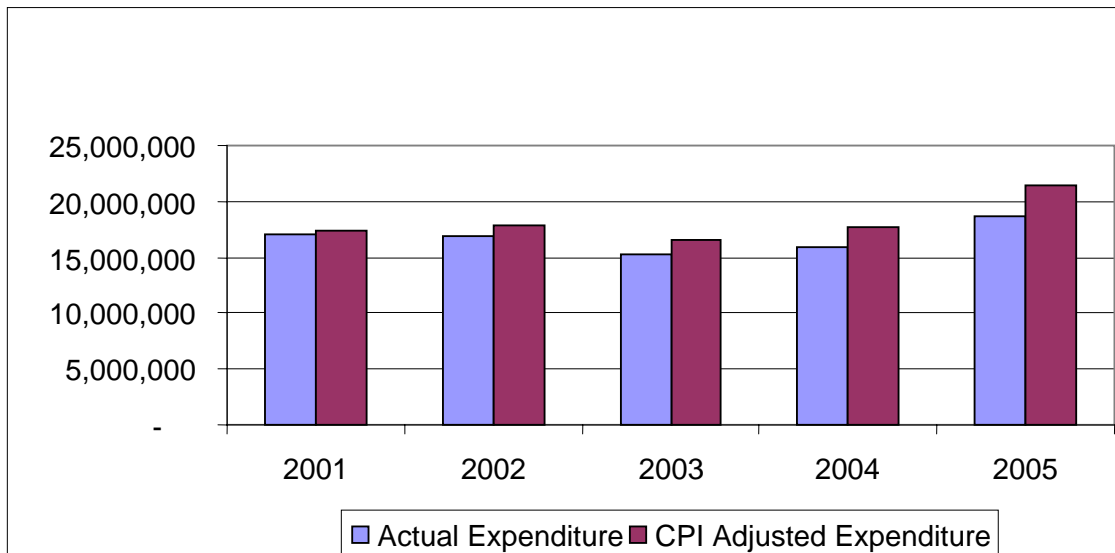
Figure 12: Actual expenditure, recurrent budget, non recurrent budget and the average total cost of items



The gap between average total cost and actual expenditure is increasing. One factor that has contributed to this is the fact that A&EP subsidies have not been indexed annually to incorporate inflation or other pricing impacts.

Figure 13 shows the difference in expenditure that would have occurred had the subsidies been adjusted for the impact of Cost Price Index (CPI) annually during the period 2001-2005.

Figure 13: Impact of adjusting expenditure for CPI



It is important to note that while the A&EP is indexed annually, this funding is currently allocated to subsidising additional clients in order to reduce waiting lists.

The subsidy levels provided through the program, as well as the range of items available, were previously reviewed by the Aids and Equipment Committee.⁵¹ Unfortunately the financial implications of many of the recommendations led to an inability to implement the proposed changes within recurrent funding levels.

Implications

Subsidy levels should be reviewed to ensure they are keeping pace with the full costs of items in order to ensure that the affordability of items is maintained.

The introduction of a means test would enable more effective targeting of resources to those most in need. An option is to link the amount of subsidisation available to a person's capacity to pay, as occurs in many of the other programs reviewed.

6.5 Types of equipment available

The A&EP aids, equipment and home modifications list provided in the Program Guidelines has not been regularly updated and the consultations highlighted that many items required by clients are not available. The program's capacity to respond to individual needs is limited by the pre-determined list of available equipment rather than providing items that would assist individuals to achieve outcomes consistent with the relevant broad policy objectives for that group.

Implication

The provision of aids and equipment should be client centred and outcome focused and link to the broader policy objectives for each of the target groups.

The items available through the program should be reviewed regularly to ensure the program is meeting its policy objectives.

6.6 Interaction between therapists, hospitals, community centres and referral sources

People requiring aids and equipment must be assessed by a relevant allied health professional to determine the most appropriate aid, equipment or home modification to meet their need. The assessor then prescribes the appropriate equipment, obtains quotes, assists the client to obtain additional funds if the purchase price of the item is greater than the subsidy and forwards all the relevant documentation to the Issuing Centre. This process sees most of the decision-making resting with the prescribing therapist.

In responding to the 2004 Client Satisfaction Survey, 87 per cent of respondents reported that therapists were attentive to their needs, listened to the client and took a practical approach to prescribing appropriate aids or equipment. However, during the consultations, some clients reported feeling disconnected from the decision-making processes.

⁵¹ The Aids and Equipment Committee included representation from DHS, A&EP service providers and relevant health professionals.

Implication

The program should be aimed at improving personal outcomes for clients and should therefore be more responsive to the client's individual circumstances and lifestyle choices. Person centred approaches to decision making should underpin the approach taken by the A&EP.

A number of Issuing Centre staff reported that there is growing pressure on the program to provide aids and equipment to prevent admission to hospital, supported accommodation or residential aged care facilities. Clients who require aids and equipment to support and improve their capacity to participate in the community, but who are not at immediate risk of hospitalisation or entry into more supported accommodation, reported that their requests are being assigned a lower priority in the A&EP. This perception is consistent with the finding that the fastest growing demand in the program is coming from older people as described in Appendix C.1.2

Implication

The Issuing Centre should be repositioned outside of hospitals and health services to reinforce its role in promoting community participation and quality of life.

6.7 Conclusion

To strengthen the capacity of the program to continue to deliver a service that effectively meets the needs of Victorians for aids, equipment and home modifications, reform is needed.

The key opportunities for reform identified by the Review process are:

The policy platform, reporting and governance arrangements

- the provision of aids and equipment should reflect the Government's overarching policy objectives for the target groups.
- the governance structure for the A&EP should be broadened to include representatives from all relevant policy areas;
- the provision of aids and equipment should be client centred and outcome focused and link to the broader policy objectives for each of the target groups;
- the program should be aimed at improving personal outcomes for clients and should therefore be more responsive to the client's individual circumstances and lifestyle choices. Person centred approaches to decision making should underpin the approach taken by the A&EP;
- more effective data collection tools and processes should be developed to improve reporting, enable better planning and equitable distribution of resources and ensure there is maximum efficiency within the program and minimum waste;

Issuing Centres

- the current distribution of Issuing Centres should be rationalised to increase operational efficiency and to improve consistency in decision making across the program;
- the Issuing Centre should be repositioned outside of hospitals and health services to reinforce its role in promoting community participation and quality of life;

Arrangements for purchasing and managing aids and equipment

- alternative purchasing arrangements, including contracted suppliers, direct payments to clients and vouchers, should be explored to increase choice for clients and to improve opportunities for securing increased value for money in the purchase of aids and equipment;
- prescribing therapists and clients should be encouraged to consider the appropriateness of standard equipment rather than customised equipment, to increase the volume of equipment available for re-issue. This may require providing additional training to therapists to improve their understanding of the range and use of available items;
- improved tools and processes for tracking stock should be developed to facilitate improved levels of recovery of equipment and increase the overall availability of stock to meet clients' needs in a more cost effective manner;
- restrictions relating to the replacement of equipment should be reviewed to ensure replacement is linked to the needs and potential outcome/benefits for clients;

Client assessment, access and prioritisation

- a standardised holistic assessment and referral format that considers the client's need for aids and equipment in the context of their social and environmental needs would assist in determining priority;
- prioritisation criteria should be redeveloped to ensure they incorporate consideration of an individual's needs (consistent with the broader policy objectives) and the risk to the person if they are not able to access the required aids and equipment. They should also consider a person's capacity to pay for required items, thus ensuring the resources of the program are indeed targeted to those most in need of assistance;
- consideration should be given to improving access to therapists in order to streamline the assessment processes for clients requiring assistance from the A&EP;
- the limit of one home modification per lifetime should be removed as people with a disability and older people, like other members of the community, may move home as their needs change and need access to home modifications when they do so;
- the Victorian and Australian Governments should work together to develop an appropriate service response for people who fall through gaps in the system including people in receipt of a CACP and those who require disposable continence aids;

Subsidy levels, contribution arrangements and equipment ownership

- ownership arrangements should be clarified and, where ownership resides with a client, recognition of maintenance and repair requirements should be built into the resourcing available to individuals;
- individuals who have the capacity to pay for aids and equipment should do so, and recognition should be given to the financial burdens placed on individuals who have complex and multiple needs and/or changing needs, e.g. children. Therefore, an annual cap for the total contribution an individual or family is expected to make and a means for recognising an individual's changing needs and lifetime requirements for aids and equipment should be established;
- subsidy levels should be reviewed to ensure they are keeping pace with the full costs of items to ensure that the affordability of items is maintained; and
- the introduction of a means test would enable more effective targeting of resources to those most in need. An option is to link the amount of subsidisation available to a person's capacity to pay, as occurs in many of the other programs reviewed.

The following chapters describe the key principles that should drive the changes to the program, the actions that are required and the implications for funding.

Principles for change

7 Principles for change

This chapter describes recommended changes to strengthen the provision of aids, equipment and home modifications in Victoria.

A series of principles are proposed to underpin the reform of the program and to provide a sound basis for the implementation of reform that has been identified through this Review.

The proposed policy framework is based on a repositioning of the program so that the service delivery model is aligned to the broader context in which services and supports are delivered to the target groups.

The principles which will then shape the program are:

- 1 Where support to obtain aids, equipment or home modifications is available through other government funded programs or schemes, individuals should be supported to access these programs.
- 2 Improving outcomes for individuals should be the core objective in the provision of aids and equipment, with an emphasis on early intervention, prevention and maintenance of functional abilities for people with a disability, people who are older and frail and their families and carers.
- 3 Access to aids and equipment should be based on an individual's circumstance, their lifestyle choices and their capacity to benefit.
- 4 Greater equity should be embedded to facilitate affordability.
- 5 The supply of aids and equipment should occur in a cost effective manner.

The rationale for each of these principles is presented in the following sections along with the changes to the program that flow from the application of the principles.

7.1 Establishing the policy framework – the foundation issue

The foundation issue in repositioning the program is to identify the target groups for this service, to articulate the policy environment within which aids and equipment are to be provided and the outcomes to be achieved.

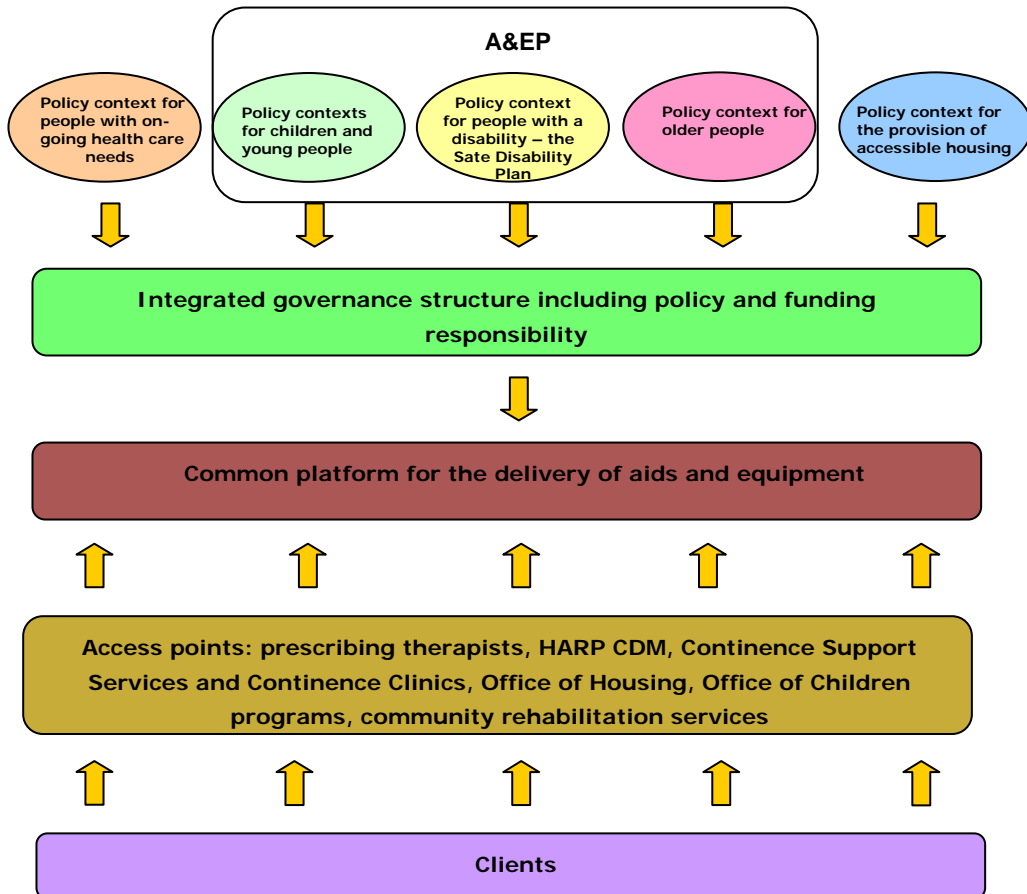
At present, the A&EP aims to meet the needs of a number of groups:

- adults with a disability who require supports to increase their independence, enable community participation and improve their quality of life;
- children with a developmental delay who require support to optimise their development and ability to participate in family and community life;
- people who are frail and aged and who require supports to enable them to continue to live in their own homes and prevent admission to an aged care facility;

- people with health needs that impact on their functional independence, e.g. incontinence and respiratory disease; and
- people who require accessible housing to live independently in the community.

While the policy objectives for these target groups share a number of commonalities, the policy frameworks which guide the delivery of services to these distinct groups differ somewhat in their emphasis on outcomes. The policy context is represented in the figure below.

Figure 14: Operating model



Aligning the provision of aids and equipment to the separate policy contexts that shape the delivery of services and supports for each of the separate target groups requires redeveloping the service delivery model and guidelines so that:

- the A&EP is refocused to provide subsidised aids and equipment to improve outcomes for individuals with an emphasis on early intervention, prevention and maintenance of functional abilities of children and adults with a disability, people who are older and frail and their families and carers;
- responsibility for policy and funding for aids and equipment for people with ongoing health needs (specifically incontinence and chronic respiratory disease requiring ongoing oxygen) transfers to Health Independence Programs, Programs Branch, MHACS; and
- responsibility for policy and funding for accessible housing for people requiring home modifications to meet their functional needs transfers to the Office of Housing.

The rationale for the repositioning of responsibilities is to create a more integrated and coordinated service system and improve access to aids, equipment and home modifications consistent with contemporary policy objectives and priorities.

This will require the establishment of an overarching integrated governance framework for the program which represents all of the above areas, to ensure the service responses for individuals remain appropriate and equitable. The integrated governance structure will also provide the mechanism for joint responses to identifying and securing the requisite funding to ensure that provision of aids and equipment occurs in accordance with policy objectives.

While it is appropriate that policy and funding responsibility be repositioned within the broader programs identified above, there should continue to be a single platform for the provision of aids and equipment i.e. a single statewide Aids and Equipment Centre that is responsible for administering the program and managing the procurement of items in accordance with the policies for each target group. This should include the provision of home modifications to ensure that these remain integrated with the broader provision of aids and equipment. The statewide Aids and Equipment Centre is also the appropriate platform for the provision of oxygen and continence aids as these programs will be able to access the procurement services of the Issuing Centre and benefit from its purchasing power.

The proposed changes will not impact upon the way that the client interacts with the program. Access to the program will continue to be through an assessment by a prescribing therapist which identifies the most appropriate items to meet the needs of the individual and the potential risks of not receiving aids and equipment. Decisions about prioritisation will, however, be linked to the broader policy objectives for the target groups.

While the alignment of service provision with the broader policy contexts will result in greater clarity of the objectives and models for the delivery of aids and equipment, there are a number of challenges that must be addressed to ensure an effective service system. The benefits and challenges are summarised in the following table.

7.2 Establishing a contemporary program framework – the principles

The changes to the A&EP should be underpinned by the following principles, along with the proposed changes in the program's administration.

Principle 1:

Where support to obtain aids, equipment or home modifications is available through other government funded programs or schemes, individuals should be supported to access these programs.

Rationale

- Individuals in need of aids and equipment should be able to access mainstream programs where appropriate.
- The access to aids and equipment through the A&EP should only be for those items not provided by other mainstream programs.

Actions

- The A&EP Guidelines should be reviewed to ensure that the program complements but does not duplicate the provision of aids and equipment available through other programs.
- Clients receiving a package of supports and services through the DHS programs such as HomeFirst, HARP, and ECIS Flexible Support Packages should continue to be supported to receive aids and equipment through the A&EP as per the current A&EP Guidelines.

Principle 2:

Improving outcomes should be the core objective in the provision of aids and equipment, with an emphasis on early intervention, prevention and maintenance of functional abilities for people with a disability, people who are older and frail and their families and carers.

Rationale

- Individuals should be able to benefit from their access to aids and equipment through:
 - improvements in their circumstance; or
 - through maintenance of their current levels of independence.
- The provision of aids and equipment should be seen as one element of a suite of options to support the overarching policy objectives established for each target group.
- The overarching policy framework should determine the nature and range of the aids and equipment available for individuals.

Actions

- The current restrictions on types of aids and equipment available should be reviewed to ensure the nature of aids and equipment provided are consistent with the broader policy framework for each target group.
- Program guidelines and the program's operating model should be linked to improving outcomes for individuals.
- A common assessment framework should be established for each target group that links the need for specific aids and equipment to the individual within the wider policy context established for each target group.
- Options for the provision of necessary aids and equipment to CACP recipients and those requiring disposable continence aids should be explored with the Australian government.
- Individuals should be able to access home modification services based on their relative need rather than being restricted to one service per lifetime.

Principle 3:

Access to aids and equipment should be based on an individual's circumstance, their lifestyle choices and their capacity to benefit.

Rationale

- Individuals who have need of aids and equipment should be able to access such assistance regardless of where they live in Victoria.
- Access to aids and equipment should be determined based on an individual's capacity to benefit and the risks that may be encountered in not providing such assistance.
- Individuals requiring aids and equipment should have their requirements assessed in terms of their individual circumstance, their lifestyle choices and their capacity to benefit.

Actions

- Establish a common assessment framework to determine an individual's need for specific aids and equipment in light of the individual's circumstances, the client's lifestyle choices and goals consistent with the policy context for each target group.
- Redevelop the prioritisation criteria to ensure that resources are effectively targeted to those most in need.
- The prioritisation criteria should ensure that decision-making about prioritisation is transparent and that outcomes for consumers and carers are considered in terms of the

potential benefit that will result from the provision of an aid or piece of equipment in terms of independence, participation and quality of life.

- Ensure that a statewide network of prescribing therapists is established and maintained to facilitate access to aids and equipment across Victoria.
- Strengthen the current network of prescribing therapists to ensure they can effectively assess and prescribe the aids and equipment that individuals require in light of contemporary developments.
- Develop supports to enable individuals requiring aids and equipment to access specialist assessment services regardless of where they live or their capacity to pay.
- Items should be repaired and replaced as required.

Principle 4:

Greater equity should be embedded to facilitate affordability.

Rationale

- Individuals who can afford to pay should pay for the aids and equipment they need.
- Aids and equipment should be available to an individual in response to their changing needs across their life.
- Recognition of product lifecycle should be built into the resourcing available to individuals to ensure their aid or equipment is effectively maintained.

Actions

- Review subsidy levels to ensure they keep pace with the full cost of items in order to maintain affordability.
- Introduce a system of client contributions based on capacity to pay. This should include:
 - a process of means testing linked to the means testing criteria used by, for example, Centrelink or other programs such as HACC;
 - an annual cap for the total contribution an individual or family is expected to make; and
 - means for recognising an individual's changing needs and lifetime requirements for aids and equipment.
- Establish a strategy to support individuals to maintain aids and equipment that have regular or high maintenance costs.

Principle 5:

The supply of aids and equipment should occur in a cost effective manner.

Rationale

- The processes to support the provision of aids and equipment should be streamlined so they are responsive to individual requirements for aids and equipment while being delivered in a cost effective manner.
- The delivery platform for the supply of aids and equipment should be rationalised to ensure efficient delivery.






















Actions

- The number of Issuing Centres should be rationalised to reduce unnecessary administrative costs, and a single statewide Aids and Equipment Centre established to provide aids and equipment within Victoria. As part of the statewide Aids and Equipment Centre, a single statewide re-issuing service should be established to recycle aids and equipment that have the potential for re-use.
- Improved tools and processes for tracking stock should be developed to facilitate improved levels of recovery of equipment and increase the overall availability of stock to meet clients' needs in a more cost effective manner. This should include the development of a statewide database of client requests and equipment available for re-issue.
- The ownership of individual aids and equipment should be rationalised so the State only retains equity where there is potential to recycle items for others to use.
- For low cost items, or where items do not require customisation, direct payments to individuals should be considered to increase consumer choice and independence. This should be informed by current work in this area (for example in DSD).
- Alternative purchasing arrangements should be considered to enhance the purchasing power of individuals and the program:
 - direct payments to consumers to assist with the cost of purchasing equipment, particularly low cost and/or frequently used items; and
 - a pool of pre-qualified or approved suppliers of aids and equipment via a competitive tendering process.

7.3 What will be the impacts of the proposed changes?

The following table summarises the benefits to clients, prescribing therapists and program administrators that will result from the proposed changes to the program.

Table 9 Impacts of proposed changes

Impact	Clients	Prescribing therapists	Program administrators
Alignment of program objectives with broader policy objectives for target groups – provides greater clarity about client outcomes to guide assessment, prescription of items, and prioritisation.			
Transferring responsibility for oxygen, continence aids and home modifications to relevant program areas – more integrated and coordinated service system, improved access and reduced waiting times for clients requesting other items, services linked to broader policy context.			
Preferred supplier arrangements – reduced costs of items, reduced administrative load for therapists by not having to source quotes, reduced administrative burden.			
Introducing a statewide Aids and Equipment Centre – greater consistency of prioritisation and decision-making and therefore greater equity, consistency of service access regardless of location; streamlined administrative processes.			
Subsidies increased – greater affordability for individuals, reduced waiting times to source “gap” funds, reduced administrative load for therapists by not having to source “gap” funds for clients.			
Investment in prescribing therapists – improved access for clients, improved capacity for assessment and decision-making linked to policy objectives for target groups, greater knowledge of available products, improved reissue rates.			
Increased number of home modification subsidies per lifetime – improved responsiveness to changing client needs.			
Prioritisation linked to capacity to pay – better targeting of resources, recognition of clients with multiple and/or complex needs, greater equity, and improved affordability for those with the greatest need.			

Recommendations

8 Recommendations

Having considered the proposed reform options for the A&EP, it is recommended that DHS implement the model described above as the optimum case. Therefore, the following actions are recommended.

Recommendation 1

Reposition the program to identify the target groups for this service and to articulate the policy environment in which aids and equipment are to be provided and the outcomes to be achieved.

- Refocus the A&EP to provide subsidised aids and equipment to improve outcomes for individuals with an emphasis on early intervention, prevention and maintenance of functional abilities of children and adults with a disability, people who are older and frail and their families and carers.
- Elements that involve ongoing clinical and health support should be integrated within the relevant mainstream programs to ensure better outcomes for clients. The continence assistance element of the A&EP should be incorporated with SACS Continence Clinics and Continence Support Services for children to streamline continence support.
- Responsibility for the provision of oxygen should be transferred to HARP Chronic Disease Management Services (HARP CDM).
- The home modifications element of the A&EP should be integrated with related services provided through the Office of Housing including the Home Renovation Advisory Service and the Home Renovations Loan Scheme.
- Implement a cross-departmental governance structure for the A&EP incorporating representatives from all relevant policy areas including Aged Care, Disability, Children, Health and Housing.

Recommendation 2

The provision of aids and equipment should improve outcomes, with an emphasis on early intervention, prevention and maintenance of functional abilities, for people with a disability, people who are older and frail and their families and carers.

- A common, comprehensive assessment framework should be established for each target group to determine an individual's need for specific aids and equipment in light of the individuals' circumstances, lifestyle choices and goals consistent with the policy context for each target group.
- Establish a transparent prioritisation framework to determine an individual's priority for specific aids and equipment that takes into consideration personal outcomes for the client, including the overall improvements to a person's quality of life that will result from access to the equipment, as well as the risks of not receiving the items.

- Individuals should be able to access the program based on their relative and changing circumstances. For example, restrictions such as allowing people to access home modifications more than once per lifetime should be removed.
- As part of this process, the Victorian and Australian Governments should work together to develop an appropriate service response for people who fall through gaps in the system, including people in receipt of a CACP and those who require disposable continence aids. This is an issue for urgent attention.

Recommendation 3

Access to aids and equipment should be based on an individual's circumstance, their lifestyle choices and their capacity to benefit.

- Strengthen the interface between the A&EP and prescribing therapists in order to reduce unnecessary administrative burden on therapists, thus enabling more timely access to therapy assessments. Provide professional development in relation to assessment and prescription of aids and equipment to meet client needs.
- Investigate opportunities to improve access for equipment purchase, maintenance and repair to maximise the affordability of private ownership.

Recommendation 4

Greater equity should be embedded to facilitate affordability

- Implement a process for periodic review of subsidy levels to maintain affordability of items for clients. Subsidy levels should be indexed annually.
- Review the system of client contributions to address issues of capacity to pay including consideration of an annual cap for families or individuals requiring multiple items, recognition of key transition points in a person's life, and alternative purchasing and contribution mechanisms such as an annual equipment rental fee.
- Redevelop the prioritisation criteria to ensure that resources are effectively targeted to those most in need including implementation of a process of means testing linked to the criteria used by, for example, Centrelink or other programs such as HACC.

Recommendation 5

- The supply of aids and equipment should occur in a cost effective manner.
- Establish a single statewide Aids and Equipment Centre to improve client access and timely provision of aids and equipment, facilitate greater operational efficiency and to develop statewide consistency in the provision of aids and equipment.
- Develop a new IT platform to support service delivery, tracking of stock, data collection and budgeting. This should also facilitate improved reporting and planning, a more equitable distribution of resources and maximum efficiency within the program.

- Implement alternative purchasing arrangements to enhance the purchasing power of individuals and the program and to achieve improved service delivery in relation to reissue, maintenance and repair. Consideration of new approaches, including establishing a pool of pre-qualified or approved suppliers of aids and equipment via a competitive tendering process, the development of a loan/rental capacity for high demand or high cost items, direct payments to clients and processes for reissue of items.

Reference List

Reference List

Audit Commission. *Fully Equipped 2002*, <http://www.audit-commission.gov.uk/reports/AC-REPORT.asp?CatID=&ProdID=2103ACC1-7512-46a0-B74C-3D28724585FE>

Australian Bureau of Statistics *Survey of Disability, Ageing and Carers 2003*. ABS Cat.No. 44300.

Australian Capital Territory Health. The ACT Equipment Scheme.
<http://www.health.act.gov.au/c/health?a=sp&pid=1059610195>

Australian Government *Hearing Services Program Guidelines* (2001),
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-hear-prog.htm>

Australian Institute of Health and Welfare, *Disability: the use of aids and the role of the environment*, AIHW, Canberra 2003, p.7

Department of Health and Community Services, *Territory Independence and Mobility Equipment (TIME) Scheme: Policy and Procedure Manual (version 2)*, Northern Territory Government, 2002.

Department of Human Services 2002, *Victoria State Disability Plan 2002 – 2012*, Melbourne, Victoria

Department of Human Services *Continuing Care and Clinical Service Development Programs Branch*. Draft Philosophy of SAC.S. Provided by DHS.

Department of Human Services, Disability Services Division, *Aids and Equipment Program Review, Request for quote*, Sept 2005

Department of Human Services Improving care for older people: a policy for Health Services. 2003.

Department of Human Services Office of Housing. *Home Renovations Scheme Brochure*.

Department of Human Services, *Victorian Aids and Equipment Program (A&EP) Guidelines*,

Department of Human Services. *Care in your community: a planning framework for integrated ambulatory health care*. 2006

Department of Human Services. Improving care for older people: a policy for Health Services. 2003.

Department of Human Services. *Victorian HACC Program Manual*.

Department of Premier and Cabinet 2005. *A Fairer Victoria – creating opportunity and addressing disadvantage*. State of Victoria, Victoria.

Department of Premier and Cabinet 2005. *A vision for Victoria to 2011 and beyond – growing Victoria together*. State of Victoria, Victoria.

Department of Veterans Affairs, *Annual Report 2004-05* <http://www.dva.gov.au/media/aboutus/annrep05/>

Directgov.uk, *Direct payments: arranging your own care and services*,
<http://www.direct.gov.uk/DisabledPeople/FinancialSupport/FinancialSupportArticles>

Directgov.uk, *Disabled people: help with buying equipment*
<http://www.direct.gov.uk/DisabledPeople/HomeAndHousingOptions/YourHome/YourHomeArticles/fs/>

Email correspondence from A&E program administrator, DHS Head Office

Enable New Zealand website, <http://www.enable.co.nz/>

Enable New Zealand, *Specialised Assessor Equipment Manual*,
<http://www.enable.co.nz/Enable+New+Zealand/WebSite.nsf/> Enable New

Government of Canada: *Federal Disability Report; Advancing the Inclusion of Persons with Disabilities*, 2004.

Government of New Zealand *Disability Strategy* <http://www.odi.govt.nz/publications/nzds/summary.html>

Ministry of Health (2004), *New Zealand Disability Strategy Implementation Work Plan – 1 July 2004-30 June 2005*, Ministry of Health, Wellington.

Ministry of Health, 2005 *The Annual Report 2004/05 including The Health and Independence Report: Annual Report for the year ended 30 June 2005: Director-General of Health's Annual Report on the State of Public Health 2005*. Wellington: Ministry of Health.

NSW Health, *Program of Appliances for Disabled People (PADP) – NSW Health Policy*, Sydney, 2005.

Prince Edward Island Government website: <http://www.gov.pe.ca/>

Scope (2006). *Too little too late: Wait times and cost burden for people with a disability in seeking equipment funding in Victoria*. Melbourne: Scope (Vic).

Tasmanian Estimates Committee – Hansard, Thursday 2 June 2005.

UK Department of Health *Fair Access to Care* <http://www.dh.gov.uk/assetRoot/04/01/96/41/04019641.pdf>

UK Department of Health *Integrated Community Equipment Services* <http://www.icesdoh.org/>

Australian Government Department of Health and Ageing, *Continence Aids Assistance Scheme* DoHA Canberra n.d., <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/continence-caas.htm>

Independent Living Equipment Independent Living Equipment Website. ILEP 2006
<http://www.ilc.asn.au/ilep/>

Walker, L 2005, *Research and Development in Australia and New Zealand* presentation
www.novitatech.org.au/

Appendices

A The Review approach

A.1 Project initiation

The project initiation stage involved three key tasks:

- confirmation of the objectives of the project, the specific outcomes desired and the general methodological approach;
- discussion and agreement regarding the roles and responsibilities in relation to project management; and
- consolidation of arrangements for project management and administration including timelines.

A.2 Research

The research phase provided the base information to inform the consultation phase and subsequent strategic development. The desktop research phase covered:

- general demographic changes that are likely to impact on the requirements for and the provision of disability services across Australia;
- an analysis of the current A&EP trends (based on data already collected by the A&EP including annual client satisfaction survey outcomes); and
- review of A&EP across Australia; and approaches adopted in Australia, and internationally, in response to changing demographics and changing demand and expectations in the provision of A&EP. Specific consideration was given to programs in the UK, Canada and New Zealand.

The desktop research phase drew on available documentation from the A&EP, along with undertaking a high level scan of programs in other domestic jurisdictions as well as the nominated international jurisdictions. Additionally, available data on expenditure patterns was collected from DHS and analysed as part of the research phase.

The research phase was used to inform the consultation phase of this project.

A.3 Stakeholder consultations

Consultations with stakeholder were undertaken in order to provide further information to:

- inform the analysis of the strengths and weakness of the current service provider network (including state-wide and local services) in relation to:
 - the administrative efficiency and capacity of the program;
 - the issues associated with client access;
 - the efficiency of interaction with prescribing therapists, hospitals, community health centres and other referral sources;
 - the processes for the purchasing, delivery, monitoring and reissue of equipment; and
 - the consistency of decision making eg. eligibility, priority.
- determine the extent to which the A&EP is meeting its stated objectives, especially in relation to specific client groups such as complex clients, children and the aged. This included consideration of:
 - access to timely and effective prescription;
 - equity of access to funds via the subsidy system;
 - the ability of the client group to fund the difference between the subsidy levels provided and the actual cost of the item;
 - ownership of equipment;
 - targeting of those most in need via the current priority guidelines; and
 - equipment types available.
- support the analysis of cost drivers for the A&EP including:
 - current demand;
 - population growth;
 - projected growth of ageing and disabled populations;
 - community inclusion as an alternative to residential care;
 - increasing complexity of support requirements for people living at home;

- lifetime requirement for equipment;
- increases or decreases in the cost of aids and equipment;
- requirements for Domiciliary Oxygen.

The consultations involved interviews with program administrators and DHS regional staff responsible for funding and administering the A&EP; interviews/site visits with a sample of Issuing Centres and specialist centres; a workshop with representatives from each of the 29 Issuing Centres, including the four specialist centres; interviews with external stakeholders such as advocacy groups; community and health service providers; and focus groups for clients, their families and carers.

A.4 Reporting on the findings of the Review

Following the desktop research, stakeholder consultations, and A&EP trend analysis, the Review team presented the draft Final Report to the Project Control Board on 13th October 2006 for consideration of the findings.

B Governance

B.1 Review Advisory Group

B.1.1 Terms of Reference

Purpose

The A&EP Review Advisory Group guided and oversaw the Review process. Members of the Group were invited to provide input to key project deliverables.

Principle functions of the Review Advisory Group were to:

- provide advice regarding processes and methodology for undertaking the Review;
- provide guidance on the most effective way to consult with the broad range of stakeholders, including people accessing A&EP and their families/carers, service providers and DHS staff;
- ensure the A&EP Review was aligned with the goals of the State Disability Plan 2002-2012;
- provide specialist knowledge on particular aspects of the A&EP as they related directly to the project, including accessibility, flexibility, viability, and quality; and
- respond to key themes and trends identified through the Review process and to consider opportunities to improve the way A&EP responds to people with a disability and the frail aged.

In all instances, the Director, Community and Individual Support Branch or her delegate, considered contributions from the Advisory Group.

Membership

Membership of the A&EP Review Advisory Group is by invitation of the Director Community and Individual Support Branch or her delegate. The Director or Director's delegate reserves the right to alter the membership of the Review Advisory Group as required. The Advisory Group Chairperson is to be appointed by the Director or Director's delegate.

Terms of Appointment

Members of the Advisory Group were appointed for a period of six months. Subsequent periods of appointment were by invitation of the Director Community and Individual Support Branch.

B.1.2 AIDS AND EQUIPMENT PROGRAM REVIEW ADVISORY GROUP MEMBERSHIP

Name	Representing	Position/Organisation
Ms Yvonne Duncan	Australian Physiotherapy Association	Physiotherapist
Ms Natasha Layton	OT Australia - Victoria	Occupational Therapist
Ms Jenny Smith	Royal District Nursing Service	Physiotherapist
Ms Jane Clements	Southern Health Aids and Equipment Program	A&EP Coordinator
Mr Mohan Bodhankar	Goulburn Valley Health Aids and Equipment	A&EP Coordinator
Ms Cath Williams	Independent Living Centre Yooralla	ILC Manager
Ms Victoria Garner	Association for Children with a Disability	Committee member and Parent representative
Ms Deb Humphris	Disability Rights Victoria	Board member and user of A&EP
Mr Gerry Naughtin	Council on the Ageing	Manager Policy
Ms Sue Whiting	Disability Justice Advocacy Inc	Chairperson and user of A&EP
Ms Willa Longmuir	Case Management Action Group	Executive member and Melbourne City Mission
Mr Calvin Graham	Aged Care Branch DHS	Manager HACC Service Development
Ms Susan Race	Metropolitan Health and Aged Care Services DHS	Manager Health Independence Programs
Ms Melissa Bennett	Victorian Healthcare Association	Nillumbik Community Health Service
Mr Paul Zanatta	Victorian Association of Health and Extended Care	Manager, Community Care and Bush Nursing
Ms Marika Jagow	Disability Services Regional Partnerships and	Community Building Project Officer
Ms Michelle Haddon	Community Care Issues Network	Uniting Care Community Options
Ms Megan Henderson	Municipal Association Victoria	Moreland City Council
Ms Sue Eddy	Disability Services DHS	Assistant Director Community & Individual Support
Ms Meredith Kefford	Primary and Community Health DHS	Manager Community & Women's Health

B.2 Project Control Board

DIVISION	BRANCH	POSITION TITLE	NAME
Disability Services	Community & Individual Support	Director	Brenda Boland
Disability Services	Community & Individual Support	Assistant Director	Sue Eddy
Disability Services	Planning & Resource Management	Director	Anne Congleton (& Kelly Richardson)
RRH&ACS	Coordinated and Home Care	Manager	Jeannine Jacobson (& Calvin Graham)
Financial & Corporate Services	Budget Planning & Review	Director	Bruce Prosser (Delegated to Stephen Grech)
N&WMR	Disability Services	Manager	Dorothy Wee
Gippsland	Disability Services	Manager	Karen Russell
MH&ACS	Programs Branch, Continuing Care & Clinical Service Development	Manager	Lea Pope
Housing & Community Building	Strategy & Corporate Finance	Director	Ed David
Office for Children	Early Years Services Branch	Director	Jeanette Nagorcka

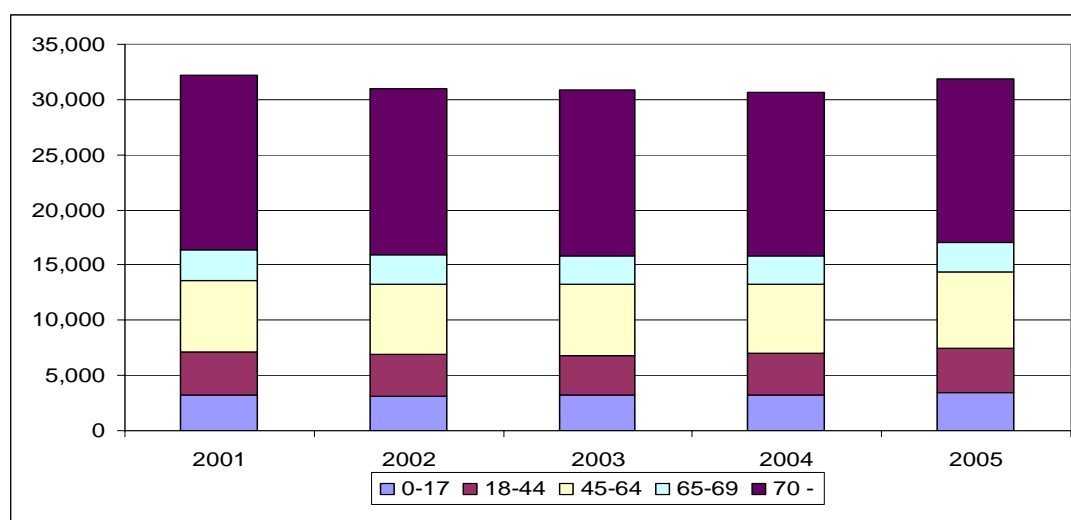
C Key performance data

The following section outlines the key performance trends for the A&EP in terms of clients, expenditure, range of items provided and unmet demand. All data provided in the following analysis has been sourced from the A&EP PADMIN database.

C.1.1 Numbers of clients 2000-2005

Figure 15 below provides a breakdown of the number of clients by five age cohorts: 0-17 years, 18-44 years, 45-64 years, 65-69 years and over 70 years for the 2001-05 period.

Figure 15 Clients by age cohort



The greatest number of clients of the A&EP are aged 70 years and over. Additionally, there have been increases in the 45-64 years and 65-69 years age cohorts.

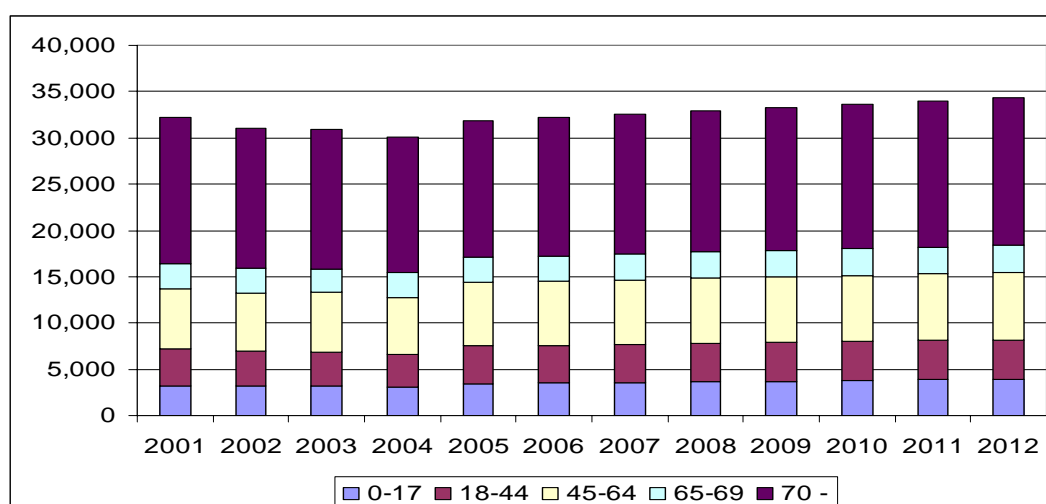
According to Table 10, the total number of people in the age cohorts 64-69 and 70 plus is expected to increase at a faster rate than the younger age groups. This trend is consistent with the general population predictions within the wider community.

Table 10 Annual rate of change in A&EP eligible population 2006-2012

	2006	2007	2008	2009	2010	2011	2012
0-17	0.27%	0.45%	0.47%	0.47%	0.47%	0.48%	0.51%
18-44	0.24%	0.87%	0.87%	0.87%	0.87%	0.87%	0.87%
45-64	0.86%	0.97%	0.97%	0.99%	1.01%	1.02%	1.05%
65-69	1.91%	1.95%	1.97%	1.99%	2.10%	2.10%	2.10%
70 -	1.92%	1.95%	1.98%	1.99%	2.20%	2.20%	2.20%

Utilising the methodology described in Appendix G, Figure 16 below shows that the number of people who would be eligible for the A&EP is projected to increase at an overall rate of 1 percent per annum in the forthcoming years. This represents the total population eligible for the A&EP under the current A&EP Guidelines. To generate the forecasts, the SDAC⁵² surveys compiled by the ABS were used as the basis. For further details refer to section G.3.

Figure 16 Numbers of clients by age cohort projected to 2012



⁵² Australian Bureau of Statistics. *Survey of Disability, Ageing and Carers: Summary of Findings (Australia)*. Catalogue 4430.0

C.1.2 Expenditure 2001-2005

A breakdown of expenditure by age groups for the years 2001 - 2005 shows that the greatest proportion of the A&EP budget is expended on the provision of items to people aged 70 and above (\$31 million or 37 percent). This was followed by expenditure for adults aged 45-64 years (\$18.6 million or 22 percent). Children and young people (0 to 17 years) were consistently the smallest component of the program's expenditure (\$13.5 million or 16 percent).

Overall, the proportion of expenditure by age groups has remained relatively stable since 2001.

Figure 17 Expenditure by age cohort

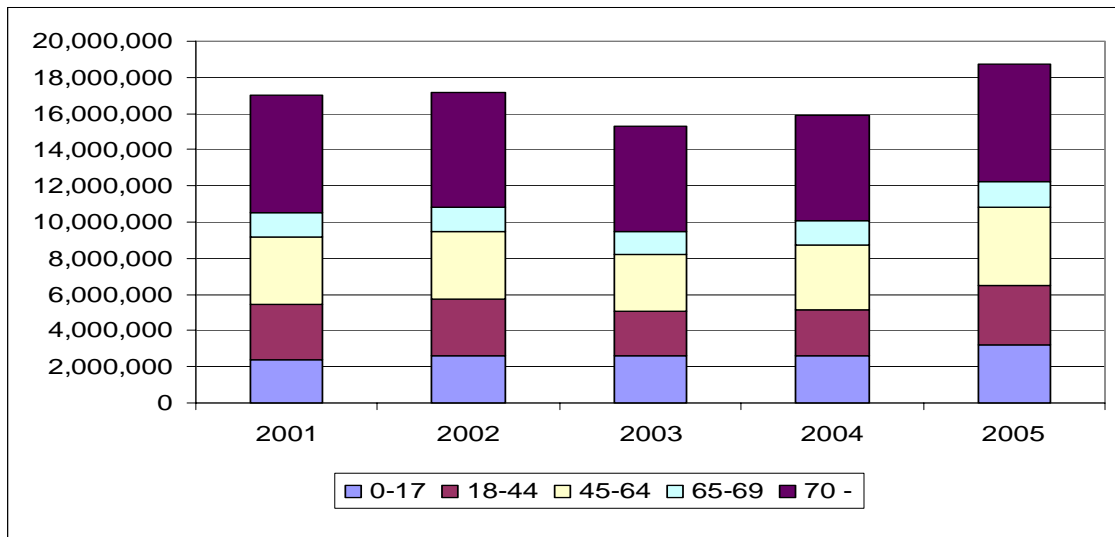
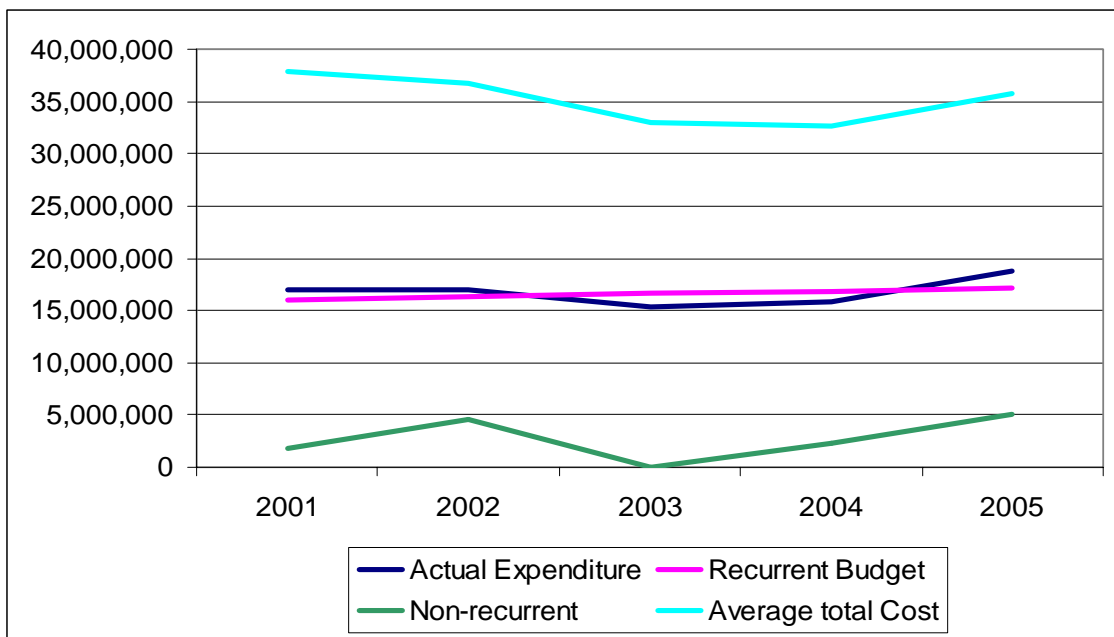


Figure 18 below shows the recurrent and non-recurrent budgets for the years 2002-2005. It also shows the total expenditure of the A&EP over that period. As can be seen from the figure, without the regular injections of non-recurrent funding, the recurrent budget for the A&EP is insufficient to meet current demand. As at the time of the Review, additional recurrent funding is required to meet the needs of those seeking assistance from the A&EP today even without any policy or program changes.

Exacerbating the pressure on the A&EP from demand is the increasing affordability gap for individuals. Figure 18 below also shows the average gap between the total amount provided by the A&EP (actual expenditure) and the full cost of aids, equipment and home modifications (average total cost). This gap is steadily widening (if only marginally over the 2001-05 period), meaning that for some items, the cost to the client is increasing, making the items less affordable for clients.

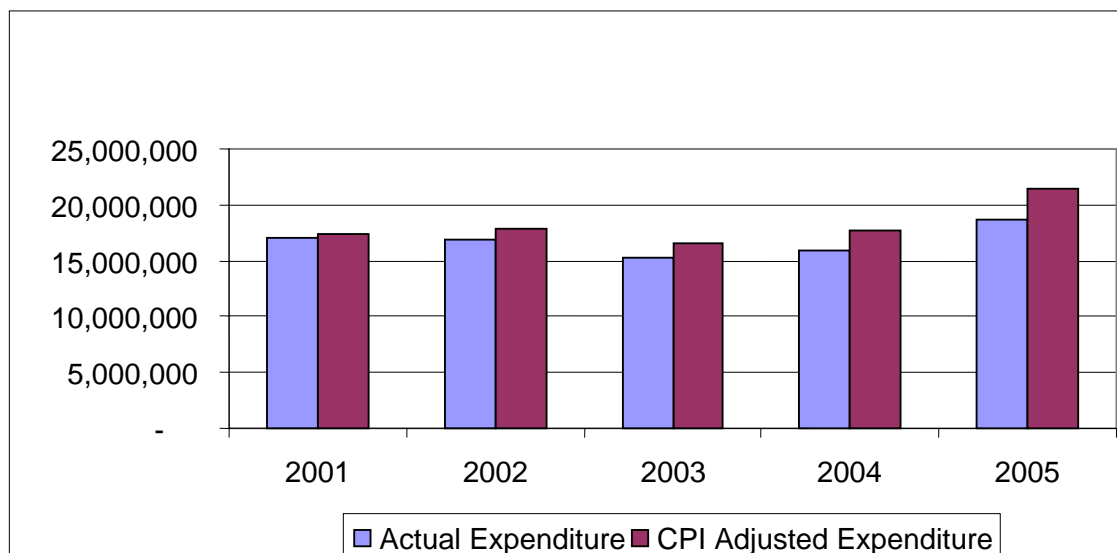
Figure 18 Actual expenditure, recurrent budget, non recurrent budget and the average total cost of items



One factor that has contributed to this widening gap is the fact that the subsidy paid by the A&EP toward the purchase of aids, equipment and home modifications has not been indexed annually to incorporate inflation or other pricing impacts. The net result of this has been in a decrease in the affordability of necessary items of aids, equipment and home modifications for clients of the A&EP.

Figure 19 below shows the difference in expenditure that would have occurred had the subsidies been adjusted for the impact of CPI annually during the 2001-2005.

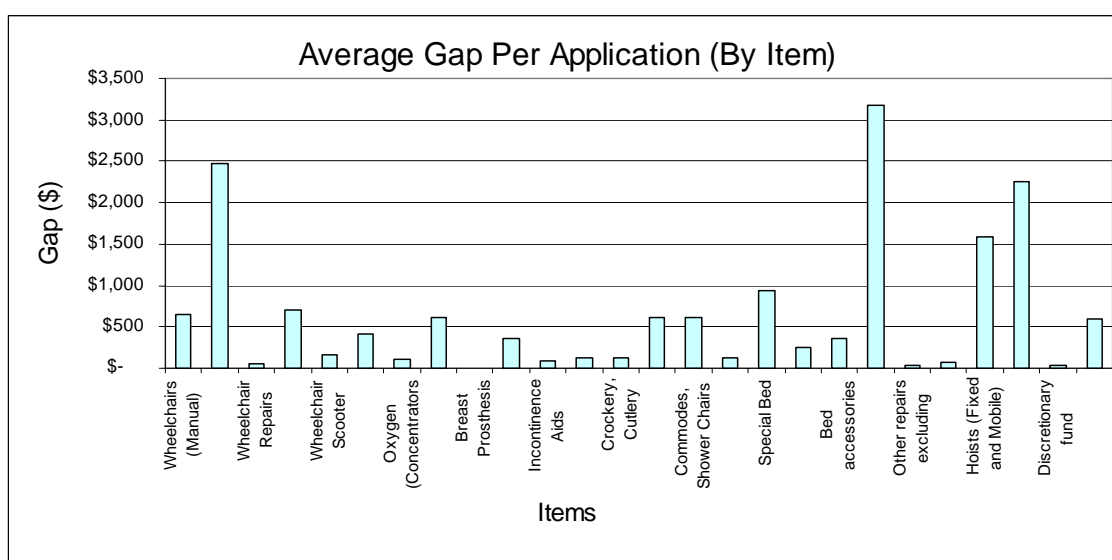
Figure 19 Impact of adjusting expenditure for CPI



The average gap between the subsidy and the full cost per application made by clients for the items available in the A&EP is provided in Figure 20 below. The greatest gap between the A&EP subsidy and full cost is for the more expensive items such as wheelchairs and home modifications. These items tend to be required by people with higher needs and frequently less capacity to pay for items.

The average gap, which is based on the difference between average annual cost and average annual expenditure per item, is not significant for lower cost and higher demand items such as oxygen and continence aids. This trend, however, masks the true cost of provision as both oxygen and continence aids these items are not one off purchases, rather they are purchased on an ongoing basis throughout a year to meet individual needs.

Figure 20 Average gap per application by item

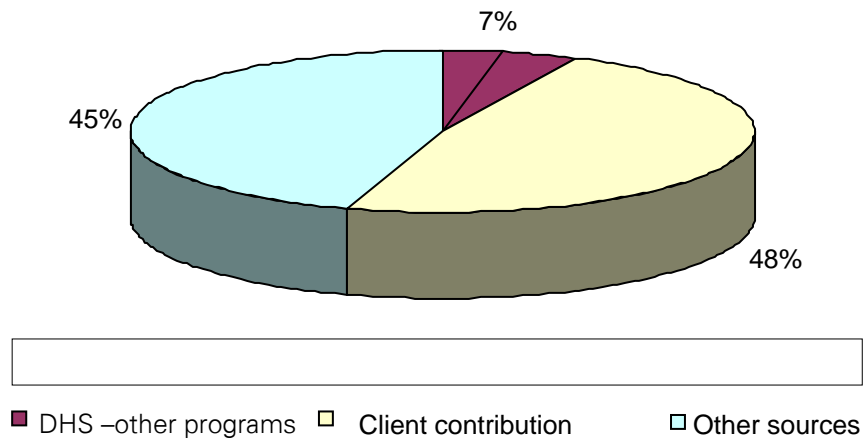


As the gap between the full cost of an item and the subsidy available through the A&EP widens, and the capacity of clients to meet the gap decreases, clients are turning to alternative sources for funding assistance to pay the gap.

Obtaining funds from other sources can be seen in many instances to result in “hidden” forms of cross subsidisation from other government programs. This need for additional funding from other sources was seen by many stakeholders of the A&EP as a significant limitation in the current program arrangements.

Drawn from a snapshot of data provided by Issuing Centres through the Review process, the sources of additional funding are shown in Figure 21 below. As can be seen “other sources” contributed 45 percent of the gap funding. A number of small programs also contributed toward the gap, but the amounts were minor and represented <1 percent of the gap funding.

Figure 21 Sources of funding for difference between full cost and A&EP subsidy



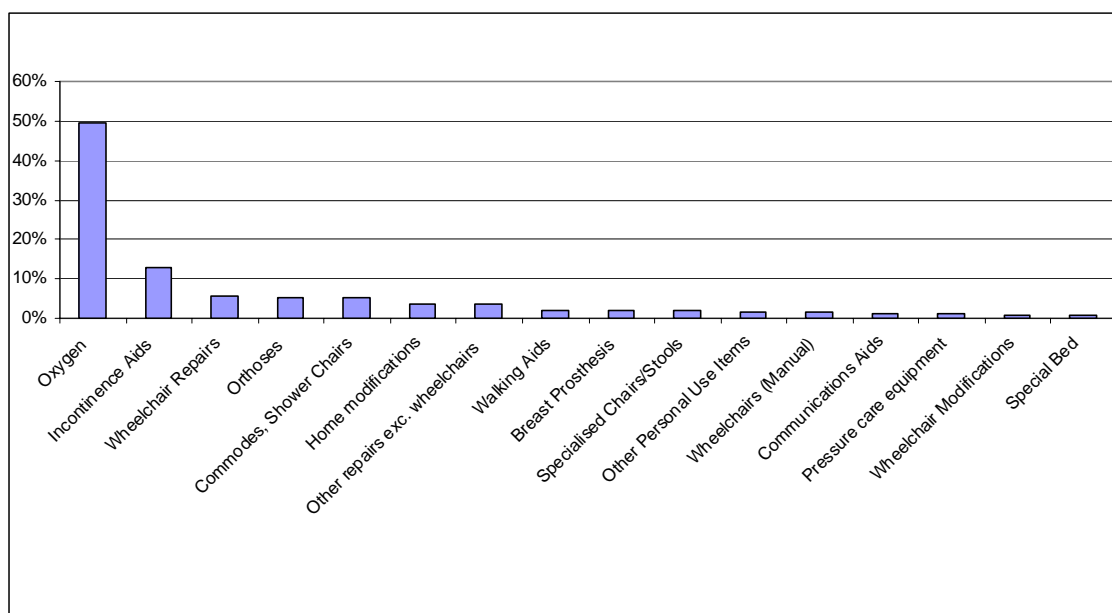
C.1.3 Applications for items

The following figure provides a breakdown of the percentage of applications⁵³ by item for 2005.

As can be seen the highest demand items are oxygen and continence aids, which are both “no wait” items according to the A&EP prioritisation criteria. The total number of applications for items available through the A&EP was in 2005 was 63,911.

The total number of applications steadily increased by approximately 1- 4 percent per annum during the 2001-05 period.

Figure 22 Application for items as percentage of total applications in 2005

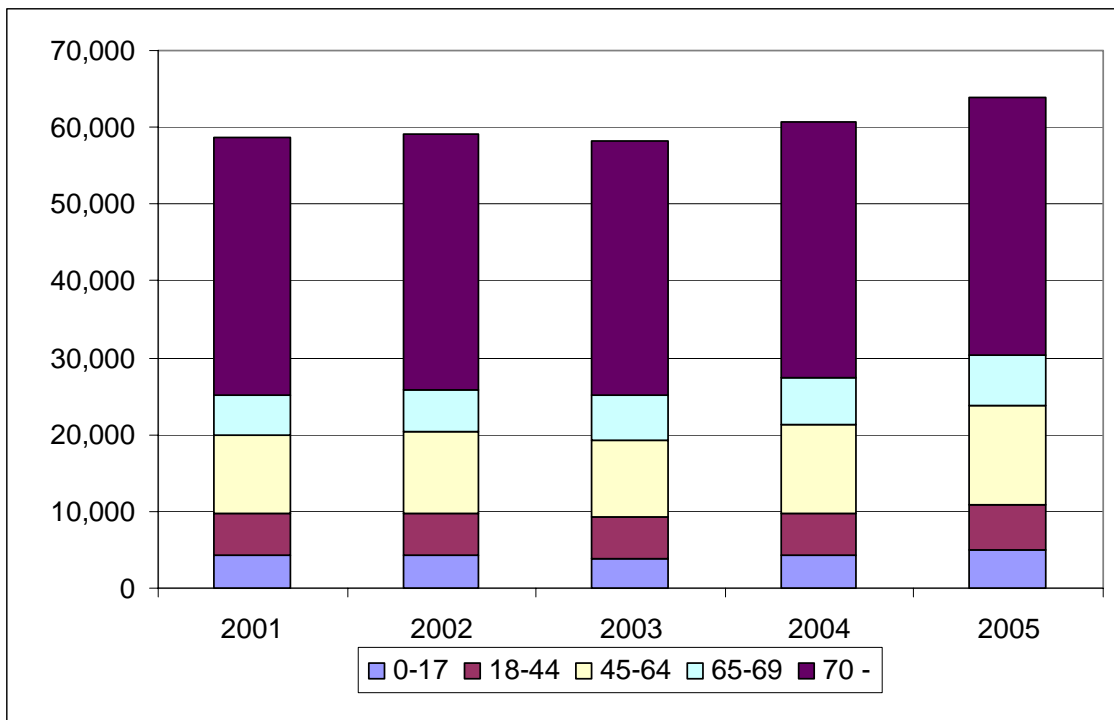


⁵³ For definition of application refer to Appendix H.

During the period 2001-05, people aged 70 years and over accounted for the majority of applications (33,662) followed by the 45-64 cohort making a total of 12,898 applications. Children and young people (aged 0-17 years) made 5,038 applications, while the 65-69 age cohort made 6,468 applications. The numbers of applications by age cohort is shown below in Figure 23.

The number of applications does not represent the number of clients in the program as an individual may apply for multiple aids and/or equipment in a financial period. However, the figure shows clearly that there is a growing demand for items through the A&EP.

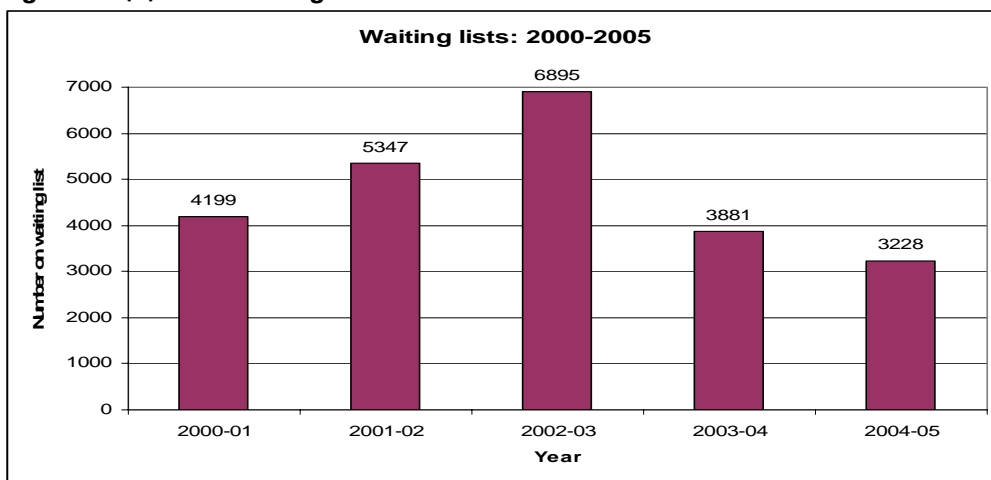
Figure 23 Applications by age cohort



C.1.4 Waiting lists

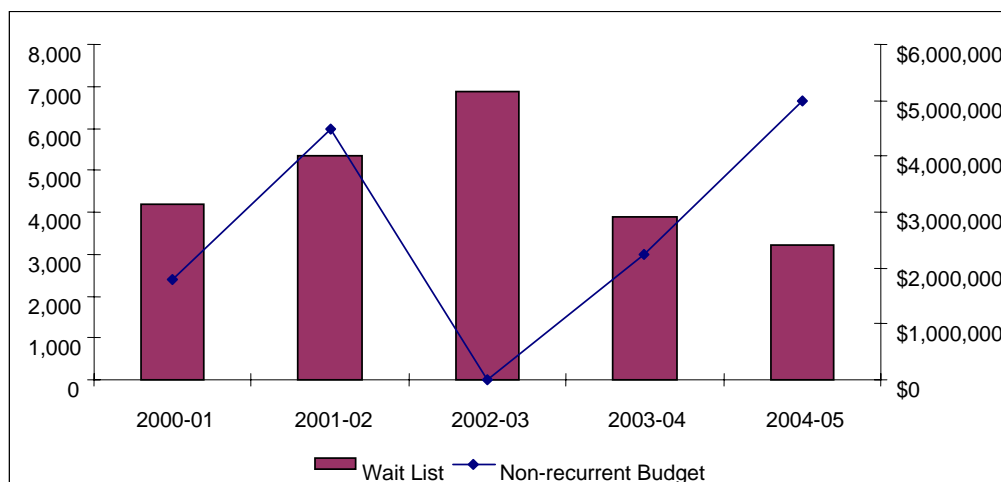
Figure 24 (a) shows that each year there are a large number of clients whose applications for assistance from the A&EP are unable to be met within the recurrent budget. While the data is provided on a statewide basis, each individual Issuing Centre manages their own separate budget and waiting list. This means that waiting times at A&EP service providers can vary across Victoria, generating inequities in access to the program. For example, a client whose application is given a high priority in Warrnambool may wait over 12 months for an item, while in Bairnsdale it could be supplied in less than 6 months.

Figure 24 (a) Waiting lists



To address the shortfall in recurrent budget and reduce the waiting lists, DHS has been providing non-recurrent budget allocations. These non-recurrent budget allocations have been able to reduce, but not always eliminate the waiting lists. Figure 24 (b) below demonstrates the relationship between the allocation of additional non-recurrent funding and the number of clients on the waiting list.

Figure 24 (b) Waiting lists and non-recurrent funding allocations



The percentage of applications for items that were unable to be met in each year, post the provision of one off funding to enhance the A&EP's annual budget, is shown on the Table 11 below.

Table 11 Items on waiting lists as a percentage of all applications by year

	2001	2002	2003	2004	2005
Applications on waiting list	4199	5347	6895	3881	3228
Total number of applications	58479	59322	58302	60739	63970
Wait listed applications as a percentage of total applications	7%	9%	12%	6%	5%

It is estimated that this is a conservative indicator of the level of unmet demand as it only reflects those individuals who have outstanding applications waiting to be filled and does not include those individuals who have chosen not to approach the program due to lengthy waits for assistance.

Table 12 Waiting time by equipment type

Item Group Name	Item Group	Average of Wait period
Repairs	1	82
Contingence	2	140
Home Modifications	3	173
Beds, mattresses, accessories	4	124
Orthoses, shoes	5	137
Walking aids, standing frames	6	150
Wheelchair modifications	7	127
Assistance accessories	8	146
Hoists	9	175
Pressure care	10	156
Voice prostheses, electrolarynxes	11	170
Electric wheelchairs	12	158
Manual wheelchairs	13	192
Scooters	14	180
Environmental controls	15	194
Other (not specified)	16	147

According to table 12, the average wait period for items can range between 82 and 194 days. The longest wait periods relate to the following items:

- Environmental controls;
- Manual wheelchairs; and
- Scooters.

These items fall within the high cost category of available items.

D Victorian A&EP Service Provider Details including Local Government Areas

Metropolitan	Address	Local Government Area
Austin & Repatriation Medical Centre	Austin & Repatriation Medical Centre Repat Campus Banksia Street West Heidelberg 3081	Banyule, Boroondara
Box Hill Hospital SAEAS CONTACT	Box Hill Hospital PO Box 94 Box Hill 3128	Manningham, Whitehorse
Caulfield General Medical Centre SAEAS CONTACT	Caulfield General Medical Centre 260 Kooyong Road Caulfield 3162	Port Phillip, Stonnington Glen Eira,
Dandenong Hospital SAEAS CONTACT	Dandenong Hospital PO Box 478 Dandenong 3175	Greater Dandenong, Cardinia, Casey (East), Bayside, Kingston
Maroondah Hospital	Maroondah Hospital PO Box 135 Ringwood 3135	Maroondah, Yarra Ranges
Royal Melbourne Hospital – Royal Park Campus	Royal Melbourne Hospital – Royal Park Campus PO Box 7000 Carlton South 3053	Hume, Moreland
Monash Medical Centre	Monash Medical Centre Centre Road Bentleigh East 3165	Knox, Monash
Mount Eliza Centre	Mt Eliza Centre PO Box 192 Mt Eliza 3930	Mornington Peninsula, Kingston (Chelsea), Casey (West), Frankston
The Northern Hospital SAEAS CONTACT	The Northern Hospital 185 Cooper Street Epping 3076	Nillumbik, Whittlesea, Darebin (North)
St Vincent's Hospital SAEAS CONTACT	St Vincent's Hospital 41 Victoria Parade Fitzroy 3065	Darebin (South), Melbourne, Yarra, Southbank
Western Hospital – Sunshine SAEAS CONTACT	Western Hospital - Sunshine PO Box 294 St Albans 3021	Brimbank, Melton, Maribyrnong, Moonee Valley, Wyndham, Hobsons Bay

Address			Local Government Area
Metropolitan			
Non-metropolitan			
Bairnsdale Regional Health Service SAEAS CONTACT	Bairnsdale Regional Health Service PO Box 474 Day Street Bairnsdale 3875	East Gippsland, Latrobe Wellington, Baw Baw	
Ballarat Health Services – Queen Elizabeth Centre SAEAS CONTACT	Ballarat Health Services PO Box 199 102 Ascot Street South Ballarat 3350	Ararat, Pyrenees, Ballarat, Northern Grampians, Hepburn, Golden Plains, Moorabool	
Barwon Health Grace McKellar Centre Geelong SAEAS CONTACT	Grace McKellar Centre 45-95 Ballarat Road North Geelong 3215	Colac Otways, Surf Coast, Greater Geelong, Queenscliff	
Bass Coast Regional Health	Bass Coast Regional Health Wonthaggi Hospital Graham Street Wonthaggi 3995	Bass Coast, French Island	
Bendigo Health Care Group Anne Caudle Centre SAEAS CONTACT	Bendigo Health Care Group Anne Caudle Centre Campus Lucan Street PO Box 126 Bendigo 3552	Campaspe(South), Mr Alexander, Greater Bendigo Loddon, Macedon Ranges, Central Goldfields	
Gippsland Southern Health Services	Gippsland Southern Health Service Private Bag 13 Leongatha 3953	South Gippsland	
Goulburn Valley Health	Goulburn Valley Health Graham Street Shepparton 3630	Mitchell, Murrindindi, Strathbogie, Greater Shepparton, Moria, Campaspe (North)	
South West Healthcare	South West Healthcare Warrnambool Campus Ryot Street Warrnambool 3280	Moyne, Corangamite, Warrnambool	
Sunraysia Community Health Services	Sunraysia Community Health Services PO Box 2803 Mildura 3502	Mildura	

Address		
Metropolitan		Local Government Area
Swan Hill District Hospital	Swan Hill District Hospital A&EP 13 Pritchard Street PO Box 483 Swan Hill 3585	Buloke, Swan Hill, Gannawarra
Northeast Health SAEAS CONTACT	Northeast Health Wangaratta Hospital PO Box 386 Wangaratta 3677	Alpine, Benalla & Mansfield (Delatite), Rural City of Wangaratta
Western District Health Service	Western District Health Service PO Box 283 Hamilton 3300	Southern Grampians, Glenelg
Wimmera Health Care Group	Wimmera Health Care Group Baillie Street Horsham 3400	Horsham, West Wimmera, Hindmarsh, Yarriambiack
Wodonga District Hospital	Wodonga Regional Health Service PO Box 156 Vermont Street Wodonga 3690	Indigo, Wodonga, Towonga
Statewide		
Mercy Hospital for Women. Lymphedema Compression Garment Program (LCGP)	Mercy Hospital for Women Ground Floor, St. Francis Building 166 Gipps Street East Melbourne 3002	Lymphedema Compression Garments Only.
Royal Children's Hospital	Royal Children's Hospital Flemington Road Parkville 3052	Children Only
Yooralla Brooklyn – Electronic Communication Devices Scheme	Electronic Communication Devices Scheme Yooralla Society of Victoria 705 Geelong Road Brooklyn 3025	Electronic communication devices only
Victorian Breast Prosthesis Subsidy Program	Victorian Breast Prostheses Subsidy Program PO Box 72 Bentleigh East 3165	Breast Prostheses only

E Summary of available items through the A&EP and maximum subsidies for each item.

Aids Available	Maximum subsidy	Aids not purchased by the Victorian A&EP
Mobility Aids and Equipment		
Walking Aids <ul style="list-style-type: none"> • walking frames • gutter crutches • specialised walking aids • standing frames 	<ul style="list-style-type: none"> • \$300 • \$550 	Sticks and crutches.
Wheelchairs <ul style="list-style-type: none"> • manual (basic chair) • manual (lightweight) • electric • scooters • customising 	<ul style="list-style-type: none"> • \$1000 • \$1250 • \$6000 • \$4000 • \$2500 	Accessories, eg carry baskets, canopies; carrier (external for car); clamps (for vans); seat belts (for vehicles); certain outdoor vehicles, eg. Batricars, disabled people transporters, Vessa Trekkers, Electrodrives, and Ortopaedias; wheelchairs for sporting purposes; tubes and tyres.
Orthoses <ul style="list-style-type: none"> • orthosis • callipers • corsets (surgical) • braces • cervical collar (customised) • shoes (specialised) • custom moulded orthosis / build-ups 	<ul style="list-style-type: none"> • \$1200 per item • \$450 per year • \$200 	shoes (regular over counter); Jobst garments; foam band (tubular sponge protective device); insoles / build-ups (over the counter); wrist / ankle / knee braces / splints (over the counter); back / hernia support (over the counter); cervical collar (over the counter); second skin garments.
Personal Aids and Equipment		
Continence Aids <ul style="list-style-type: none"> • anal plugs • catheters • connectors • drainage bags and bottles 	<ul style="list-style-type: none"> • \$1200 per year 	Disposable continence pants; disposable continence pads drip collectors; colostomy appliances; urinals

Aids Available	Maximum subsidy	Aids not purchased by the Victorian A&EP
<ul style="list-style-type: none"> • intra-vaginal bladder supports • washable incontinence pants/pads • tubes • waterproof covers or mattress • protectors, eg. kylies, bluies, washable • floor mats 		
Environmental Control Units	<ul style="list-style-type: none"> • \$3000 	
Lymphedema Compression Garment Program	40 - 60% of cost of garment	
Mammary Protheses mammary protheses (one per mastectomy)	<ul style="list-style-type: none"> • \$300 per prosthesis 	not applicable
Oxygen <ul style="list-style-type: none"> • concentrators • oxygen gas 	<ul style="list-style-type: none"> • \$200 per month 	medical pumps eg . flatus, suction, clinical air pumps; nebulisers, ventolin pumps; sleep apnoea units; resuscitators; ventilators.
Personal Use Items <ul style="list-style-type: none"> • bath seats • beds / mattresses (specialised) • manual • electric • bed sticks, rails, cot sides • blocks to raise height of bed/chair 	<ul style="list-style-type: none"> • \$80 • \$1200 • \$2000 • \$200 • \$200 	Air conditioners; fans; alarm systems; standard armchairs; artificial; eyes; artificial limbs; automatic feeders; communication boards; back brush; baseboards and bed boards; non slip bath mats; bed ladders; bed ropes; button hooks and dressing sticks; can openers; car hoists and fixed car ramps; combs; computers; disability –specific crockery; disability -specific cutlery; denture brushes; dosette boxes; dressing and undressing aids; dycem mats; elastic and antiembolitic stockings; footstools; glucometers; stocking and sock aids; surgical supplies eg. sterile dressings,
<ul style="list-style-type: none"> • child car seat • commodes / shower / transporter: <ul style="list-style-type: none"> - Mobile / self propelled - fixed commode - Customisation • electronic lounge chair • hoists; 	<ul style="list-style-type: none"> • \$850 • \$200 • \$1000 • \$500 • \$1000 	

Aids Available	Maximum subsidy	Aids not purchased by the Victorian A&EP
<ul style="list-style-type: none"> - ceiling (not available for SAEAS) - subsidy installation - electric mobile • hydraulic adjustable height change table (SAEAS only) 	<ul style="list-style-type: none"> • \$3300 • \$300 • \$2600 • \$2000 	bandages, surgical gloves, syringes and needles; tap turners; TENS machines / nerve stimulators; teapot pourers; throat dilator; grips; hand controls for cars or other car modifications; handle grips; hearing aids; inversion frames; intravenous feeding equipment; jar openers; key turners; magnifying glasses; nail brushes or nail files; naso gastric tubes; page turners; pharmaceuticals, eg. medications, solutions, ointments; pick-up sticks; reaching aids; pillows; plate guards; pot and pan holders; scissors; seat belts (motor cars); sheepskin booties; sheepskin covers; shoe horns; spectacles; visual aids; tilt
<ul style="list-style-type: none"> • over toilet rails, raised seats • portable ramps • pressure care equipment • safety helmets • seating (specialised) • self help poles • shower chairs/stools • transfer equipment • trolley - kitchen 	<ul style="list-style-type: none"> • \$80 • \$400 • \$800 per 2 years • \$200 • \$500 • \$200 • \$90 • \$200 • \$135 	tables; toe cleaners; toothbrushes; traction kits; trolleys; urinals and bed pans; vegetable and chopping boards; vehicle modifications; washing and drying aids. Car seats; ergo chairs; industrial seats.
<p>Wigs</p> <ul style="list-style-type: none"> • two basic synthetic wigs (or equivalent contribution towards human hair wig, or more expensive synthetic wig up to the subsidy cost) • one human hair wig (child 16 years and under) 	<ul style="list-style-type: none"> • \$240 per 2 years • \$600 per wig 	not applicable

Aids Available	Maximum subsidy	Aids not purchased by the Victorian A&EP
Communication Aids and Equipment		
<ul style="list-style-type: none"> • Electronic Voice Aids / Electrolarynx • Voice Prothesis • Electronic Communication Device Scheme (ECDS) 	<ul style="list-style-type: none"> • \$1500 per 5 years • \$300 per year • \$6000 for 6 years and over • \$4,500 for children 0-6years. 	<ul style="list-style-type: none"> • laryngectomy protector
Home Modifications – Not available under SAEAS		
<ul style="list-style-type: none"> • bathroom, toilet, kitchen and laundry modifications specifically related to the consumers Disability. • bidet / bidet toilet attachment • door fittings (special) • door widening • hand basins for WC access only and • insulation of pipes to prevent burns. • hand held showers and switchcocks. • hand rails and grips • painting repairs which are needed due to other A&EP modifications. • non-slip paint for ramps. • power outlets and switches. • shelving where it facilitates WC access. • safety flooring (associated with home modifications). • shower screen where it is part of the shower recess unit. • taps (where a tap turner can not be 	<ul style="list-style-type: none"> • \$4400 per person per lifetime including GST 	<ul style="list-style-type: none"> • Baths. • Basin / sinks / toilets - plumbing can be altered or items repositioned to facilitate access for WC. • Complete new bathrooms including plumbing. • Concrete pathways and driveways. • Construction of extensions. • Flooring. • Fittings such as mirrors, fans, soap holders, towel rails. • Hot water services. • Shower curtains / screens. • Toilets. • Vanity units.

Aids Available	Maximum subsidy	Aids not purchased by the Victorian A&EP
<ul style="list-style-type: none">• used)• ramps / step modifications• thermostats		

F Stakeholder perceptions of the A&EP

F.1 Strengths of the A&EP

Clients, their carers and families unanimously agreed that the key strength of the A&EP is its very existence. The key reason given for this is that the cost of purchasing necessary aids and equipment is high and without the program most clients and their families or carers would be unable to afford the aids and equipment required.

Clients also reported that the aids and equipment accessible through the program enable independence and are therefore important to their quality of life and well-being. Many families also reported that without the program, they would be unable to continue to care for the person with a disability, especially as ageing carers find themselves less physically able to assist people with a disability or those who are older and frail to mobilise or undertake the key activities of daily living.

In responding to the Client Satisfaction Survey, the majority of the sample indicated that they were generally satisfied with the A&EP. However, satisfaction rates were lower when a financial contribution towards the equipment was required. Many clients and their families and carers indicated that the lack of means testing was a strength of the program, although conversely, a number of people indicated that the program would better assist those in the greatest need if it was means tested.

According to the survey respondents, the strengths of the A&EP are its quality of staff, ease of use of equipment and the personal benefits derived from the program.

Feedback received from external stakeholders, both at the consultation forums and through written submissions, focused on the benefits to clients and their carers, but also identified positive aspects of the operation of the program. These included the access to maintenance of equipment available through the program which means that clients can have their aids and equipment repaired in a timely manner and the reduction in waiting times that can result from the re-issuing of equipment.

The cooperation and responsiveness of individual staff at many of the Issuing Centres was also identified by some prescribing therapists and case managers as a strength of the program, with a number of prescribing therapists providing feedback to the effect that they are able to draw upon their relationships with Issuing Centre staff to ensure that their clients are given priority. However, some therapists acknowledged that while this served the purpose of ensuring that their clients received equipment quickly, it could also be seen as "queue jumping" and thereby undermining the prioritisation process and equity of access to the program for other clients.

The staff operating the Issuing Centres identified many strengths of the current program, primarily in relation to its actual operation. Most agreed that the major strength is the localised nature of the program and the majority would like to see this practice continued. Other strengths identified included the experience of Issuing Centre staff, the level of support received through the network of Issuing Centre staff and from DHS administrators and the location of Issuing Centres in hospitals because of the capacity to utilise the hospital's infrastructure such as IT support.

Some Issuing Centre coordinators felt that the administrative system, PADMIN, provides good support to coordinators and is comprehensive, easy to use and quick to access. However, others identified the IT systems that support the program as being an area that needs to be improved, with many offering suggestions about how this might be achieved.

A number of Issuing Centre staff also identified the improved outcomes for clients as a strength of the program, identifying the provision of oxygen, communication devices, and lymphedema compression garment and breast prosthesis programs as being particularly beneficial to clients.

Regional managers responsible for the A&EP primarily commented on the experience and stability of the Issuing Centre workforce as contributing to the overall effectiveness of the program. Some regional managers noted that Issuing Centre staff have established a good rapport with the prescribing therapists and the local suppliers and that this was also an important factor in the overall functioning of the program. Managers from a couple of regions also provided feedback about the cooperative relationship that has been established with suppliers, which has led to improved efficiencies within the program.

F.2 Areas for improvement

The majority of the verbal and written feedback received through the consultations was in relation to people's views about how the current A&EP could be improved.

People drew upon their own experiences of the program as a client, a carer, a therapist or case manager, an advocate, a service provider or a program administrator to provide comments about possible improvements. Despite the diversity of personal experiences reflected in the feedback, there was a significant degree of consistency in the themes that emerged.

The feedback is organised below according to key themes.

F.2.1 Access and equity

Four key issues emerged under this theme:

- the appropriateness of the eligibility criteria;
- timely access to prescribing therapists and aids, equipment and home modifications;
- prioritisation criteria; and
- geographical access to the Issuing Centres.

F.2.2 Appropriateness of eligibility criteria

The most common comment in relation to the A&EP's eligibility criteria was in respect to the exclusion of people receiving Australian Government funded Community Aged Care Packages (CACP). These packages are intended to support older people to remain at home rather than enter residential aged care facilities. Access to aids and equipment through these programs is limited, and yet clients and families who receive services such as case management and

personal care through these schemes often need aids and equipment if they are to remain living in their own homes.

Another concern regarding eligibility was the requirement that people have a long term disability or be an older frail person. Clients and their carers raised the issue of people with rapidly deteriorating conditions who had been declined access to items through A&EP because their condition was interpreted as not being "long term" in nature.

Specific feedback was also received regarding people with spinal cord injuries. Of particular concern is the 30 day wait post discharge before becoming eligible for A&EP assistance. People with a spinal cord injury generally require aids, equipment or home modifications to enable them to return home and commence the process of re-connecting with their communities. The exclusion of people who require aids, equipment or home modifications related to their hospital admission means that people with a spinal cord injury, even though it will be permanently disabling, are unable to commence the process of applying to A&EP for necessary aids, equipment and home modifications until 30 days post discharge.

The feedback about eligibility criteria provided by stakeholders indicate that the criteria are out of date and do not appear to be consistent with contemporary approaches to service delivery. They need to be updated to better align with current thinking about service responses for people with a disability, older people and people with ongoing health conditions that result in functional limitations.

F.2.3 Timely access to prescribing therapists and aids, equipment and home modifications

Although waiting lists may be regarded as an indicator of other issues such as funding or subsidisation levels, prioritisation criteria, or even availability of supply, the volume of feedback received about this topic warrants a more detailed consideration of this issue.

The A&EP requires clients to be assessed by an appropriately qualified therapist in order to apply for items through the A&EP. Therefore, clients potentially face two delays in accessing the aid or equipment they require. The first of these involves waiting to see a therapist, the second relates to obtaining funding to purchase aids and equipment.

Feedback about waiting times was substantial, with all groups consulted identifying this as a significant issue. According to feedback received, waiting times can be for a year or even longer, and many clients highlighted the personal hardships that arose while waiting for aids or equipment, including use of old equipment that was no longer appropriate or safe. The risks that are posed to clients and carers were also noted.

One impact of the waiting time for the program is that it can lead to the need for multiple therapy assessments and re-assessments as a client's functional status changes. Often when the client eventually receives their equipment or modification, their needs have changed and the item required has changed. This issue was raised in relation to both people with rapidly declining conditions, and children as a matter that required urgent attention.

It was also noted that the program does not allow for forward planning even when changing client needs are predictable. The impact of this is that individuals need to re-apply as their

needs change, once again having to undertake the process of assessment, application and eventual allocation of the prescribed aid or equipment.

The growth in the number of older people accessing services to stay at home (such as those funded by the HACC program) has placed increasing pressure on the program. The need to ensure that basic Occupational Health and Safety requirements are met prior to receiving home based service provision creates a "Catch 22" for some individuals. Without access to the necessary equipment, these individuals are often unable to access other services such as personal care, which in turn is required to enable them to continue to live in the community. Having to wait for the required equipment further exacerbates the individual's physical status and functional independence and often leads to an increase in their needs.

Overall, there was strong consensus amongst the stakeholders that waiting times must be addressed if the program is to effectively meet the needs of clients.

F.2.4 Prioritisation criteria

The issue of prioritisation was frequently raised in association with waiting times for equipment. Effectively, the prioritisation criteria as specified in the Program Guidelines determine who receives equipment immediately or as a matter of high urgency, and who is deemed a lower priority and therefore waits to receive equipment.

Specifically, concerns were raised about the lack of transparency of decision-making with regards to prioritisation, the lack of consistency of application of prioritisation guidelines between Issuing Centres, and the lack of communication to clients about their priority and the expected wait for items.

The Program Guidelines state that the program aims to assist people to achieve greater independence and participation in the community. However, the feedback received revealed that the program is highly medicalised, with the majority of prescribing therapists who provided feedback using language such as "clinical outcomes" for "patients" to describe the desired goals of the program. Many therapists and Issuing Centre staff also identified a client's capacity to benefit in terms of clinical outcomes as a key consideration in determining the client's priority for assistance through the A&EP. This is inconsistent with the A&EP's stated objectives.

Linked to this is the growing pressure on the program to provide aids and equipment to older people who are frail to prevent admission to supported accommodation or residential aged care facilities. Clients who are requesting aids and equipment to support and improve their capacity to participate in the community but who are not at immediate risk of hospitalisation or entry into more supported accommodation perceived that their requests are treated as a lower priority.

Some clients also expressed the view that hospital outpatients are being given priority over community clients. This view was supported by program administrators who reported that if the centre is located in a hospital the focus is on preventing re-admission of clients to hospital and trying to ensure they are moved through the health system, and on improving clinical outcomes. Whereas if the centre sits in a community health centre the focus tends to be more on social inclusion and personal outcomes for the client. These perceptions and experiences suggests that there is a disconnect between the policy objectives for the various groups supported by A&EP and the operations of the A&EP.

A number of stakeholders expressed the view that the criteria for prioritisation should be expanded to include quality of life and improved community participation, and should also give greater consideration to carers' needs. Many carers are becoming older and are not able to continue to care without the necessary equipment, and this can impact on the client's ability to continue in their own home.

The feedback around the prioritisation criteria for the program indicates that there is a need to link prioritisation criteria to the wider policy context in which the provision of aids and equipment occurs and to increase transparency and consistency of decision making. There is also a need to improve communication with clients regarding their priority of access and the implication for waiting times for allocation of equipment in responding to their presenting needs.

F.2.5 Geographical access to the Issuing Centres

The other dimension of access that received comment during the consultation is that of geographical access. The program currently includes Issuing Centres that provide a service to a specified geographical area, as well as specialist Issuing Centres that provide a statewide service to their target groups. Therefore, some clients and prescribing therapists currently have interaction with two different models of service delivery.

Generally, the geographical location of Issuing Centres was not an issue of particular concern to clients or their carers as most clients had no direct contact with Issuing Centres. For clients, contact with the A&EP is through the prescribing therapists who they access through hospital outpatient therapy services or through community health services. Clients did not report difficulty accessing therapists in geographical terms, although they did note that there could be a wait to see a prescribing therapist because of demand for the services of the therapist.

Accessing specialist assessment services such as seating clinics that tend to be only available in Melbourne or Adelaide was raised as an issue. For example, the Royal Children's Hospital (RCH) is a statewide service and offers a specialised seating clinic. However, very few children living outside of Melbourne are able to access this service because of distance and cost, creating a potential barrier to access within the system.

The current operational model indicates that the operation of Issuing Centres across 29 locations offers little, if any, direct benefit to clients in terms of accessibility. In fact the capacity to access prescribing therapists locally is a more critical factor for clients accessing the A&EP, and the capacity of prescribing therapists to respond effectively to these clients should be strengthened.

F.2.6 Funding levels

The most common issue raised throughout the consultations was that the program needed more funding. Comments about funding levels pertained to both the total amount of funding for the program, and the individual subsidies for each item in the program.

Overall, feedback to stakeholders indicated that more funding would mean that more people would be able to get assistance and that each person would get more assistance. It would also

mean that people could access equipment when they needed it rather than being restricted to the timeframes in the guidelines.

The Program Guidelines prescribe specific subsidies for each item available through the A&EP. However, these subsidies have not been increased to take account of the rising costs of items, with the result that the gap between the subsidy and the full cost of equipment is increasing, making it more difficult for many clients to fund the difference. This is supported by the analysis of the A&EP data regarding the difference between full cost and the subsidy level which is contained in Appendix C.

Therapists also reported spending an increasing amount of time assisting clients to source additional funds. This activity diverts the prescribing therapist from their core role in assessment and provision of treatment to clients and inappropriately leads to further delays in the assessment process.

The lack of available funding for other costs such as transport to and from fitting appointments or to take equipment for repairs, the costs of trialling equipment, and travel to statewide assessment services such as the Royal Children's Hospital was also raised as problematic for many clients.

Means testing received some support as a way of ensuring that the available funds are directed toward the most financially disadvantaged. However, other stakeholders held views that everybody should be entitled to support through the A&EP and should not be 'disadvantaged' because they are working or have alternative means of paying for equipment.

Concerns were expressed about the Program Guidelines relating to the ownership of equipment. Given that with increasing gaps between the subsidy and the full costs of equipment such as wheelchairs, the proportion of the purchase being met by the client is more likely to be greater than 50 percent and therefore defined as private purchase. When this occurs, the client becomes responsible for maintenance and repairs which can be very costly and difficult for some clients to afford. However, even when the client purchases more than 50 percent of an item, they may elect to transfer ownership to the A&EP in which case the A&EP will assume responsibility for maintenance and repairs.

There was also concern about the impact on clients with complex needs who require a number of items for A&EP to meet their needs. The Program Guidelines need to recognise the financial burden that meeting the costs of equipment and aids can place on these clients and their families. This is also the case for people with deteriorating conditions such as Motor Neurone Disease, and children, who may also require access to aids and equipment to meet their rapidly changing needs as they develop.

Stakeholders indicated that greater targeting of resources to those most in need is required, and that greater equity could be achieved by linking subsidy levels to an individual's capacity to pay. Complementing such an approach is the need to ensure that consideration is given to the need by some individuals for multiple items at key transition points, and the potential financial burden that can arise from the need to regularly replace aids and equipment in response to such changing needs.

F.2.7 Types of equipment available

The A&EP Program Guidelines specify the items of equipment that are available through the program. There were a number of comments received from stakeholders about the lack of some types of equipment currently available and the need to expand this list. Specific additional items stakeholders would like to see added to the program include:

- disposable continence aids;
- an annual allowance for customised footwear;
- a separate annual allowance for orthoses;
- spare orthoses;
- sun canopies for wheelchairs; and
- a backup manual wheelchair when a person has an electric wheelchair.

The need for access to disposable continence aids was frequently raised by many stakeholders. Currently the provision of continence aids is limited to reusable items such as catheters and drainage bags. However, many people with continence problems do not require such invasive aids, and would be able to effectively manage their incontinence with disposable pads. Continence pads were reported as costly, however, and the level of financial assistance available through other schemes such as the Australian Government's Continence Aids Assistance Scheme (CAAS) was reported as being insufficient to offset the costs of disposable pads.

Clients want the current restrictions about when equipment can be replaced removed to enable a more needs based approach to requesting and replacing equipment. For example, many clients indicated that wheelchairs do not last seven years when used daily. In considering the issue of replacement of equipment, there is a need to balance this requirement with ensuring that due care and upkeep to maintain the item has occurred.

The restrictions on the replacement of aids and equipment apply to all clients at present including children. Feedback was received that suggested that this restriction is particularly inappropriate given that children are outgrowing equipment sooner than they are permitted to request replacements.

A further issue raised by both external stakeholders and clients is the restriction to one set of home modifications in a lifetime. This limitation does not recognise the needs of children whose parents may not live together, nor does it support people with a disability to leave the family home once they reach adulthood. If the family had modifications to the home to meet the needs of a child with a disability, that child cannot request home modifications as an adult.

Linked to this is the difficulty of arranging home modifications - lack of builders in some areas, delays in funding meaning that quotes have expired before funds are available, the cost of transporting materials in rural areas, and the role that therapists have to play in assuring the final modification meets the required specification are all hindrances.

Therapists also provided a lot of comments about the lack of items necessary to ensure that clients achieved "clinical outcomes". Some of the items suggested for inclusion in the program were of a highly specific therapeutic nature, suggesting that there is a lack of clarity about

whether the aim of the program is to facilitate community inclusion, or is a medical equipment program, or both.

As an alternative to adding items to the list following a periodic review, it was also suggested that the program be refocused to supply or subsidise whatever equipment an individual required to enable them to participate in the community. That is, there should be no list of 'approved' equipment, but rather a person-centred approach taken to the provision of aids and equipment targeted to respond to assessed requirements.

Stakeholder feedback indicates that there is strong support to remove the current restrictions around types of aids and equipment and the limits on the frequency of replacement of items. This reinforces the need to review the A&EP so that the provision of equipment and aids is aligned to the achievement of improving outcomes for individuals consistent with the broader policy objectives for each of the different client groups.

F.2.8 Supply issues

The A&EP guidelines require therapists to obtain quotes for items of equipment and forward these with the referral for the item.

However, this practice is time consuming and administratively expensive. In some cases, too, the available pool of suppliers is so limited that suppliers hold almost a monopoly on the market and there is thus little opportunity to affect cost savings through a competitive purchasing approach. Where there is only a single supplier of an aid or equipment available in a location, as was reported to be the case in some rural areas, the requirement to obtain quotes was seen as administratively burdensome and of little benefit in terms of ensuring that the best price for an item was obtained.

The feedback from clients indicated that there were often difficulties obtaining equipment locally, especially in rural areas. This, in turn has the potential, once an item is provided, to affect a client's capacity to afford maintenance and repairs of an item where they are responsible for the cost. In relation to home modifications clients in rural areas also reported a lack of builders prepared to provide home modifications in rural areas. Some builders would not travel the distance to undertake small jobs such as those funded by the program

Another issue raised was the influence that suppliers have in determining which items a client received. Some clients indicated that suppliers were unduly influencing prescribing therapists to recommend their own merchandise, whether it was the most appropriate for the client's needs or not. Some therapists also expressed concern about the possibility that sales representatives from suppliers were unduly influencing prescription decisions, resulting in clients receiving less than the most appropriate items of equipment.

A number of Issuing Centre staff stated that administration of the program could be improved by eliminating the need for quotes for all items, but wanted to balance the possibility of contracts with suppliers for high volume items against the benefits of using local suppliers with who they had established relationships.

Program managers were primarily concerned about obtaining the best value for money for aids and equipment, with a number of managers proposing that alternative procurement strategies such as contracted suppliers be considered.

This feedback indicates that alternative purchasing arrangements such as competitive tendering should be explored to maximise the cost effectiveness of the program.

F.2.9 Repairs

The A&EP Program Guidelines identify wheelchair repairs as being of a "no wait" priority. Repairs and maintenance are only undertaken and funded by the A&EP where the program has greater than 50 percent ownership of an item or if a client pays more than 50 percent toward the purchase of an item but cedes ownership to the A&EP.

Clients and their carers were concerned that repairs and maintenance for items such as electric wheelchairs can be expensive and there is no assistance available to cover costs for items where the client has paid more than 50 percent of the purchase price. An example of an ongoing cost is that of tyres for wheelchairs which are not funded by the A&EP.

In the case of an item owned by the program requiring repairs, the client must obtain authorisation to proceed with the repair. The Program Guidelines say that a client who arranges repairs prior to obtaining authorisation will not be reimbursed for any costs incurred. Some Issuing Centres leave a mobile number or have a recorded message stating what to do if authorisation for emergency repairs is required after hours. However, this is not the case at all Issuing Centres. The A&EP will also not authorise repairs outside the state. Given the essential nature of some equipment and aids, this requirement has the potential to cause a client undue hardship and may even place the client at risk.

Apart from the financial burden that can result from the cost of repairing equipment, a key issue that was raised was the lack of loan equipment available while items were being repaired. It was noted that this is becoming more problematic as equipment such as wheelchairs become increasingly customised.

The lack of skilled people to undertake the repairs, particularly in rural areas where the problem is compounded further by a general shortage of skilled labour, means that there are often long waits to have equipment fixed. For example, in one rural town there is only one retired mechanic who will undertake wheelchair repairs, but as he only does this on a part-time basis clients can wait for a week or more to have a simple repair done. Alternatively, clients who have a majority interest in, or own, their equipment may need to pay the cost of freighting equipment to Melbourne or another regional centre for repairs which add to furthering their financial burden.

Another issue that was discussed throughout the consultation process was the recognition of the risk to the program arising from not having a regular program of inspecting the condition of equipment owned by the program. If a client is injured as a result of faulty equipment owned by the program, the program (and thus the service provider and possibly DHS) would have a potential liability in law for damages.

Program managers highlighted the increasing cost pressure on the program as a result of the rising costs of repairs. They also commented that as a result of previous non-recurrent funding that saw a significant investment in the program to reduce waiting lists, items such as wheelchairs that were purchased then are now requiring repairs and maintenance. There has not been an additional allocation of funds for this purpose, despite the fact that it was foreseeable that the demand for repairs would occur.

This feedback indicates that an allocation for the costs of maintenance and repairs should be built in to allocations for items of aids and equipment. Means of improving access to timely repairs should also be explored, potentially within the context of competitive procurement practices.

F.2.10 Re-issuing

Although the A&EP Program Guidelines describe this program as a subsidy scheme, the program also requires items that are no longer needed by a client to be returned for re-issue. This particularly applies to more expensive items, and to those where the program has a greater than 50 percent ownership. The performance indicators for services funded to deliver the A&EP include a target re-issuing rate of 10 percent. There is quarterly monitoring of whether this target is reached.

Clients were concerned that re-issuing is not being managed well within the program. They indicated that they would be happy to be provided with re-issued equipment if it met their needs and meant reduced waiting times.

There was also concern, however, with the current program requirements about returning equipment for re-issue. Clients noted that they could contribute thousands of dollars toward an expensive item such as an electric wheelchair or motorised scooter, and yet this contribution is non-refundable. Therefore, there is little incentive to return equipment once they no longer need it.

Clients also indicated that given that re-issuing seemed to them to be particularly targeted at wheelchairs and scooters, there was little point returning a wheelchair after using it for seven years, as by then the wheelchairs are so worn out there would be little to be gained for the program financially after the cost of recovery and repairs were considered.

Prescribing therapists noted that the increasing tendency toward customising items such as wheelchairs is reducing the capacity of the program to reissue these items.

Program managers concurred with the view that reissue rates are being affected by the increasingly customised nature of expensive equipment, with therapists usually prescribing equipment that must be modified to meet a particular client's needs. If returned for re-issue, the likelihood of the item being appropriate for another client is somewhat limited.

Issuing Centre staff were concerned about the costs associated with the recovery, repair and reissue of equipment as the A&EP budget does not provide funding for the time and costs involved in re-issuing equipment.

The capacity to reissue is also hampered by the lack of a statewide database of client applications and items available for re-issue. As a result, Issuing Centre staff reported that re-issuing tends to occur at the local level, and there is limited capacity to match available items to client needs across the state. It was also noted that it would be costly to transport items to meet the needs of clients in other locations.

Re-issuing has the potential to increase the amount of stock available for immediate allocation to clients and effective methods for tracking, recovering and re-issuing should be explored. A

single statewide database of requests for equipment and available stock would also improve the capacity of the A&EP to reissue appropriate items more effectively.

F.2.11 Communication and information

Although not as frequent as the feedback received about the previous issues, the Review did attract a number of comments regarding communication about and within the program.

Clients indicated that they would be better able to make decisions about what they need if there was a publicly available list of items accessible through the scheme. Although this information is available in the A&EP Guidelines on the internet and in the A&EP brochure, these comments suggest that clients are not receiving or able to access the information.

Communication about the receipt and prioritisation of individual requests for equipment, progress of the request, and availability of equipment would also be appreciated by clients and their carers. Many reported having no contact with the Issuing Centre ever, and having to rely on their case manager or prescribing therapist for information about the progress of the application in the A&EP.

Communication and information about using an item once it is issued is important to many clients and their carers. Although the Program Guidelines require service providers to ensure that clients are provided with training in the use and maintenance of items, there were numerous examples provided of this not occurring or only occurring in a limited way.

Communication between Issuing Centres and therapists is variable, with some therapists reporting that they receive no communication about receipt, prioritisation or progress of requests for equipment from the Issuing Centre. Others reported receiving regular communication from Issuing Centres.

Therapists also reported a level of frustration about the lack of communication between Issuing Centres and therapists about equipment that may be available around the state for re-issue.

The feedback indicates that improving communication between the Issuing Centre, the prescribing therapist and the client should be a priority for the A&EP. The development of standard procedures for communication regarding receipt of an application, prioritisation, anticipated waiting time and reports on the progress of the application would ensure consistency of provision of information and allay many of the concerns clients have with the current administration of the program.

F.2.12 Program administration

A number of the stakeholders consulted also provided feedback about the current administrative practices within the A&EP. These included relationships between prescribers, Issuing Centres and suppliers, and issues of performance and reporting.

Clients and prescribing therapists commented on the apparent inflexibility of the existing Program Guidelines, while also noting that there seemed to be significant difference in how funding and guidelines were applied at differing Issuing Centres. It was also suggested that

much of the decision-making was locally driven rather than in accordance with the statewide Program Guidelines.

Overall, the perceived lack of consistent application of the Program Guidelines between Issuing Centres was seen as the greatest problem in respect to the program's administration. This lack of consistency is perceived to be resulting in a lack of equity of access to the program for clients.

Feedback indicated prescribing and prioritising aids and equipment was done with a clinical focus rather than being about personal outcomes for clients. Clients frequently indicated that factors such as living circumstances and lifestyle choices should be given greater consideration, than they currently are.

Staff of Issuing Centres also indicated that better tools were required to improve program administration. A number of these staff indicated that PADMIN is not as easy to use or as effective as it should be.

The current operation of the A&EP through 29 separate Issuing Centres is problematic in terms of ensuring that there is consistency, and therefore equity, in the operation of the A&EP. The issues highlighted in the feedback also suggest that opportunities for improving administrative efficiency should be explored.

G Forecasts of people with a disability who will access the A&EP

The objective of this aspect of the analysis is to forecast the number of people who have a disability and will access the A&EP. The process of generating such forecasts is twofold:

- develop forecasts of the total population of people with a disability
- extrapolate from the total population forecasts the number of people with a disability who are likely to access the A&EP.

The forecasts are generated for the period 2006 – 2012.

One of the constraints in trying to generate forecasts of people with a disability relates to the availability of robust information relating to disability prevalence. The issues relating to the methodology used by the Australian Bureau of Statistics (ABS) have been well documented. This report uses the ABS information in conjunction with population projections for Victoria developed by the ABS.

This analysis employs several methodologies to generate the forecasts. The methodology adopted makes the best use of the available information which in most cases is fragmented and not considered a continuous time series

The primary source of information on disability prevalence comes from the SDAC survey by ABS. The SDAC survey forms a valuable tool used by various governments and non-government organisations to analyse disability prevalence and trends. A survey has been done for each of the years of 1981, 1988, 1993, 1998 and 2003 and was conducted in private and special dwellings in addition to establishments such as hospitals, nursing homes and retirement villages. Results are published in Catalogue 4430.0 Disability, Ageing and Carers: Summary of Findings (Australia).

Comparisons across four ABS disability surveys (1981, 1988, 1993 and 1998) showed that the rates were higher for 1998 for most age groups than previously (AIHW 2003). There were distinct patterns of prevalence and features of policy relevance in the three different broad age groups (under 15, 15-64, and 65 and over). Specifically:

- for children aged under 15 years, the rates of severe or profound core activity restriction has increased markedly from 2.7 per cent to 4.9 per cent;
- for the population of working age (15-64), the age-standardised rate of severe or profound restrictions was stable between 1981 and 1993, but increased from 2.4 per cent in 1993 to 3.3 per cent in 1998; and
- for the population aged 65 and above, disability rates were the highest among the three age groups at 19.6 per cent in 1998.

Using this and the information gathered in the abovementioned surveys, a regression analysis would be used to come up with disability projections going forward. Due to the lack of continuous historical time series data on disability rates (i.e. no annual rates), it is difficult or

impossible to use simple regression analysis to uncover previous underlying trends in determining future outcomes.

Essentially, the SDAC surveys were used to extrapolate a rate of change between 1998 and 2003 for different age cohorts (aggregated in the table below). This rate of change was then applied to population forecasts developed by the ABS and the Victorian Government.

Table 13 Population forecast

2006-12				
	0-14	15-64	65	Total
Vic Govt. Forecasts	15,886	53,814	99,107	168,807
KPMG Forecasts	16,979	53,473	99,522	169,974
SDAC historic rates of change (applied to ABS forecasts for the total population)	17,288	56,522	100,824	174,634

The scenario used in this analysis is based on the SDAC historic rates of change applied to ABS forecasts for 2006-12 for the total Victorian population.

The historic A&EP client number data for the 2001-05 was then used to extrapolate a percentage of the total number of people in Victoria who have a disability and who would access the A&EP for the 2006-12. The forecasts are detailed in Table 14 below.

Table 14 A&EP population forecast

2006-12						
Total A&EP Population (Forecasts)						
2006	2007	2008	2009	2010	2011	2012
32,241	32,574	32,909	33,249	33,592	33,938	34,289

H Glossary

Application

A request for an item available through the A&EP.

Although a client may complete an application form requesting multiple items, for the purpose of this Review, each individual item requested is counted as an application.

Average expenditure per client

This is the expenditure divided by the total number of clients for the year.

Average gap

The difference between average annual cost and average annual expenditure per item.

Average total cost

This figure represents an assumption about the total cost of the items available under the A&EP. An average was used since the total cost information as supplied by the Issuing Centres varied from centre to centre.

Full cost

The total purchase price of an aid, equipment or home modification.

HACC

The Home and Community Care Program. This program jointly funded by the Australian government and the Victorian Government. The aims of the HACC program are to:

- provide a comprehensive, coordinated and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers; and
- support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing their inappropriate admission to long term residential care.

Issuing Centre

One of the 29 service outlets through which the A&EP is operated. Issuing Centres are responsible for scrutinising, prioritising and responding to requests for items through the A&EP.

SACS

Sub-Acute Ambulatory Care Services. SACS are operated by Victoria Health to deliver an interdisciplinary clinical service that provides assessment, diagnosis, evaluation, treatment, education and support for people of all ages who have limited function as a consequence of disease, injury, impairment and/or disorder.⁵⁴ SACS provide both in-patient and community based services.

The SACS target group includes people who have ongoing health needs that impact upon their functional independence.

Service provider

An organisation, often a health service, funded by the A&EP to operate one or more Issuing Centres.

Subsidy

The contribution paid by the A&EP toward the full cost of an aid, equipment or home modification. The subsidy levels are listed in the A&EP Guidelines.

Victoria Health

A portfolio of the Department of Human Services.

Waiting list

A list of applications that are eligible for assistance through the A&EP but which have not yet received assistance. A client may be placed on a waiting list because of their prioritisation under the program Guidelines, or because the program does not have funds available to supply the item at the time. No client should be placed on the waiting list if a suitable item is available for re-issue.

⁵⁴ Department of Human Services Continuing Care and Clinical Service Development Programs Branch. Draft Philosophy of SAC.S. Provided by DHS.