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Australian Orthotic Prosthetic Association – Relating To Prosthetic Services For Amputees

Dear Sirs,

Thank you for the opportunity to contribute to the Productivity Commission's review of Disability Care and Support. The Australian Orthotic Prosthetic Association (AOPA) is Australia's peak representative body for prosthetists (clinicians who provide artificial limbs) and orthotists (clinicians who provide braces & supports). It represents approximately 300 members across Australia from a workforce of approximately 400 nationwide. This submission to the Productivity Commission seeks to comment upon prosthetic service provision and the care of the nation's amputee population.

We would like to note that one of the primary focuses of AOPA's upcoming 2010 national congress and scientific meeting, being held on Friday 20th and Saturday 21st August 2010, is to review current care models, funding models, and produce a discussion paper and plan for integrated and consistent care for amputees across Australia. This submission is an initial attempt to outline some historical facts, the current platform of care across the states and territories of Australia, and provide some broad recommendations for a successful model in the future. A working panel represented by members from all states and territories has been appointed to create a comprehensive and detailed model. This model will be developed over the coming 9 months with a deadline for final submission in May 2011. We subsequently humbly request that the Productivity Commission permit further contributions from AOPA following this initial submission.

There is no disputing that the current system is broken and heavily flawed, with variable care provided to amputees across the nation. Independent workforce analysis shows Australia has approximately half the required prosthetic practitioners needed to meet demands. Long-term sustainability of service provision is under threat and requires a well considered plan to ensure long-term capacity meets the community's needs. We hope our initial and further future submissions may shed some light on how an equitable and efficient system based on world's best practice may be constructed and implemented.

Demographic data

Demographics show amputees represent 1 per 1,000 individuals across Australia, and subsequently there are in excess of 20,000 amputees living in Australia. Annual service provision provides intervals of care for approximately two thirds of the population per annum, with approximately 5,000 new prostheses provided to amputees each year. The service is provided by 125 prosthetists across the nation. 70% of amputees lose their limbs as a result of diabetes and vascular disease. The remaining 30% of amputations are caused by a mix of road accidents, occupational trauma, cancer & neoplastic disease, congenitally acquired limb deficiency, and infection related conditions.

Historical data

Prior to 1973, prosthetic care was primarily delivered to Australia's amputees by the Department of Veteran's Affairs (DVA) repatriation centers and a very small private sector, who were not tertiary trained. Veterans were provided prostheses at no cost, whilst community patients had to purchase their prostheses. The DVA centers in capital cities and a handful of larger rural centers provided almost exclusive care to Australian amputees. In 1973, the Whitlam government established the

Free Limb Scheme (FLS). The scheme was designed to provide state-of-the-art modern care and prostheses for all Australian amputees, whether they were veterans, or general community patients.

As anticipated, demand for services was strong, and to enable demand to be met, private licenses were offered to select practitioners across the country (generally one or two in each state), and subsequently amputees were given the choice of public or private service provision. Policy development, administration and funding remained the responsibility of the DVA. The scheme was managed nationally. At the time of its inception and roll-out, it was a world class program, and the envy of most nations.

In 1990 the Industry Commission undertook a review of amputee services. This coincided with the decline in veteran amputee numbers and the increase in diabetic community amputees. The findings of the commission recommended a closure of the DVA facilities, and the devolution of the national DVA administered program to each independent state health department. The federal DVA provided recurrent funding for a 5-year period to most states as a “carrot” to entice them into assuming responsibility for service provision. This spelt the end of the nationally coordinated program.

Current status

Each state health department has developed its own model of care and funding, with a generally adversarial position taken with service providers. Some states are dominated by public service provision and some have primary provision through private providers. An initially under-resourced situation has further deteriorated in most states. There are now extreme differences in the standards and models of care provided to amputees across Australia. Amputees in some states are provided with well resourced and well integrated services in the pre-operative, post-operative, acute, rehabilitation, and long-term care phases. In many states this is not the case. In some states across Australia, care models and prosthetic technologies from the 1980’s are still the benchmark provided to amputees. If chemotherapy services were in a similar position, there would be an outcry across the nation.

Policy development, and subsequent ongoing service development has stagnated and in some states regressed. In the past “stakeholders” such as amputees, prosthetists, physiotherapists and medical specialists all provided input to advisory panels at national and state levels. Sadly these bodies no longer exist, and transparency, accountability and governance is desperately lacking in most states. This has led to disjointed service provision, and decisions regarding service models that make no economic sense because they are not viewed from global health cost and outcome perspectives. For example the refusal in NSW to employ a \$200 rigid dressing immediately post-operatively for budgetary reasons is fiscally incomprehensible, when this dressing may reduce acute and rehabilitation hospital stays by as much as 14 days and decrease total treatment costs by tens of thousands of dollars. Cross-border service provision is chaotic with most state health departments unwilling to service amputees from other states. It appears to make no sense for an amputee living in Tweed Heads to travel to Newcastle or Sydney for services when providers are available on the Gold Coast and in Brisbane.

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

In some states, prosthetists are the primary avenue for prescription (responsible for determining the type of prosthesis each patient requires), however in many other states, the responsibility resides with administrators or rehabilitation specialists. Whilst checks and balances are required, and are in

fact a vital component of a successful model, all those involved in amputee care agree that the current format underpins an inefficient model.

In most states, community patients, who lose their limbs due to vascular disease (70% of all amputees) and congenital amputees (those born with limb deficiency), cannot access services and prostheses to the standard that compensable amputees can (those who have undergone amputation as a result of road or occupational trauma). This imbalance is not equitable and requires addressing. In most states of Australia, amputees who lose their limbs as a result of road or work trauma are ultimately provided with a payout of their insurance claim, and are made responsible for financially managing their lifetime prosthetic care. This lump sum settlement in many instances is used not for ongoing lifetime prosthetic care. Often amputees mismanage these funds and then become reliant upon the government community programs for their long-term care. Victoria and NT have systems by which settlements do not include major lump sum payments for lifetime care, but instead provide ongoing lifetime care, support and funding. This model appears to make a great deal of sense.

Immediate needs

Amputee care comprises many facets (from pre-amputation care through to long-term life management). To ensure the opportunity for optimal outcomes and a return to a full and valuable life, a well structured and integrated pathway of care is vital. The pathway of care is represented by three basic phases.

Acute – Pre and post-amputation and acute hospital care. This generally represents the first 2-3 weeks of an amputee's journey and occurs in the acute hospital setting.

Rehabilitation – Stabilization, mobilization, gait training and physical conditioning. This generally represents the next 60-days care and occurs initially in a rehabilitation hospital and then as an outpatient once safe to return to the home environment.

Lifelong care – Ongoing care for the remainder of an amputee's life.

In most states, well integrated and seamless services spanning acute, rehabilitation and long-term care does not exist and services are relatively uncoordinated. The most pressing need is to ensure a platform is established to deliver best practice and seamless pathways of care throughout the amputee's journey, irrespective of which part of Australia the amputee is from. Funding for acute best practice inpatient services and good rehabilitation programs and systems is a prerequisite. Built into this must be a clear understanding of the different needs of metropolitan and rural/remote amputees.

The prescription of appropriate and modern technologies is vital to good outcomes, and a stagnation of funding for modern technologies over the past two decades in most states of Australia has greatly restricted the functional output and lives of most non-compensable amputees. This deficiency has been clearly outlined in numerous reviews. This must be addressed by collective review by independent experts. Prescription rights should be provided to prosthetic practitioners in all states.

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

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

Future needs

We need to design a system for tomorrow which delivers seamless coordinated care from pre-amputation, to acute care, to the rehabilitation phase, into lifetime care. This task must be undertaken by a panel of domestic and international experts, whose findings are not refuted due to historical economic arguments or entrenched positions.

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

A national information system should be constructed and rolled out to ensure thorough and standardized data collection occurs across the nation. This data collection is a missing platform required for ongoing analysis and service development. Information must be collected from the point of amputation or earlier in the case of at-risk diabetic clients.

Equitable and transparent funding models for all states and service providers (whether public or private) in line with competitive neutrality legislation, will provide a sustainable environment for all services across the country.

Equitable and consistent care provision to all amputees is required, irrespective of whether they lose their limb from road trauma or due to diabetes. The current system penalizes community patients who are not compensable.

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

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

The creation of a panel responsible for policy and operational planning for amputee services across Australia is also required. This panel should include representatives from amputee user groups, multi-disciplinary professional organisations who's members deliver services at the coalface, health economists and government representatives. This should be supplemented by periodic independent financial analysis of the system put in place to determine sensible and sustainable funding and resource requirements.

Summary

AOPA would like to thank the commission for the opportunity to contribute to this most important of tasks. We aim to continue to provide further submissions as the Association's members and industry experts develop a sustainable and best-practice plan for the future of amputee service provision across Australia. We offer our support and also offer our openness and willingness to discuss all issues with the Productivity Commission over the coming 18-months.

Yours respectfully,

The Australian Orthotic Prosthetic Association National Council