2008

PARLIAMENT OF TASMANIA

JOINT STANDING COMMITTEE ON COMMUNITY DEVELOPMENT

REPORT

ON

THE PROVISION OF ASSISTIVE TECHNOLOGY AND EQUIPMENT FOR PEOPLE WITH DISABILITIES

Membership of the Committee

Hon. Kerry Finch, MLC (Chair)	Mrs Heather Butler, MP
Hon. Allison Ritchie, MLC	Mr Brenton Best, MP
Hon. Norma Jamieson, MLC	Mr Brett Whiteley, MP
Hon. Terry Martin, MLC	Ms Cassy O'Connor, MP

TABLE OF CONTENTS

GLOSSARY OF TERMS

A&EP	Aids and Equipment Programme
AIHW	Australian Institute of Health and Welfare
APA	Australian Physiotherapy Association
AT	Assistive technology
BEN	Board of Exceptional Needs
CACM	Community Care and Assessment Management
CBS	Community Based Support South
CAEP	Community Aids and Equipment Programme
CES	Community Equipment Scheme SCES: southern CES NCES: northern CES NWCES: north west CES
CHC	Calvary Health Care
CHES	Community and Health Equipment Scheme
CTS	Children's Therapy Services
DHHS	Department of Health and Human Services
DVA	Department of Veterans Affairs
HACC	Home and Community Care
ILC	Independent Living Centre
ISP	Individual Support Programme
LGH	Launceston General Hospital
MASS	Medical Aids Subsidy Scheme
NDS	National Disability Services Formerly ACROD
NGO	Non-government organisation
OT	Occupational therapist
PADP	Programme of Appliances for Disabled People
RAP	Rehabilitation Appliances Program
TasCOSS	Tasmanian Council of Social Services

CHAIR'S FORWARD

The provision of equipment and technologies that enable people with disabilities to live as full a life as possible can no longer be seen as an ideal to be pursued when government budgets allow, but a right that is now enshrined in international law.

On 17 July 2008 the Australian Government ratified the UN Convention on the Rights of Persons with Disabilities and consequently the Tasmanian Government is bound by the provisions of this treaty and must now ensure equality of access for all.

Many witnesses appearing before the Committee emphasized this point to Members noting that:

> *You cannot say on the one hand that we will get rid of institutions and we will let people participate in the community but we will not support them.(Mr Michael Sertori)*

Members were touched by the personal accounts of hardship related to the Committee by witnesses who had encountered difficulties in accessing equipment for themselves or their children, knowing that the timely provision of even simple appliances could mitigate their condition and make life more tolerable.

> *We need to say that there are a lot of people who could be enabled via the appropriate use of technology and that rather than talking about people having to prove every day how pathetic they are in order to get benefits, perhaps we could help people to imagine how wonderful they are and how much they could achieve in life.(Dr Christopher Newell)**

Whilst the Committee acknowledges the complexities involved in the operation of the Community Equipment Scheme the Committee found that serious underfunding of the service has skewed its priorities and many individuals on waiting lists have little hope of ever receiving help.

The timely provision of equipment and technologies to people with disabilities should be seen as a social investment as it helps to prevent the deterioration of conditions that would otherwise need more intensive and costly interventions and more importantly it helps to restore dignity to the individual.

Hon Kerry Finch MLC
CHAIR

* Associate Professor Newell passed away 24 June 2008

FINDINGS

1. The Committee found that a significant number of people with disabilities who require the use of aids and equipment have given up on receiving help from the Community Equipment Scheme and either seek help from charitable organisations for the purchase and maintenance of equipment or simply resign themselves to a lower quality of life.

2. The Committee found that the Community Equipment Scheme is not functioning as efficiently as possible and is in need of restructuring or a complete overhaul to more effectively address the needs of its clients.

3. The Committee found that the Community Equipment Scheme does not have sufficient performance indicators in place to ensure optimum efficiency and transparency.

4. The Committee believes that the guiding principle in assisting people with disabilities should be one of enabling people, that is, to provide the support that will allow them to function at their fullest capacity. The Committee contends that this approach broadens social inclusion, and is a prudent exercise in preventative economics.

5. The Committee found that funding for the Community Equipment Scheme is unevenly distributed across the State and that areas of high demand such as the north-west have fewer resources to address the need.

6. The Committee found that the use of thresholds in the funding of equipment is redundant and inequitable. Community Equipment Scheme clients are typically disability benefit recipients and are unlikely to have sufficient funds to meet the exorbitant and increasing cost of aids and equipment, especially non-standard equipment and associated repair and maintenance costs.

7. The Committee found that the budget management of the Community Equipment Scheme is less than adequate as evidenced by the chronic deficiency in budget allocations year after year.

8. The Committee found that many seemingly high priority applications for assistance from the Community Equipment Scheme were rejected without sufficient explanation.

9. The Committee found that access to funding for equipment became more difficult once a child reaches 18 years of age.

10. The Committee found that people requiring communication devices received low priority under the current system.

11. The Committee found that current equipment storage and distribution facilities are inadequate.

12. The Committee found that there is no central database that maintains records of available equipment and equipment on loan. Such a database would ensure that the location of all equipment is known and can be retrieved when no longer needed.

13. The Committee found that a lack of forward planning tends to create a crisis management approach in the provision of equipment to people with disabilities. A case management approach is vital in matching funding and the timely delivery of equipment to clients and can ensure that orientation and training in the proper use of equipment is provided.

14. The Committee found that the timely provision of equipment and maintenance to equipment was likely to enhance independence and quality of life for individuals and reduce the need for more serious future intervention such as acute care and as such is seen as a social investment.

15. The Committee found a shortage of allied health professionals in Tasmania such as physiotherapists, occupational therapists and speech therapists. Furthermore the Committee found that whilst some undergraduate training is provided, the University of Tasmania does not provide courses for these professions.

16. The Committee found that people with disabilities encounter difficulties at home that could be alleviated if home building regulations took into consideration such things as door and passageway widths to accommodate wheel chairs and other equipment.

17. The Committee does not see the transfer of the Community Equipment Scheme to the non-government sector in the short or medium term as the solution to the current shortcomings of the scheme.

RECOMMENDATIONS

1. The Committee found that the Community Equipment Scheme (CES) is not functioning in an optimal manner and recommends a restructuring of the service to more effectively address its clients' needs.

2. The Committee recommends that Disability Services conduct comprehensive survey work and collect appropriate data to establish the full extent of the client base for assistive technologies and equipment in Tasmania and publish its findings.

3. The Committee sees the need for an overhaul of CES budget management. The Committee recommends increased and indexed funding to meet increasing costs and increasing demand for services.

4 The Committee recommends that funding for aids and equipment be provided on a per capita basis to address the current inequitable distribution between regions.

5. Whilst the Committee is aware of the hardship provisions in the CES guidelines, evidence suggests that many low income families struggle to meet their needs for aids and equipment due to the enormous costs involved. The Committee recommends a more flexible assessment approach that may even include middle income families if the cost of equipment is beyond their capacity, especially in respect to non-standard equipment.

6. The Committee sees the need for maintenance planning for all CES equipment and recommends that a mobile maintenance service be established that can visit clients at home and can be accessed outside of normal business hours in urgent cases.

7. The Committee recommends that Disability Services extend its maintenance services for assistive technologies and equipment to all users irrespective of the ownership of the equipment.

8. The Committee is aware that many items of equipment (standard and non-standard items) lay in storage in the community when no longer required by the original user. The Committee recommends that a concerted campaign be conducted to have such items retrieved or donated for refurbishment and further use.

9. The Committee recommends that equipment purchased by the education department for the use of individual students in school be allowed to be used in out of school settings where practical to assist families and reduce costs and duplication.

10. The Committee recommends establishment of central facilities within administrative regions that can act as a one-stop shop for the provision of aids, equipment and maintenance.

11. The Committee recommends that regional equipment facilities be linked to a central on-line database that can provide information on the availability of

equipment State-wide. A triage program should be incorporated into the system to ensure that the allocation of equipment corresponds with areas of greatest need.

12. The Committee recommends that a case worker model be adopted in relation to people with disabilities to facilitate personalised life-long planning that will anticipate their equipment needs as their circumstances change, thus avoiding the current crisis management approach.

13. The Committee recommends that the Tasmanian Government with the University of Tasmania examine the feasibility of providing courses for allied health professions in Tasmania, including but not limited to, speech therapy, physiotherapy and occupational therapy.

14. The Committee recommends that any new configuration of the CES include funding for specialised communication equipment. Under the current scheme people with communication difficulties are seriously disadvantaged as communication devices are given low priority for funding.

15. The Committee recommends that consideration be given to the amendment of building regulation to take into consideration the needs of people with disabilities.

16. The Committee recommends the establishment of a help desk that can provide information and assistance to people with disabilities and their families seeking access to aids and equipment and provide full and transparent explanations when their applications are unsuccessful.

17. The Committee recommends that the current Federal Government review of taxation include a consideration of tax breaks for employed individuals who require disability aids and equipment for themselves or their children, but are ineligible for assistance under current equipment schemes due to their employment status.

18. The Committee recommends that the Tasmanian Government consult with the Commonwealth on the possibility of making the provision of aids and equipment to people with disabilities a national scheme funded by the Federal Government under the Medicare scheme. The Committee expects that all other recommendations will be enacted in the interim.

EXECUTIVE SUMMARY

The Community Equipment Scheme (CES) is tasked with providing aids and equipment to people with disabilities to lessen the barriers that could prevent them from living in the community and participating in day-to-day activities as equal and valued members of our society.

This principle is in accord with the objectives of the *Disability Services Act 1992* that declares its aim to be:

(a) t**o** enable persons with disabilities to achieve their maximum potential as members of the community;

(b) t**o** enable persons with disabilities to –

(i) further their integration into the community and complement services available generally to persons in the community; and
(ii) achieve a better quality of life including increased independence, employment opportunities and integration in the community; and
(iii) use services that are provided in ways that promote in the community a positive image of persons with disabilities and enhance their self-esteem;

(c) to ensure that the quality of life achieved by persons with disabilities as the result of the services provided for them is taken into account in the granting of financial assistance for the provision of those services;

(d) to encourage innovation in the provision of services for persons with disabilities;

(e) to provide a system to administer funding in respect of persons with disabilities that is flexible and responsive to the needs and aspirations of those persons.

In the course of this inquiry the Committee found that significant underfunding of the Community Equipment Scheme over many years, coupled with increasing costs and demand for services has meant that these objectives are not being realised and that many of the most vulnerable people in our community are being disadvantaged.

The pressure of competing claims and increasing costs in an underfunded scheme have caused distortions to the way the Community Equipment Scheme operates and has shifted its focus to serving only the highest priority clients.

The Community Equipment Scheme provides assistance to three main client groups, these are:

- people requiring assistive equipment to facilitate their discharge from hospital,
- people with temporary or permanent disability who need assistance to live at home, and
- people with catastrophic injuries that need assistance to integrate back into the community.

Evidence presented to the Committee suggests that patients being discharged from hospital are given higher priority over people with disabilities in the community.

The crisis in community equipment funding was graphically illustrated in evidence provided by a member of the Northern Equipment Scheme panel who indicated that the monthly allocation for the north of the State (for standard items of equipment) totalled $6000, whilst monthly applications for assistance were typically in the region of $100,000.

The Community Equipment Scheme deals with both standard and non-standard equipment. Standard equipment usually consists of smaller items with a value of less than $500, non-standard equipment includes such things as customised electric wheelchairs that may cost up to $20,000. The CES provides funding up to $6000 towards such items.

People with disabilities being discharged from hospital tend to need more non-standard equipment, and are therefore or more expensive to accommodate. Thus the resources of the CES become even more skewed towards this sector.

The Committee was told that the Community Equipment Scheme seems to have lost its community aspect; where once it helped people in their daily lives it has now become a scheme for keeping people out of hospital.

Many submissions to the Committee told of the struggle that people with disabilities have in sourcing funding for equipment.

The cap on assistance for non-standard equipment was especially onerous for people with disabilities who may have to contribute as much as $14,000 towards items such as electric wheelchairs.

The Committee heard complaints about inconsistent treatment and a lack of transparency in the determination of priority status. Many said they had given up applying for assistance to the CES, as they were not priority one, and would have to wait for as long as 2 years for assistance.

Allied health workers also told the Committee that in the case of some categories of equipment, such as specialised communication equipment, there had not been any successful applications for funding in the past ten years.

Lengthy delays in providing assistive equipment to people with disabilities can contribute to a deterioration of the person's condition and this can lead to unnecessary suffering, waste and increased overall costs. The Committee was told for example, that delays in providing children with wheelchairs often meant that they would outgrown them by the time they arrived and then the whole process of applying for assistance would have to start again.

The need to do more with less has highlighted some of the deficiencies and inefficiencies of the Community Equipment Scheme.

The Committee was told that the shortage of funding had created a reactive approach to service delivery with few resources being directed at preventative interventions or planning for the future needs of clients.

Funding is unevenly distributed across the three administrative regions, with scarce resources not being matched to areas of greatest need.

There is no central data base to track and effectively distribute equipment across the State. The Committee heard that many items of equipment are lost or lay unused in garages and sheds across the State.

There is no maintenance plan in place for CES equipment. Equipment is serviced and repaired when it breaks down and this has the effect of reducing the life of the equipment.

Clients are greatly inconvenienced when equipment is taken away for maintenance and there are no replacement items available for loan whilst the servicing is done. The Committee was told of instances where clients were bedridden for weeks whilst parts were sought for their electric wheelchairs.

The Committee feels that a complete overhaul of the Community Equipment Scheme is necessary in order to improve governance and the delivery of services.

Increased funding to address the unmet demand is an immediate priority with indexation to ensure that future demand can be accommodated.

Greater efficiencies can be realised if all the regional centres are linked through a central data base that can help to direct resources to areas of greatest need.

Further efficiencies will flow from strategic planning that ensures the timely arrival of funds and equipment to meet predicted future individual needs and this will help to remove the crisis or reactive approach to service delivery.

INTRODUCTION

ESTABLISHMENT OF THE INQUIRY

In November 2007, the Joint Standing Committee on Community Development ("the Committee") agreed to conduct an inquiry into the provision of assistive technology and equipment for people with disabilities.

A reference for an inquiry can arise via three sources: a Government Minister; either House of Parliament; or Members of the Committee. In this case, the reference for an inquiry was a request from Members of the Committee.

TERMS OF REFERENCE

This report is presented in accordance with the following terms of reference:

1: Strategies, policies, and practices to ensure the effective and consistent operation of the Community Equipment Scheme (CES) including the following issues:

   a): Current and future resourcing;
   b): Caps on contributions;
   c): Eligibility criteria; and
   d): Prioritisation method.

2: The ability of people with disabilities to access funds for equipment and assistive technology in the community;

3: The establishment of a centralised system to track and audit available equipment and assistive technology that could be implemented in Tasmania;

4: Community Equipment Schemes operating in other jurisdictions and possible alternative models that could be implemented in Tasmania; and

5: Any other relevant matters.

PROCEEDINGS

The Committee sought and received submissions from the public during late 2007 and early 2008, until 3 March. Public hearings were held during March, April, and May 2008.

The Committee expresses its appreciation to those who took the time to provide evidence in person or to prepare written information.

Details of submissions, witnesses, and documents received are contained in the appendices to this report.

STRUCTURE OF THE REPORT

The report is divided into chapters structured around the terms of reference. Some background information is provided preceding the main report.

Conclusions (findings) and recommendations are listed in consolidated form at the beginning of the report and also at the end of each chapter as they relate to the terms of reference.

An additional chapter has been inserted concerned with other relevant matters.

BACKGROUND

DISABILITY IN TASMANIA

A recent KPMG review of disability services in Tasmania summarised the extent of disability in the State as follows:

> *"It is estimated that at least 111,700 people in Tasmania or 23.5% of the Tasmanian population had a disability in 2003, representing the highest rate of disability in Australia. This in part relates to Tasmania's ageing population. Approximately 22,100 Tasmanians under the of 65 had a profound or severe disability."*[1]

In 2006 ACROD (since re-branded as National Disability Services) analysed Tasmanian disability statistics in more depth, finding:

- There are in total 111,700 people with disabilities (or 23.5% of the population) in Tasmania;
- Among 111,700 people with disabilities, 15,200 have no specific limitation or restriction and 96,500 have limitations or restrictions;
- Among 96,500 with limitations or restrictions, 10,000 are restricted from school or work and 86,500 have a core activity limitation;
- Among 86,500 with core activity limitation, 49,400 have a mild or moderate core activity limitation and 37,100 have profound or severe activity limitations, representing 10.4% and 7.8% of the Tasmanian population respectively.[2]

Definitions of disability tend to focus upon functional impairments and restrictions.[3] However, as Assoc Prof Christopher Newell (School of Medicine, UTAS) highlighted to the Committee, disability also has a social aspect:

> *"People have a variety of impairments, yet whether or not those become disability depends upon the social milieu within which they exist. … In other words, there is a significant cultural and social dimension to disability, which needs to be understood in order to fully understand what needs to be done in providing technology for people who live with impairments and are disabled by society."*[4]

WHAT IS ASSISTIVE TECHNOLOGY AND EQUIPMENT?

The Department of Health and Human Services (DHHS) and the Independent Living Centre (ILC) (Tas) each defined assistive technology as being:

> *"A term for any device, system or design whether acquired commercially or off the shelf, modified or customised, that allows an individual to*

[1] KPMG/DHHS, 'Review of Tasmanian Disability Services', June 2008, p. 16
[2] ACROD Tasmania, 'There's No Place Like Home: Living with Disabilities in Tasmania', 2006, p. 6
[2] Newell, submission, p. 7
[3] ACROD Tasmania, 'There's No Place Like Home: Living with Disabilities in Tasmania', 2006, p. 6
[4] Newell, submission, p. 1

perform a task that they would otherwise be unable to do, or increase the ease and safety with which a task can be performed."[5]

An Australian Physiotherapy Association (APA) paper of 2006 provided to the Committee contained the following definition of aids and equipment:

"Aids and equipment are products that assist a person with a disability by improving their functioning. Aids and equipment include specialised aids for breathing, eating, drinking, bathing, toileting, mobility, positioning (lying, seating, standing) and sleeping; home modifications, hoists, augmentative communication devices and environmental control units. Aids and equipment provide comfort, pain relief, safety, and support and can assist in the pursuit of education, training, employment, and participation in community life."[6]

WHAT IS THE COMMUNITY EQUIPMENT SCHEME?

The CES is the main scheme, among numerous other smaller schemes, which facilitates the distribution of equipment and assistive technology to eligible individuals with disabilities for loan or hire in Tasmania. Administration and funding for equipment was the responsibility of the Federal Government, under a scheme known as the Programme of Aids for Disabled People (PADP), until 1987. It was then transferred to the States, with the Tasmanian scheme operating as a State PADP until the inception of the present CES model in 1999.[7] Access to CES loan services is subject to eligibility criteria and the order of equipment provision is subject to a priority ratings regime. Clause 1 of the CES Guidelines outline the scheme as follows:

"1.1 CES provides aids an appliances to eligible Tasmanian clients, who have been referred by an authorised prescriber, to enhance their quality of life in the community.

1.2 CES comprises three regional outlets [south, north, north-west], which integrate all equipment schemes run by the Department of Health and Human Services that are providing aids and appliances listed in these Guidelines.

1.3 CES is an integral part of the statewide Community Health Equipment Scheme (CHES) and it governed by its umbrella policy framework [see below].

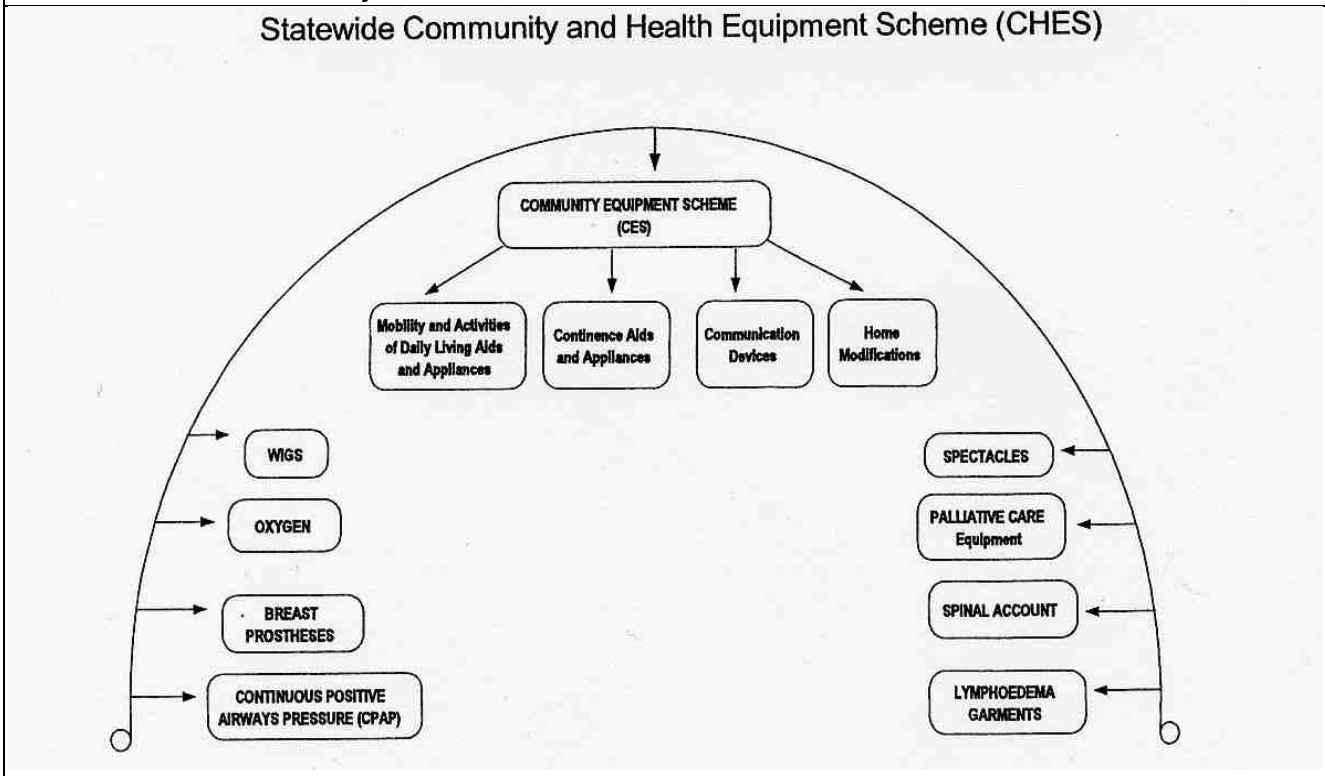
1.4 The budget holder for CES is the State Manager, Community Assessment and Care Management (CACM).

1.5 CES is based on the revised Guidelines for the previously known Programme of Aids for Disabled People (PADP). It is intended to work

[5] DHHS, submission, p. 7; ILC, submission (revised), p. 2
[6] Australian Physiotherapy Association, 'APA Position Statement', November 2006, p. 1 (provided by APA Tas Branch)
[7] DHHS, submission, p. 9

with the development of the CHES through quality improvement processes."[8]

CHES Umbrella Policy Framework



Source: Statewide CES Guidelines, Clause 1.3

The CES has three regional outlets servicing the north, north west, and south of Tasmania. Overall management is the responsibility of the CHES Steering Committee and the CES Statewide Steering Committee. There are also committees at the regional level.[9] Management and funding structures differentiate slightly, as DHHS explained in its submission:

"In the south and north west funding is provided through the Primary Health business unit. In the south the service is managed by the Manager, Community Occupational Therapy. In the north west the service is managed by the Manager, Occupational Therapy Services NW Regional Hospital. In the north of the State the CES component of the 'non-standard equipment' is funded by Primary Health with the remainder of the Budget held by the Launceston General Hospital (LGH), as part of physiotherapy services. It is managed by the Manager, Occupational Therapy, LGH. The three CES managers are members of the CES Statewide Steering Committee which includes the statewide fund manager and others."[10]

[8] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 3 (provided by DHHS)
[9] DHHS, submission, pp. 10-11
[10] DHHS, submission, p. 13

Equipment provided through the CES is categorised as being either standard – common items costing less than $500, or non-standard – specialised items costing more than $500.

WHAT IS THE COMPLEXITY OF PROCURING EQUIPMENT?

Standard equipment can be provided on loan or hire from the CES and is ordinarily available off-the-shelf. Non-standard, customised, or expensive items are more problematic for clients, equipment suppliers, and financiers.[11] Individual cases and circumstances may vary; nevertheless, the following section is intended to illustrate in general terms the complexities of procuring customised and expensive equipment for CES clients.[12]

Assessment and Prescription

- The client is self-assessed/professionally assessed as having a need.
- Prescription/referral is sought from a qualified health practitioner to access the CES. If a client is borrowing or purchasing an item privately, however, a clinical assessment may not necessarily take place.
- Basic research is conducted to find out what equipment is available.
- Services come into demand as increasing numbers of people seek to be enabled and socially included through the use of equipment, leading to waiting times.

Application to CES

- Eligibility status is clarified.
- Equipment is either provided off-the-shelf or a special purchase is arranged, with the client co-contributing to the item cost if a certain cost threshold is exceeded.
- If a special purchase is required, the client is allocated a priority category and awaits CES contribution to funding.
- Potentially, some clients may use private suppliers/financiers or have access to other government sources for their equipment, thereby not necessarily having contact with the CES.

Searching and Financing

- Depending on finance and changes to the clients condition since original assessment, an appropriate and available item of equipment is selected for purchase and eventual use.
- The client arranges finance for their contribution towards the likely final cost of the selected item.
- The Committee understands that communication devices can be particularly difficult to acquire.

[11] CES Guidelines define 'standard' and 'non-standard' equipment as follows: "Standard: basic items of equipment that are kept in stock and frequently requested for loans which are non-specialised, or off the shelf, or inexpensive (<$500); Non standard: equipment not kept in stock that has to be ordered and which is specialised, or customised, or expensive (>$500). Regional CES committees require applications from authorised prescribers prior to purchase." DHHS, 'Statewide Community Equipment Scheme Guidelines', April 2004, p. 10

[12] In compiling this section, information has been drawn from OT Australia (Tas), submission, pp. 7-8

Testing, Trial and Customisation

- The client tests and trials equipment for suitability prior to purchase.
- Equipment may need to be shipped from an interstate or overseas supplier.
- Equipment is fitted or modified if required, depending on the nature of the item and client requirements.
- If the client's condition has changed, a new assessment may be required or the process virtually restarted, as the original item would be inappropriate hence a new item is required.

Growing Dependent Children

- Children can quickly outgrow an item of equipment after a relatively short period of time.
- Families can come under pressure to acquire numerous items before a young person attains 18 years old and thereafter cannot access certain services and subsidies, such as those provided by schools.

Familiarisation and Adaptation

- The client (and or their carer) may require additional training in the proper usage of an item. Some items could require computer software to operate, also requiring user training.
- Some clients may find that certain items, such as wheelchairs, necessitate home or vehicle modifications. The purchase of secondary items to maximise the use of the primary item may also be necessary.

Maintenance and Servicing

- Maintenance and repairs are required from time to time. If an item is owned by the CES, the scheme's subsidised maintenance service provides assistance (except for tyres and batteries). This service, however, operates only during business hours Monday to Friday.
- During maintenance periods, the client has to organise alternative equipment or technology arrangements (if an alternative can be found).
- The CES does not provide a maintenance subsidy for privately owned equipment.

CHAPTER 1

THE EFFECTIVE AND CONSISTENT OPERATION OF THE COMMUNITY EQUIPMENT SCHEME

1.1 Introduction

The CES was subjected to criticism in submissions and during presentations of verbal evidence. The Department of Health and Human Services (DHHS), as overall CES administrator, while sometimes acknowledging the views of critics, nevertheless highlighted the challenging nature of the scheme's assignment. Issues of concern involve the appropriateness of the scheme's aims and objectives, the degree of openness and transparency, questions of ownership, fees and charges levied, service responsiveness, and equipment maintenance and handling. Other issues additionally identified relevant to terms of reference 1 a, b, c, and d, which are concerned with resourcing, contributions, prioritisation method, and eligibility criteria, are addressed later in this report.

The difficulties of measuring performance and the absence of indicators, in terms of equipment and assistive technology provision, one witness noted, makes identifying a threshold for effectiveness and consistency a problematic task. For other witnesses, their observation was that the entire scheme should be overhauled.

As well as suggesting what could be amiss with the CES or how it might be improved, witnesses and submissions also sought to remind the Committee why, from their perspective, equipment and assistive technology is important and the rationale for supplying it to people with disabilities in the community. Two different views – though not necessarily competing views – arose on this question. On the one hand, it was emphasised to the Committee that equipment and assistive technology is cost effective and saves expenditure, on the other, the importance of improving quality of life was emphasised.

1.2 Performance Measurement

Although certain specific inadequacies with the CES may have an aura of being self-evident, the Committee was informed that there is not a system in place to measure the performance of equipment schemes in Tasmania against particular criteria, benchmarks, or indicators. Were such a system to exist, witnesses questioned how indicators capable of showing progress rather than activeness could be developed. Other witnesses stated that the general under-performance of the scheme is not in doubt and that the CES requires an overhaul.

Michael Sertori (CEO, St Giles Society Inc) said any changes to the CES should be:

> *"Subject to some sort of performance indicators so that we have an ability in future to measure the performance of the scheme, particularly*

the effective impact of any funding or additional funding that is applied into the scheme. At the moment there is not a system of measure."[13]

Peter Nute (CBS) said performance measuring of equipment and technology services does not exist. He said:

"It is not a measurable system; the HACC [Home and Community Care] system and Disability Services don't have measurements for these things. So not being measurable is not an outcome, but just because we are not measuring anything doesn't mean that nothing is going on."[14]

Members asked if he was saying there is not a baseline. He responded, "No, there isn't."[15] He continued:

"The problem with the current system is that you tend to sit more, and if you sit more you become less fit, less strong, less able to do all the other things and less able to connect with the community. We have been inadvertently contributing to a downward spiral and it is but for the insertion of some other types of support, which are more difficult to measure. You can measure the number of hours we supply in support – that's an easy, direct measurement. Then we put that into the system and off it goes to the data repository and everybody is happy, but there's one problem – people become more and more dependent over time."[16]

Members asked Megan Morse (Allied Health Manager, Calvary Health Care) how her organisation measures success. She said *inter alia* each client has an individual threshold of success:

"I guess in some respects that is a particularly difficult question for us to answer because of the scope of clients that I am responding in relation to. The way we indicate success in a very small child would obviously be different to our adult clients. We are using a range of objective measures within our agency. We have a range of very key parameters around safety in particular of our children our primary clients, and occupational health and safety when we are thinking around child-care workers and teachers. There is a range of mechanisms by which we would measure success. In our adult clients the abandonment of devices is a really genuine problem. It just gets too hard and people shove them in a cupboard. I guess the continuing use of a device is the first sign that you are still in the game. I realise that is a fairly vague answer, but short of being able to speak around specific instances again it is an issue that, because of the scope of clients that we work with that, it is among things that we will be using. But the short answer to it would be that all of our clients have functional clinically orientated goals and so each of them would have a measure of success."[17]

---

[13] Sertori and Merry, transcript of evidence, 28 April 2008, p. 11
[14] Nute and Guy, transcript of evidence, 20 May 2008, p. 2
[15] Nute and Guy, transcript of evidence, 20 May 2008, p. 2
[16] Nute and Guy, transcript of evidence, 20 May 2008, p. 2
[17] Morse and Donward, transcript of evidence, 20 May 2008, p. 31

Margaret Reynolds (State Manager, National Disability Services (NDS) (Tas.)) said the CES "needs a total overhaul."[18]

Michael Sertori (CEO, St Giles Society Inc) similarly asserted that the CES "is in need of a major overhaul".[19] He elaborated:

> *"We have certainly grown weary of the constant battle in trying to secure funding for clients. We are frustrated with the inconsistent governance, the compromised prioritisation arrangements, inconsistent treatment of standard and non-standard equipment, the need to pursue political interference to achieve funding, inconsistencies in the timing of the release of funds, and this haphazard notion of throwing one-off funds each year, as has just happened."*[20]

He commented further:

> *"You cannot say on the one hand that we will get rid of the institutions and we will let people participate in the community but we will not support them. It is not either/or."*[21]

Angela Dodd said:

> *"I just need to see a change or I will go stark raving mad. I need a better process so that I do not have to fill in so much paperwork, and so that people listen to you. I would invite anyone to come to my home and see what we are dealing with."*[22]

Millicent Subonj (Executive Director, Multicap) was not quite as critical, saying "You have a waiting list but it is a fairly good system."[23]

1.3 The Logic of Equipment and Assistive Technology for the Community

Witnesses and submissions presented both economic and social arguments to explain the significant role equipment and assistive technology has in the community. In economic terms, equipment and assistive technology is credited with reducing the need to place people with disabilities into supported facilities, homes, or hospitals to be cared for at a greater financial expense. In social terms, equipment and assistive technology is ascribed as improving quality of life, facilitating independence, and enabling people with disabilities, rather than having individuals confined to their house or supported accommodation.

Assoc Prof Christopher Newell (School of Medicine, UTAS) said people should be enabled through the appropriate use of technology:

> *"In the current environment where we are very close to full employment in some areas, I suggest that we need to, in a Marxian-type sense, look*

[18] Reynolds and Wilkinson, transcript of evidence, 20 May 2008, p. 12
[19] Sertori and Merry, transcript of evidence, 28 April 2008, p. 3
[20] Sertori and Merry, transcript of evidence, 28 April 2008, p. 4
[21] Sertori and Merry, transcript of evidence, 28 April 2008, p. 14
[22] Dodd, transcript of evidence, 29 April 2008, p. 13
[23] Daley and Subonj, transcript of evidence, 29 April 2008, p. 22

at disability in terms of a lumpenproletariat. We need to understand the Reserve Army dimension of that. We need to say that there are a lot of people who could be enabled via the appropriate use of technology and, rather than talking about people having to prove every day how pathetic they are in order to get benefits, perhaps we could help people to imagine how wonderful they are and how much they could achieve in life."[24]

He added:

"The real challenge with anyone living with an impairment is not so much how much they cannot give us but how much we are prepared to allow them to give us."[25]

The Equipment and Technology Library submitted:

"Over the past fifty years the life expectancy and medical care of children born with disabilities has improved enormously. Over the past twenty years equipment and technology has improved so that the quality of life of those living with a disability, their families and carers, can approach a standard that the able-bodied take for granted, and would regard as basic."[26]

Catherine Merry (Allied Health Manager, St Giles) said:

"It is almost a joke trying to compare the cost of equipment to maintain people in their own home versus the cost of providing a hospital bed while they wait for a nursing home bed. The former is such a small amount compared to what the demands on the system might be otherwise."[27]

Christopher Bryg (Independent Living Centre (Tas)) explained:

"The point is to enable someone to be more independent, to perform activities more independently or more safely, and the underlying principle behind that is that people are valued to contribute to the community, that everyone should have equal access to the same things to be able to do the same types of activities. So we are talking about function, we are talking about people functioning within the community and contributing to the community, but also the health benefits that they receive from that. …If someone has the right equipment for their needs to be able to function within their community, then they can contribute to that community."[28]

Diane Ewington said some families, unable to receive proper assistance, have handed their children to group homes to be cared for at the expense of taxpayers:

[24] Newell, transcript of evidence, 20 May 2008, p. 60
[25] Newell, transcript of evidence, 20 May 2008, p. 63
[26] Equipment and Technology Library, submission, p. 3
[27] Sertori and Merry, transcript of evidence, 28 April 2008, p. 14
[28] Frost, Bryg, O'Connor, transcript of evidence, 28 April 2008, p. 21

"I have come across… families who have decided that they cannot do this anymore. They have relinquished their children into family care. They asked and were not able to access the assistance that they needed, and of course that is a huge cost to the Government. I understand group homes cost $100,000."[29]

Peter Nute (Community Based Support South (CBS)) described the supply of support services "to meet what is a fairly low level need" in lieu of inexpensive equipment as "crazy to me".[30] He added:

"Small-level assistive devices that are very low-tech can make quite a huge difference to people's lives; rather than see them go into a spiral of decline because they do less, the potential is there for people to rebuild confidence and capacity and move forward in that way."[31]

Mary Guy said a few pieces of equipment "pay for themselves very quickly in the sense that you are not paying wages".[32] She said delays for equipment from the CES were "disgusting". She added:

"This is essential equipment. I don't see the provision of an electric wheelchair or a wheelchair as being generous to people with disabilities."[33]

Margaret Reynolds (State Manager, National Disability Services (NDS) (Tas.)) said community living "just is not possible" without equipment.[34]

Megan Morse (CHC) said providing equipment early in a child's life improves their development and saves money in the long-term:

"There's a very strong body of evidence that shows that the faster we provide exposure particularly to issues around the use of communication devices, and the faster that child has access to that equipment, the more likely they are to use it successfully. Delays have really been very significant in terms of the long-term outcomes of that intervention, and we are talking about some fairly serious dollars there, so if down the track we're not getting maximum benefit from spending that money because we were a bit slow at the start, it's a really unfortunate outcome."[35]

Millicent Subonj (Multicap) and Steve Daley (Devon Industries) noted the importance of equipment in terms of easing pressure on families caring for a person with a

[29] Ewington and Patchin, transcript of evidence, 29 April 2008, p. 41
[30] Nute and Guy, transcript of evidence, 20 May 2008, p. 1
[31] Nute and Guy, transcript of evidence, 20 May 2008, p. 1
[32] Nute and Guy, transcript of evidence, 20 May 2008, p. 5
[33] Nute and Guy, transcript of evidence, 20 May 2008, p. 11
[34] Reynolds and Wilkinson, transcript of evidence, 20 May 2008, p. 12
[35] Morse and Donward, transcript of evidence, 20 May 2008, p. 28

disability.[36] Mr Daley also commented that equipment shortages place support staff at risk of injury.[37] Ms Subonj explained further:

> *"I know how much it takes out of my staff and they only work probably 40 hours to 60 hours a fortnight. These parents are doing it day in and day out, 24 hours a day, and they have no assistance other than the person who comes in for an hour in the morning and maybe an hour in the afternoon. Their backs have got to be gone. … Shot, and without that equipment they will depend on respite, they will depend on all sorts of things – family, friends, brothers and uncles – it is hard. So equipment does mean a lot."*[38]

In its submission, DHHS recognised the expectations of clients and the tendency for people to want to live independently at home, expecting that "they should be able to access all options" for equipment and technology.[39] Furthermore, the Department stated:

> *"People with disabilities, like other members of the community, wish to maximise their independence. There is a significantly increased expectation among this client group that they should be able to socialise in the community and not be confined to a home environment."*[40]

1.4 Aims and Objectives

With an imbalance between available resourcing and total demand for equipment and assistive technology in Tasmania, CES administrators have had to rationalise and provide financial aid only to the highest priority clients. Witnesses and submissions indicated that the CES has lost, or is losing, its community aspect with clients having the highest clinical priority consuming resources. Some suggested the role of the CES has moved to facilitating hospital discharges only. DHHS acknowledged that from an administrative perspective, servicing all clients is a source of tension.

The CES' Guidelines describe the scheme as having three objectives:

> *"Facilitate discharge of clients from hospitals back into the community; Enable people with a temporary or permanent disability to live at home either independently or with their carer and prevent premature admission to institutional care; [and] Assist integration of people with a permanent disability back into the community."*[41]

The Guidelines also describe the scheme's target population:

---

[36] Daley and Subonj, transcript of evidence, 29 April 2008, p. 27
[37] Daley and Subonj, transcript of evidence, 29 April 2008, p. 28
[38] Daley and Subonj, transcript of evidence, 29 April 2008, p. 28
[39] DHHS, submission, p. 30
[40] DHHS, submission, p. 30
[41] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 3 (provided by DHHS)

"Permanent Tasmanian residents… ; People living at home in the community who have a disability of an indefinite or long-term duration and their carers.[42] *… ; People who have a demonstrated financial need for assistance to access prescribed equipment and home modifications in order to achieve a satisfactory level of safety and independence in their home in the community; [and] People whose discharge from hospital back into the community depends on access to prescribed equipment."*[43]

According to Robyn Sheppard (APA), the CES has lost its community aspect:

"Some 12 years ago this scheme was purchasing equipment to enable people to get to doctors' appointments, so it had a bit of a community feel; it was keeping them in the community. Now basically it is a scheme to keep people out of hospital. Unless you are a priority one rating, which means you are at risk of not being able to live at home, if you have obvious pressure sores or pain or no equipment… Otherwise you are a priority two, and a priority two may stay on that waiting list for 18 months to two years or longer than that."[44]

Peta Raison said the CES has taken on a new persona, from helping people with supplementary items to becoming critical for their wellbeing:

"That has been the enormous change from just hiring some equipment to get a few bits and pieces to tide you over, as opposed to enabling somebody who is totally and absolutely debilitated to go back into their own home with modifications, equipment and everything. You could be looking at up to $80,000 or $90,000 for one person."[45]

Michael Sertori (St Giles) said additional general demand on the CES, as well as clients leaving hospital, is consuming the resources of the CES and changing the way funding is prioritised:

"The number of people accessing the scheme has expanded considerably which is affecting the level of funding available to people with disabilities and it is certainly affecting their priority level in trying to qualify for funding. These circumstances have been compounded by the number of people exiting our hospital system. These people have consumed not only funding but also priority under the scheme."[46]

Anglicare's submission stated that budget limitations are creating problems:

---

[42] The Guidelines also note: "In the case of employed carers, this does not include equipment to meet OH&S responsibilities of the employer."

[43] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 7 (provided by DHHS). When describing general categories of CES clients during verbal evidence, Pip Leedham additionally cited clients of Disability Services and children surviving birth and catastrophic events. Leedham *et al*, transcript of evidence, 6 March 2008, p. 4

[44] Sheppard, transcript of evidence, 20 May 2008, p. 37

[45] Raison, transcript of evidence, 20 May 2008, p. 52

[46] Sertori and Merry, transcript of evidence, 28 April 2008, p. 3

"This has limited its ability to meet demand, increase the range and quality of equipment on offer and to cover the cost of maintenance, repair and replacement of loan equipment. This causes delays in supplying standard equipment and unpredictable waiting times and leads to clinical need being prioritised at the expense of aids to promote community integration and participation."[47]

OT Australia (Tas) submitted that decisions to provide (or not to provide) equipment give "little consideration… to the emotional, psychological, or social implications". It stated the focus of the CES "seems to be on physical needs with the aim of keeping clients out of hospital" as well as resulting in "reactive intervention rather than promoting a preventative enabling service."[48]

Assoc Prof Christopher Newell (UTAS) commented:

"Too often what occurs is that schemes about disability address the situation of those who are making decisions as opposed to ultimately the clients."[49]

Pip Leedham (DHHS) said that servicing the needs of all clients is difficult:

"There are tensions in the types of clients that are supported by the schemes because you have those that are requiring discharge from hospital, those that are in the community that are needing to function independently, those that are clients of Disability Services, and then the paediatric clients. We are trying to meet the needs of all of those groups of people from the one scheme."[50]

In response to a question on notice from the Committee regarding the Department's responsiveness to CES objectives, DHHS submitted in response:

"The Department believes that it is adhering to its objectives in a balanced way, in the face of competing and increasing demands. Hospital care is costly and patients increase their risk of infection and further debility with longer hospital stays; to consistently prioritise community clients over hospital patients would be to increase risks for in-patients, increase hospital costs and in some instances, increase waiting lists."[51]

1.5 Openness and Information Delivery

Some NGOs imparted to the Committee concerns that not enough information is provided to the public about the CES and equipment and assistive technology services in Tasmania. Specifically, these concerns related to transparency and accountability, and ensuring individuals and families are aware of available equipment and assistive technology services that exist.

[47] Anglicare, submission, p. 4
[48] OT Australia, submission, p. 8
[49] Newell, submission, p. 6
[50] Leedham *et al*, transcript of evidence, 6 March 2008, p. 17
[51] Information provided by DHHS, 23 September 2008, p. 6

In its submission, the ILC recommended that the CES produce an annual report to improve transparency and accountability:

> *"The CES does not produce readily available information or information that is publicly released on their availability of budgets, how expenditure decisions are made and how applications are prioritised. … Production of a publicly released document such as an annual report would assist in improving the transparency, accountability and dissemination of information."*[52]

Members asked Catherine Merry (Allied Health Manager, St Giles) if she was aware of the rationale for allocating CES resources to each region. She responded:

> *"I don't know that I can tell you much about that either. I almost feel that information, for example, from the south is a little bit secretive and we are not allowed to know so there is again a sense of mystery around who gets what and why. I do not think I can enlighten you any further on that one either."*[53]

Members asked Megan Morse (Calvary Health Centre) whether she believed a need exists for a committee to review disputes and claims of unfairness. In response, she said:

> *"The fundamental ethos of consumer participation is always a good thing philosophically from our perspective, so I am wanting to give good credit to that. … I would be putting my hand up for a more closed communication loop probably as a precursor step to the need for a formal sort of complaint or grievance committee-type thing. … …The [equipment] schemes have a multi-agency review panel and I think the sense in the therapy community at least is that that is a pretty effective process that is done in a way that sits pretty comfortably with us, short of the fact that it is loaves and fishes and there is just not the money to go around."*[54]

Gordon Patchin commented:

> *"I think if the assistance was made available, you could find people coming out of the woodwork and saying, 'I didn't even know this was available so I've never known to ask for it'. We find it with equipment; they will suddenly see some piece of equipment and think, 'Gee, I could have used one of those' but they did not know it was available."*[55]

According to TasCOSS:

---

[52] ILC, submission (revised), p. 14
[53] Sertori and Merry, transcript of evidence, 28 April 2008, pp. 8-9
[54] Morse and Donward, transcript of evidence, 20 May 2008, p. 29
[55] Ewington and Patchin, transcript of evidence, 29 April 2008, p. 41

"There is currently inconsistency with regards to information received about the scheme and its policies and some clients have experienced difficulty obtaining information about fees, charges and eligibility."[56]

A submission from the Tasmanian Association of People with Disabilities and Their Advocates detailed several problems that can arise due to insufficient information and advice:

"Most often, people with disabilities, particularly those over 30 years of age and still living with their aged parents, have limited knowledge about what is available, and therefore are unaware or uncertain of what positive outcomes can be achieved with appropriate technology. … Parents and carers often find new technology difficult and a nuisance because they are not technologically literate… It takes many hours… for the person with a disability and their support network to 'figure out' how something works."[57]

The Association suggested having a help desk for information technology inquiries:

"Access to an IT/Help desk would be greatly beneficial. Historically, there have been numerous occasions where such a service would be time saving. Some organisations that assist people with disabilities do not have the benefit of an IT professional for instances where there are equipment malfunctions and breakdowns."[58]

Pip Leedham (DHHS) agreed that some people in the community are "unaware that they can access allied health professionals for advice around improving their mobility." She also asserted that some general practitioners might be unaware equipment schemes exist and would not be recommending clients to the CES.

Members asked what action DHHS has taken to distribute information. Ms Leedham replied:

"We try where we can. … Part of the challenge is that the information we send to GPs sits on GPs' desks and they do not read it because they get inundated with information."[59]

She later commented:

"There are probably a cohort out there in the community that are not aware this sort of support exists and have not tapped into it."[60]

1.6 Equipment Ownership

The Committee was informed that inequitable and anomalous monetary costs and losses could be imposed on clients or borne by the CES due to questions of who

[56] TasCOSS, submission, p. 5
[57] Tasmanian Association of People with Disabilities and Their Advocates, submission, pp. 1-2
[58] Tasmanian Association of People with Disabilities and Their Advocates, submission, p. 4
[59] Leedham *et al*, transcript of evidence, 6 March 2008, p. 12
[60] Leedham *et al*, transcript of evidence, 6 March 2008, p. 16

owns an item of equipment. With both the CES and clients jointly contributing towards the cost of non-standard items[61] not otherwise available from the existing equipment pool, when the client no longer requires items, a decision has to be reached as to which party will retain ownership. Witnesses and submissions expressed concern that this can result in an anomalous situation for either the client or the CES. Further, it was observed that some clients might then have to make a co-contribution for a replacement item, yet the original piece could be issued from the equipment pool to another client who has not contributed towards the cost of purchase.

Clause 13 of the CES Guidelines explains the terms and conditions of ownership:

> *"Equipment provided by regional CES outlets remains the property of the Statewide CES. When no longer required by the client, it must be returned to regional outlet from where it was issued."*[62]

The Guidelines further explain that when a client has made a financial contribution towards the cost of an item, it ordinarily remains the property of the Statewide CES. If a client has contributed more than 50% of the cost, "legally they have a right to ownership", and:

> *"In such cases the Statewide CES will enter into a contractual arrangement with the client about dispersal of the asset when it is no longer required."*[63]

Arrangements can be negotiated for clients to retain equipment (and eventually return it) if they move interstate or into an aged care facility.[64]

Phillipa O'Connor (ILC) added:

> *"If the client has put in 50% of the cost of the wheelchair, should they not be able to try to recoup some of their funds? By the same token, if CES owns it, that is a wheelchair that probably has gone into a second-hand market that may not be appropriate for the next person who gets it. They deplete their funds and they are not eligible for maintenance if the client owns it."*[65]

In its submission, Calvary Health Care Tasmania explained the ownership problem from the point of view of families and individual clients:

> *"Despite contributing more than 60% of the purchase price, in some instances, recipients are obligated to relinquish the piece of equipment*

[61] The CES contributes up to $6,000 towards the cost of an item with the remaining cost being the responsibility of the client to fulfil.

[62] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 13 (provided by DHHS). Clause 13.2 notes three exceptions: permanently installed home modifications, consumables, and "when an arrangement is entered into where the client pays the full cost of the cost price of the item supplied through CES."

[63] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 14 (provided by DHHS)

[64] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 14 (provided by DHHS)

[65] Frost, Bryg, O'Connor, transcript of evidence, 28 April 2008, p. 26

to the CES at the conclusion of its use. In the CTS [children's therapy services] context, this apparent inequity is heightened where a family returns an item they, theoretically, 'co-own' but need to replace because their child has outgrown it. If the equipment is, again, not available within the pool, the family are expected to make another significant contribution towards the 'replacement' item. Meanwhile the next recipient receives the original equipment for the standard loan fee."[66]

OT Australia (Tas) summarised the potential unfairness that can arise from ownership issues as follows:

"Clients are expected to pay the gap in cost, however they have no ownership over the piece of equipment. This means clients can pay several thousands of dollars and once their child grows out of the equipment they hand it back and have to provide funds again for a larger version. Meanwhile the returned piece of equipment can be re-issued to a family who makes no co-contribution even though the value of the equipment exceeds the cap. Clients may even have taken loans to meet this cost, yet they can be left with nothing to show for it."[67]

The ILC, in its submission, similarly outlined the same situation above although also explained how the CES could be disadvantaged:

"If the CES does not retain ownership of the equipment, the equipment is not required to be returned to the scheme when it is no longer required, depleting the resources of the CES."[68]

DHHS informed the Committee that by purchasing equipment, this assists the CES to create an equipment pool. The Department also noted:

"If clients were to own equipment outright, they would incur much higher maintenance costs, and perhaps would not maintain equipment at all if their funds were limited. It is arguable that this could lead to increased numbers of applications for new equipment if clients considered their equipment irretrievably damaged through non-repair."[69]

1.7 Fees and Charges

The impost of fees and charges were criticised as being hard for low-income earners to afford. DHHS drew attention to the existence of a hardship policy for clients who have difficulty paying. The Department also indicated that it is considering increasing fees and charges.

Clause 10 of the CES Guidelines describe how fees and charges are applied:

"Assistance is available to eligible clients in the form of either: loan of equipment for an annual fee of $50, irrespective of number of pieces of

[66] Calvary Health Care Tasmania, submission, pp. 3-4
[67] OT Australia, submission, p. 12
[68] ILC, submission (revised), p. 6
[69] Information provided by DHHS, 23 September 2008, p.

equipment loaned; [or] financial assistance for non-standard equipment as specified for an annual fee of $50."

"Non-eligible, non-compensable clients can access aids and appliances for a monthly hire fee of $20, irrespective of the number of pieces of equipment hired. …"

"Clients will be required to contribute a maximum of $50 in a 12-month period towards the cost of spare parts for maintenance and repairs of items issued to them through CES."[70]

Robin Wilkinson said the fee imposed for equipment maintenance is hard for low-income earners to necessarily pay:

"You pay I think, and I might be wrong, $50 or $100 hiring fee or whatever it is, but then you are still responsible for maintenance. So even if you have a faulty chair you have to pay an extra $50 every time you get the maintenance people out. That might seem okay for most people but it is very difficult when you are on a low income… You [the Committee Members] do not have to buy replacement batteries for your legs. You might for your car but not for your legs."[71]

She noted that while $50 is "not the true cost of the maintenance", the expense means, "If things are going wrong you say, 'I'll make it last a bit longer'."[72]

In its submission, DHHS explained the fees and charges applicable to CES clients:

"Eligible clients are charged an annual fee of $50 regardless of the number of items on loan. Non-eligible non-compensable clients can access the CES and pay a monthly fee of $20, regardless of the number of pieces of equipment hired. CES clients are required to contribute $50 per annum towards the cost of spare parts for equipment maintenance. The maintenance fee is only payable if the client has an item that needs maintenance, and the fee is only payable once regardless of how many items are maintained during the year. There has been no increase in CES fees and charges since 1999. There is provision for financial hardship for eligible clients. Proposals to increase fees and charges, and refine processes, have been developed and are still under consideration by the Department."[73]

Specifically, the submission flagged the Department's proposal of increasing equipment hire fees to "create a level playing field" with private suppliers, allowing the scheme to "increase responsiveness to the CES-eligible clients."[74]

---

[70] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 12 (provided by DHHS). Clients are exempt from cost of repairs due to manufacturing faults. MAIB and DVA clients may receive temporary assistance for a $20 monthly hire fee. Batteries and tyres are the client's responsibility.

[71] Reynolds and Wilkinson, transcript of evidence, 20 May 2008, p. 14

[72] Reynolds and Wilkinson, transcript of evidence, 20 May 2008, p. 17

[73] DHHS, submission, p. 15

[74] DHHS, submission, p. 34

The submission also noted that revenue from client fees and charges is being re-invested in equipment. [75] Additionally, the submission drew attention to provision in the CES Guidelines for instances of hardship related to capacity to pay prescribed fees, albeit involving a "very small" percentage of clients.[76] Clause 11 states:

> *"It is recognised… that for some clients there may be a genuine and unreasonable hardship involved in the payment of fees or an incapacity to pay at all. In these cases the Hardship provision should apply to ensure that clients are provided with flexible and realistic options and alternatives in the method and amounts of payments over a 12-month period."*[77]

The following table shows figures extracted from DHHS' submission, indicating revenue the CES has received in recent years.

CES Revenue[78]
2003-2007 ($)

	2003-04	**2004-05**	**2005-06**	**2006-07**
North	79,420	80,990	73,230	84,575
North west	73,672	63,927	63,782	106,776
South	150,835	187,930	206,736	213,564

1.8 Service Organisation and Timeliness

Some witnesses were of the view that the provision of items through the CES could be inflexible, unresponsive, and inefficient. Yet, by contrast, one witness described her paradoxical experiences of being over-serviced as well as also being under-serviced at other times. CES administrators highlighted that the scheme has been under administrative and operational pressures recently.

DHHS submitted to the Committee that the CES has come under a degree of administrative and budgetary pressure "in recent years". Specifically:

> *"With double the number of applications there has been double the administrative effort required to be carried out by the same number of staff. Many of the processes are manual due to the limitations of the information system."*[79]

In a written submission, Tom Butler commented:

> *"It is very unhelpful to have a system that works with monthly budgets that can result in unacceptable delays of ordering of equipment when*

[75] DHHS, submission, p. 15
[76] DHHS, submission, p. 18
[77] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, pp. 12-13 (provided by DHHS). Also, Clause 11.6 provides that if a client has no capacity to pay, the CES Statewide Steering Committee may consider waiving the usual fees. DHHS noted in its submission (p. 18) that non-eligible clients who hire equipment cannot access the Hardship Provision.
[78] DHHS, submission, appendix B
[79] DHHS, submission, p. 16

multiple high priority items are needed at the same time. There needs to be flexibility in the system to cope with such circumstances."[80]

Peter Nute (CBS) described the CES regime as inflexible, saying for example shoehorns provided through the scheme at $12.50 each could be found through an alternative supplier at $2.95 each. He commented:

"There are a lot of rigidities in the system that are really stupid. If you were a private individual you would never have that happen."[81]

Members asked Mr Nute if he thought having funding flexibility would alleviate problems. In response, he said:

"It's not quite that simple. The difficulty is that we really need to show that the outcome has a value and that we can still meet audit requirements and all those kinds of things. It is about governance of programs in a lot of ways. There is an inability in a lot of ways to measure that. The problem is measurement and meeting contracts – how do we reframe those contracts? – and it is a challenge. There are a lot of other things that go with it because if we started working that way, the work for our staff would be less regular. It would put a lot more highs and lows into their work. We would then need to employ our staff on a much more regular basis in order to overcome the issues that would arise from casual employment in such a scene. If you are helping someone a lot for a short period and then you are off quickly, how do you get the staff to cooperate in that process of downgrading their own work? I think there is a lot to be considered."[82]

Robyn Wilkinson said that in some instances, too much service is provided:

"You have agencies such as the CES that suddenly ring me up and say, 'Robyn, we've decided you need a seat in the bath'. Again, I wasn't asked about this; this was because a worker had gone in and said they were really concerned about the way I get in and out of the bath. Nobody discussed any of that with me. If that person who came into my home had spoken to me about it I would have said, 'I'll use another method of getting in if you are really worried about that one', so I have been through all this thing with an OT – I have gone around looking at hoists and God knows what – but I don't want a hoist yet. I'm sorry; I just find that too much. … Sometimes you are almost over-serviced and then at other times you are really under-serviced."[83]

Robin Wilkinson said delays could be so lengthy once equipment is provided it "does not necessarily meet your need" because a person's condition can "have gone downhill" whilst awaiting an item.[84]

---

[80] Butler-Ross and Butler, submission, p. 4
[81] Nute and Guy, transcript of evidence, 20 May 2008, p. 7
[82] Nute and Guy, transcript of evidence, 20 May 2008, p. 9
[83] Reynolds and Wilkinson, transcript of evidence, 20 May 2008, p. 16
[84] Reynolds and Wilkinson, transcript of evidence, 20 May 2008, p. 13

Megan Morse (CHC) said that the present system is not able to provide items "on the spot". She said there is "tension" between what individuals and families would like and what the system can respond to. While the current system can be unresponsive, she said, sometimes families are not ready to be pushed according to a schedule:

> *"We could have done the best forward planning in the world but if a family is not ready it may be that we are just not able to move forward until they are ready. The system cannot respond to that, unfortunately. … There is no perfect answer to that."*[85]

Millicent Subonj told the Committee about difficulties in one instance of acquiring a change table:

> *"Disability Services kept telling us, 'We've got one, it's up here in the north-west', and for six months they could not find it. In the end I ordered one and sent them the bill. … They paid it too. But it is just lost in that system and the system needs to be addressed."*[86]

She also spoke of another instance:

> *"We had a situation with a family who had supported their son with Parkinson's disease for 14 years at home. They could not longer do that. They had to hospitalise him. The hospital called us and said, 'We are ready to release him; will you take him?' If we could take him, he would need a wheelchair. I said, 'Okay, order the wheelchair and get all that done before he comes'. He was with us for 18 months and it was only when a local member became involved that a wheelchair was forthcoming. It was unfortunate that he died three months after the wheelchair was provided. So there is an empty wheelchair and he had no use of it for 18 months."*[87]

Diane Ewington (Association for Children with Disabilities) also imparted to the Committee a variance of the same story.[88]

DHHS explained the challenges it faces providing services in information provided in notice to the Committee:

> *"The CES responds as well as it is able to, given the resourcing available. Equipment is provided as equitably as possible, drawing on evidence of clinical needs and individual circumstances as articulated by the prescribing therapists. There are, however, a several elements of the equipment hire process which are beyond the control of the CES management and staff. These elements include the following:*
>
> - *It is the prescribing therapists, both DHHS and private providers, who deal directly with the client;*

[85] Morse and Donward, transcript of evidence, 20 May 2008, p. 32
[86] Daley and Subonj, transcript of evidence, 29 April 2008, p. 22
[87] Daley and Subonj, transcript of evidence, 29 April 2008, p. 23
[88] Ewington and Patchin, transcript of evidence, 29 April 2008, p. 32

- *There is uneven demand through the year (creating differing levels of competition for available funds);*
- *Equipment providers and manufacturers provide differing levels of responsiveness; [and]*
- *The on-going difficulties in recruiting allied health professionals."*[89]

1.9 Equipment Maintenance and Handling

Witnesses and submissions had numerous points of complaint in relation to the handling and maintenance of equipment. The Committee was told that equipment has been issued to clients in poor condition or with pieces missing, and that physically retrieving equipment from CES storage facilities has become hazardous. Equipment maintenance, the Committee heard, is conducted on demand rather than according to schedule, creating inconvenience for clients, leading to equipment under-utilisation due to maintenance neglect, and creating risks of safety and client hospitalisation. DHHS acknowledged the desirability of scheduled, regular maintenance and the provision of temporary replacement items to clients during maintenance periods.

Calvary Health Care Tasmania submitted:

> *"One of the areas where erosion of service has become increasingly noticeable is in the management of the equipment pool. Whilst acknowledging the dedication of SCES staff… … Our experience suggests this has reached a stage where it is impacting on the efficacy of the SCES, with our agency having to frequently return equipment that has arrived without all its components. Ultimately, separations of this nature may render an item unusable, highlighting the 'false economy' of cutting back on maintenance."*[90]

ILC submitted:

> *"There have been times that [sic] an expensive wheelchair cannot be reallocated as there are insufficient funds to pay for a part that may cost little. There appears to be little, if any, funding specifically allocated for repairs and maintenance of equipment."*[91]

Jane Wardlaw said there is not a proper service for handling unexpected equipment failures. She said:

> *"This has severe ramifications on personal care support and life participation. … …Awaiting approval for repairs impacts on the emotional and physical health of the consumer and their families because they are constantly told there is not enough funding, thus physical support falls on the carer or the family. It is really stressful when you need to wait three or four days for an approval process to go through a system that you are not familiar with and do not understand…*

[89] Information provided by DHHS, 23 September 2008, p. 3
[90] Calvary Health Care Tasmania, submission, p. 3
[91] ILC, submission (revised), p. 5

Not knowing when you are going to be able to get back to work or back on your feet is an awful experience. … A seven-day breakdown service must be established to avoid over-expenditure of repairs and ensure that compliance of repairs is adhered to."[92]

Grace Brown (Burnie and Devonport Special Schools) said the longevity of equipment could be improved if a maintenance scheme could be accessed:

"While technology is changing so frequently it is very difficult for us, as therapists, to prescribe a device that is then going to belong to the individual and has to meet their needs for the next 30 years. That is impossible for us predict. So the situation can often emerge where it meets their needs for a number of years and then their needs change or the equipment becomes redundant or is not maintained because there is no scheme that supports maintenance and repair. By then they are collecting dust in a cupboard and all of that resource and time and effort from the community for fundraising is wasted."[93]

OT Australia (Tas) noted that when equipment is sent for maintenance, clients "generally have no access to back-up equipment", leaving their mobility and access to the community compromised.[94] OT Australia suggested that:

"A maintenance system needs to be resourced to enable routine maintenance of equipment with replacement items made available for the client during the maintenance period."[95]

Additionally, OT Australia's submission stated that equipment issued through the CES could require "further cleaning" and it is also "not uncommon to find parts missing."[96]

Catherine Merry (St Giles) said the CES does not take responsibility for maintaining equipment the scheme does not hold ownership of. She said she knew of a family who had given up waiting for CES assistance, having sought alternate funding for the purchase of two wheelchairs for their children, thereby also being unable to receive maintenance support. She commented:

"The Community Equipment Scheme will not pay for repairs and maintenance of those chairs, even though there has been no impost on the scheme by this family who have two children. … It simply reflects how tight it [the CES] is with the money and whatever inequities you might look at, it all comes down to quite insufficient funds, and it is reflected constantly."[97]

During verbal evidence, CHC representative Megan Morse said families and individuals who have self-funded their equipment cannot access CES maintenance services and have to "bear all the repairs and maintenance costs". She said that this

[92] Wardlaw, transcript of evidence, 28 April 2008, pp. 30-31
[93] Lovatt and Brown, transcript of evidence, 29 April 2008, p. 15
[94] OT Australia, submission, p. 5
[95] OT Australia, submission, p. 5
[96] OT Australia, submission, p. 5
[97] Sertori and Merry, transcript of evidence, 28 April 2008, p. 9

could be offset by the ability to sell items at a later time, but described this situation as "a really big impost" on families.[98]

Robyn Sheppard (Australian Physiotherapists Association) said equipment at a Davey Street store in Hobart is an "occupational health and safety issue for all those staff working there."[99] She also said new equipment is ordered rather than re-assembling existing items:

> *"There are lots of pieces of equipment there in parts. They have told us now just to order a new one because they do not have the time to put parts together to make a whole."*[100]

In its submission, DHHS claimed that the CES has a "growing pool of ageing equipment" that is "escalating" in cost to repair.[101] DHHS described various complications of managing equipment maintenance in its submission to the Committee:

> *"The cleaning, repair and maintenance of equipment is part of the Department's duty of care. … Although it is highly desirable for maintenance to be scheduled regularly, current resourcing does not allow for this. Repair and maintenance of equipment is therefore a demand-driven service, with CES staff responding to requests for repairs as breakdowns and equipment failure occurs. Emergency breakdowns add to the already heavy workload of the CES staff, who are faced with collecting the broken piece of equipment, quickly assessing the repairs required, and providing, if at all possible, a temporary replacement."*[102]

The submission acknowledged that the risks of not repairing and maintaining equipment include issues of safety for clients and carers and the possibility a client may require hospitalisation.[103]

[98] Morse and Donward, transcript of evidence, 20 May 2008, p. 29
[99] Sheppard, transcript of evidence, 20 May 2008, p. 36
[100] Sheppard, transcript of evidence, 20 May 2008, p. 36
[101] DHHS, submission, p. 18
[102] DHHS, submission, p. 19. Logistical difficulty in regard to spare parts was also cited as an issue.
[103] DHHS, submission, p. 19.

Chapter 2

CURRENT AND FUTURE RESOURCING

2.1 Introduction

Overall, witnesses and submissions were of the view that funding for equipment and assistive technology in Tasmania is insufficient, while in the meantime demand continues to increase. Witnesses also agreed that due to resourcing shortages, there is extensive unmet need in the community, although a precise estimate of numbers is not available. Further, this unmet need remains unrecorded, as witnesses pointed out, due to perceptions applications for assistance will be met only after significant time delays. DHHS also acknowledged these issues and other broader factors are creating demand for equipment and assistive technology.

There were limitations on the scope, detail, reliability, and time periods pertaining to data DHHS could produce. The Department advised that providing certain information would have necessitated a manual data extraction process and created unresolvable inconsistencies across data sources and methods.

2.2 Current Funding

Figures provided by DHHS show that CES spending has had a tendency to exceed budgets for the financial years 2002-03 onwards. Other witnesses described the CES as funding equipment only at crisis point with the Scheme having insufficient total funds.

The following table shows CES budgets and expenditure in recent years.

CES Expenditure,[104] total
2002-2007

	2002-03	2003-04	2004-05	2005-06	2006-07
CES Net Expenditure[105] (total) ($)					
North	551,235	406,183	547,885	587,865	511,761
North west	180,411	330,712	261,851	348,833	208,798
South	769,404	580,566	784,226	793,372	927,029
Tasmania	1,501,050	1,317,460	1,593,961	1,594,999	1,514,012
CES Budget (total) ($)					
North	231,688	236,507	249,635	246,737	252,000
North west	323,167	325,167	330,167	356,000	368,400
South	588,754	575,754	604,754	679,000	729,200
Tasmania	1,143,609	1,137,428	1,184,556	1,281,737	1,349,600

DHHS observed in its submission:

> *"The variation between budget and actual expenditure for the CES over the last four years demonstrates increasing difficulty meeting the*

[104] Information provided by DHHS, 11 July 2008, p. 2
[105] Less revenue received

growing demand for equipment. … Despite increasing expenditure, and utilisation of slippage and other one-off funds, it has been the case for some years that only high priority applications to purchase non-standard equipment have proceeded. Examination of expenditure over recent years indicates that without additional resources, many applications allocated a rating of between priority 2 and 5, are unlikely to ever receive assistance, due to higher priority applications constantly appearing."[106]

The following table provides details of expenditure on equipment, which DHHS provided to the Committee.

CES Expenditure,[107] equipment
2003-2007

	2003-04		2004-05		2005-06		2006-07	
Standard Equipment[108]	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
North	?[109]	188,741	?	291,201	?	296,531	?	206,610
North west	59,000	45,188	62,000	55,601	70,000	53,045	70,000	26,175
South	77,000	92,547	77,000	101,979	77,000	109,461	80,000	126,430
Tasmania	136,000	326,476	139,000	448,781	147,000	459,037	150,000	359,215
	2003-04		**2004-05**		**2005-06**		**2006-07**	
Non-Standard Equipment[110]	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
North	69,000	64,293	77,140	61,446	69,080	61,329	69,000	66,399
North west	74,000	96,012	74,000	12,046	74,000	108,738	78,000	61,265
South	128,000	153,473	128,000	298,095	145,000	320,741	164,000	401,347
Tasmania	271,000	313,778	279,140	371,587	288,080	490,808	311,000	529,011
	2003-04		**2004-05**		**2005-06**		**2006-07**	
Communication Devices and Surgical Footwear[111]	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
North	?	37,252	0	31,644	0	31,729	?	30,938
North west	3,000	2,536	0	3,582	0	3,386	29,000	3,023
South	17,000	40,425	17,000	65,834	20,000	53,238	24,000	47,131
Tasmania	20,000	80,213	17,000	101,060	20,000	88,353	53,000	81,092

DHHS later explained to the Committee the apparent under-budget expenditure for the northern regions and the absence of budgets on some lines:

"The costs for non-standard equipment are dependent on demand, and expenditure from year to year is dependent on the timing of purchases due to the fact that a cash system of accounting is used.

[106] DHHS, submission, p. 33
[107] DHHS, submission, Appendix B
[108] Standard Equipment: basic items of equipment that are kept in stock and frequently requested for loans which are non-specialised, or off the shelf, or inexpensive (<$500).
[109] Information provided by the Department did not indicate a figure on occasions.
[110] Non-Standard Equipment: equipment not kept in stock that has to be ordered and which is specialised, or customised, or expensive (>$500). Regional CES committees require applications from authorised prescribers prior to purchase.
[111] These were provided as one single budgetary and expenditure line.

…

"The budget for standard equipment for the North is held by the Launceston General Hospital and unlike the arrangements for the CES in the Northwest and South it does not have a separately identified cost centre. However appropriate coding is used to identify what is spent on standard equipment."[112]

The following table presents expenditure on a per capita basis:

CES Net Expenditure Per Capita[113]
2002-2007

	2002-03	2003-04	2004-05	2005-06	2006-07
CES Net Expenditure (per capita) ($)[114]					
North	4.28	3.12	4.17	4.43	3.82
North west	1.76	3.20	2.51	3.31	1.96
South	3.42	2.55	3.40	3.40	3.93
Tasmania	3.29	2.85	3.42	3.38	3.18
CES Net Expenditure (per capita with a disability) ($)[115]					
North	18.96	13.83	18.47	19.62	16.91
North west	7.80	14.17	11.12	14.67	8.71
South					

The Committee also received information from two other submissions containing estimates of equipment funding in Tasmania. NDS provided figures from the early 2000s estimating total funding for equipment in Tasmania, at that time, was $470,000 per year;[116] St Giles attached information to its submission, from a review of the NSW PADP, which estimated the base funding for Tasmania's equipment scheme to have been $300,000 (or 60 cents per capita) in 2004.[117]

DHHS rejected the claim that 60 cents per capita is expended on equipment in Tasmania, and also noted that expenditure may not be an appropriate means to measure effectiveness:

"The Price Waterhouse Coopers report provides little indication of how the calculations of expenditure were made. Analysis of figures over the past few years indicates (as noted in the DHHS response provided to the

[112] Information provided by DHHS, 23 September 2008, p. 10

[113] Information provided by DHHS, 11 July 2008, p. 2; and information provided by DHHS, 23 September 2008

[114] These are estimates based upon 2001 and 2007 Census population figures. 2002-03 estimates rely on 2001 Census data. For 2003-04 to 2005-06, rates are based on 2001 Census population figures plus a percentage of the difference with 2007 Census population figures (proportionately 25%, 50%, and 75% for these years respectively). 2006-07 population figures are based on the 2007 Census.

[115] Based on estimates of 22.6% of the population having a disability. Incremental adjustments have been made for years between the 2001 and 2006 Census figures. See notes in information provided by DHHS, 23 September 2008.

[116] NDS, submission, p. 2

[117] St Giles, submission, Appendix; Price Waterhouse Coopers/NSW Health 'Review of the Programme of Appliances for Disabled People', June 2006, p. 47

Committee on 9 July 2008[118]) that expenditure is higher than this. Tasmanian CES expenditure over the five years from 2002-03 to 2006-07 ranges from $2.85 to $3.42 per capita. Expenditure per se *would not appear to be a sound means of assessing the effective operation of a program such as this. A better measure may be an assessment of how well demand is met."[119]*

As well as standard and non-standard equipment, the overall CES budget and expenditure also covers salaries, freight, other medical equipment, the Seating Clinic, home modifications, repairs and maintenance, and "other" costs.[120] In addition, DHHS declared in its submission that Disability Services, through its Individual Support Programme, has funded equipment, continence aids, and home modifications for clients who may also been CES-eligible clients. These amounts are shown below.

Allocations from Disability Services' ISP[121]
2003 to 2007 ($)

Year	Total	Year	Total
2003-04	263,245	2005-06	422,620
2004-05	547,690	2006-07	260,868

According to TasCOSS, "the overall budget of the CES has not increased for six years."[122] Anglicare's submission commented similarly.[123] Michael Sertori (CEO, St Giles Society) said that levels of funding for the CES are "totally inadequate" having "failed to keep pace" with rising costs.[124]

Phillipa O'Connor (ILC (Tas)) commented:

"It is not that the Community Equipment Scheme has the funding priorities all wrong; it is just that there are not enough resources."[125]

The ILC additionally commented in its submission that due to funding fluctuations, "feast and famine conditions" result, and approvals for equipment depend upon "whether a client happens to apply at an opportune time."[126] In relation to the overall cost of operating the CES, the ILC commented that some wages are paid from other budgets:

"The true cost of wages is not easily identified within the current format as very few staff are paid out of the CES. … For example, the CES is managed at a regional level in the north and north west via usage of the hospital and ambulance (HAS) budget."[127]

[118] This information was received by the Committee on 11 July 2008, and is dated as such where mentioned herein.
[119] Information provided by DHHS, 23 September 2008, p. 2
[120] DHHS, submission, Appendix B
[121] DHHS, submission, p. 23. These figures are GST exclusive.
[122] TasCOSS, submission, p. 3
[123] Anglicare, submission, p. 4
[124] Sertori and Merry, transcript of evidence, 28 April 2008, p. 3
[125] Frost, Bryg, O'Connor, transcript of evidence, 28 April 2008, p. 20
[126] ILC, submission (revised), p. 4
[127] ILC, submission (revised), p. 12

APA submitted that there is "a current tendency… not to fund equipment until crisis point is reached", which can lead to "increased deformities, contracture, and loss of function" for those waiting.[128]

In its submission of 3 March 2008, DHHS informed the Committee that $609,307 of item requests was outstanding at 30 June 2007. Pip Leedham (DHHS) said that an addition of $609,000 into the budget "would make a heck of a difference."[129] She later reiterated this point, saying "I think we could benefit from some more resources to the scheme."[130] On 13 March 2008, an additional $855,000 was earmarked for CES equipment purchases.[131] According to additional information received from DHHS in May 2008:

> *"In March 2008 Treasury made a one-off provision of funds of $855,000 to the CES to enable equipment to be purchased for clients on the waiting list. Each of the regions is in the process of expending those funds."*[132]

2.3 Levels of Demand and Waiting Times

DHHS was able to supply the Committee with information providing an indication of demand, waiting lists, and waiting times. Witnesses and submissions representing NGOs working in the field suggested official figures are underestimates and that clients, assuming delays will be lengthy, are not coming forward. The Department acknowledged that demand has been increasing and attributed this to various factors, such as demographic changes. However, data limitations have not allowed for the most ideal analysis of quantitative information.

Pip Leedham (DHHS) told the Committee that at 30 June 2007, there were 187 clients on the waiting list awaiting non-standard equipment,[133] valued at $609,000.[134] She said the CES has been experiencing "far greater demand" in the last two years than in the past.[135] In regard to standard equipment, information received from the Department noted that waiting lists are not maintained, except for the SCES (with a list of 63 clients at 31 March 2008).[136]

In its submission, DHHS estimated current waiting times as being "between weeks and months". Due to data limitations, the Department could not provide actual figures and averages.[137] Nevertheless, DHHS was able to provide an indication of clients numbers at 30 June each year, the value of outstanding equipment requests, and the longest waiting times for non-standard equipment in 2006-07.

---

[128] APA, submission, p. 5
[129] Leedham *et al*, transcript of evidence, 6 March 2008, p. 13
[130] Leedham *et al*, transcript of evidence, 6 March 2008, p. 17
[131] Minister for Health and Human Services, press release, 'More Money for Community Equipment Scheme', 13 March 2008
[132] Information provided by DHHS, 12 May 2008, p. 3
[133] Leedham *et al*, transcript of evidence, 6 March 2008, p. 10
[134] Leedham *et al*, transcript of evidence, 6 March 2008, pp. 12-13; DHHS, submission p. 18
[135] Leedham *et al*, transcript of evidence, 6 March 2008, p. 17
[136] Information provided by DHHS, 11 July 2008, p. 4
[137] DHHS, submission, p. 17

Non-Standard Equipment Waiting List: clients[138] 2004-2008 (regions by number of clients)					
	30 June 2004	**30 June 2005**	**30 June 2006**	**30 June 2007**	**31 March 2008**
North	22	26	14	14 Priority 1: 0; P2: 5; P3: 4; P4: 1; P5: 4	16 Priority 1: 3; P2: 4; P3: 1; P4: 3; P5: 5
North west	4	14	40	65 Priority 1 to 3: 50; P4 to 5: 15	0
South	67	62	67	108 Priority 1: 29; P2: 11; P3: 26; P4: 41; P5: 1	68 Priority 1: 5; P2: 2; P3: 26; P4: 35; P5: 0
Tasmania	93	102	121	187	84

In July 2008, following allocation of $855,000, the Minister for Health and Human Services said that there were two clients on the northern waiting list, nine on the southern waiting list, and the north west waiting list had reduced to zero.[139]

Non-Standard Equipment Waiting List: equipment value[140] 2004-2007 (regions by dollar value of items on waiting list)				
	30 June 2004	30 June 2005	30 June 2006	30 June 2007
North	151,301	143,372	64,221	116,250
North west	17,352	32,735	75,359	118,402
South	179,989	201,489	283,463	374,655
Tasmania	348,642	377,596	423,043	609,307

Longest Waiting Times for Non-Standard Equipment[141] 2006-07 (months)		
	Longest waiting time for high priority applications (1 to 3)	**Longest waiting time for low priority applications (4 to 5)**
North	26	33
North west	29	30
South	41	66

The Committee sought more details pertaining to the number of applications the CES receives. In terms of standard equipment, according to DHHS, in the southern region more than 20 requests are received daily. Due to this volume, "application processes are kept to a minimum".[142] In terms of non-standard applications, DHHS provided the following figures for the period 2003 to 2007.

[138] Information provided by DHHS, 11 July 2008, p. 5; information provided by DHHS, 12 May 2008, pp. 3-4. Figures for 31 March 2008 are prior to the allocation of $855,000.
[139] House of Assembly, *Hansard*, 3 July 2008 p. 16
[140] Information provided by DHHS, 11 July 2008, pp. 5-6
[141] DHHS, submission, p. 17
[142] Information provided by DHHS, 11 July 2008, p. 4. Figures for the north and north west were not available.

CES Non-Standard Equipment Applications[143] 2003-2007 (number)				
	2003-04	**2004-05**	**2005-06**	**2006-07**
North	53	126	93	89
North west	89	136	179	210[144]
South	114	170	161	136
Tasmania	256	432	433	435

In its submission, DHHS had stated:

> *"It is not uncommon to note falls in the numbers of applications; this is due to the perception that there is little point in submitting an application, as the likelihood of equipment being provided to the client is very low."*[145]

Members told Michael Sertori that DHHS had informed the Committee that 187 clients were awaiting non-standard equipment and sought his response. He said:

> *"Rubbish. They would not know. They do not have a rigorous methodology in place to measure it. I think you will get meaningful information from those making submissions. They are out there on the ground delivering the service and seeing the people present each day who have given up registering in the system because they see it as a waste of time."*[146]

Christopher Bryg (ILC (Tas)) also agreed that the official waiting list is an underestimate.[147] As Karen Frost (ILC) pointed out, estimating the exact extent of demand is a question of "how long is a piece of string".[148] She said:

> *"We have no idea because the numbers are doubled up in different places because people are on two, three or four different waiting lists for different groups around the place; people are not on waiting lists at all or whatever."*[149]

Felicity Lovatt told the Committee:

> *"It is hard to quantify and identify the need because there has not been an effective mechanism for people to get access to what they need and show that they do have the need."*[150]

Steve Daley (Executive Director, Devon Industries) said that if a person applied in Autumn 2008 for a wheelchair, the expected waiting time would be one to two years.[151] Mr Daley also said that the official waiting list is an underestimate.[152]

---

[143] Information provided by DHHS, 11 July 2008, p. 4

[144] DHHS noted the following in relation to north west figures: "In 2007, NWCES required all required re-issuing of non-standard equipment to be managed via a formal application processed by the NWCES Committee, leading to higher figures." Information provided by DHHS, 11 July 2008, p. 4

[145] DHHS, submission, p. 16

[146] Sertori and Merry, transcript of evidence, 28 April 2008, p. 6

[147] Frost, Bryg, O'Connor, transcript of evidence, 28 April 2008, p. 21

[148] Frost, Bryg, O'Connor, transcript of evidence, 28 April 2008, p. 25

[149] Frost, Bryg, O'Connor, transcript of evidence, 28 April 2008, p. 25

[150] Lovatt and Brown, transcript of evidence, 29 April 2008, p. 20

Members asked Pip Leedham (DHHS) how many people she estimates are seeking assistance though are not recorded on the waiting list. She replied: "I think that is just too difficult to estimate."[153]

She added:

> *"If I understand your question, you were asking me how many are out there in the community that have not come anywhere near this scheme. I really would not have any idea."*[154]

The Equipment and Technology Library submitted:

> *"We are aware that already overstretched therapists may choose not to 'waste time' submitting requests which will never reach a high priority. Any figures would, therefore, greatly underestimate the need."*[155]

According to OT Australia:

> *"Often the removal of a client's name [from the waiting list] is secondary to them passing away or deteriorating to the extent that the original prescription is no longer valid."*[156]

In its submission, DHHS also sought to explain the wider context of increasing demand for equipment in Tasmania. The increased demand was attributed to the following factors:

- An increased proportion of people in Tasmania with disabilities;
- Higher survival rates for people with medical conditions related to trauma and disability;
- More people with disabilities living at home rather than in institutional care;
- An ageing population, which for some as they age, also suffer medical events leaving them permanently disabled;
- People with long-term disabilities are living longer – a "generation who can realistically hope to live a near normal lifespan";
- Patients from acute hospitals are being discharged and sent home earlier in the recovery process, also increased hospital separation rates;
- A need to meet safety standards for carers, with manual lifting no longer appropriate; and

---

[151] Daley and Subonj, transcript of evidence, 29 April 2008, p. 23
[152] Daley and Subonj, transcript of evidence, 29 April 2008, p. 25
[153] Leedham *et al*, transcript of evidence, 6 March 2008, p. 11
[154] Leedham *et al*, transcript of evidence, 6 March 2008, p. 11
[155] Equipment and Technology Library, submission, p. 3
[156] OT Australia, submission, p. 4

- Servicing clients who have exceptionally high and complex needs resulting from catastrophic injuries.[157]

As a result of this situation, according to DHHS:

> *"The increased demand has created tensions for the Department in trying to meet the needs of the three main groups of clients… The allocated resources and the range of Departmental budget priorities mean that meeting the equipment needs of all applicants is increasingly challenging. This is evidenced by the growing size of waiting lists, though it must be acknowledged that some therapists no longer apply for some equipment, knowing it will not be able to be provided."*[158]

2.4 Regional Parity

Some witnesses and submissions were of the view that resourcing for equipment and assistive technology is inequitable among Tasmania's three regions. For figures showing regional apportionment of funds, readers should refer to tables in the preceding sections of this chapter.

According to Michael Sertori (St Giles), in terms of funding for equipment, there are "enormous inequities" among the three regions of Tasmania.[159]

He suggested that a regional committee structure, consisting of representatives of NGOs and possibly government representatives, be established with "the duty to ensure objective allocation of funds."[160]

Robyn Sheppard (APA) said there are "discrepancies between the regions" with southern Tasmania having more equipment and the north-west having "quite limited" quantities.[161] In its submission, the Neuro-Muscular Alliance Tasmania also claimed there are regional inequities in the State.[162]

DHHS, when asked about regional equity through a question put on notice, responded that perceptions of inequalities of resourcing between regions of the State are "incorrect".[163] Readers may also wish to refer to section 2.2 of this chapter, which shows figures of per capita expenditure in each region.

2.5 Human Resource Issues

Witnesses and submissions cited a shortage of human resources within the disability sector in Tasmania and difficulties with recruitment and retention as a concern. Health professionals are required *inter alia* to conduct client assessments and prescriptions for equipment and technology. The Committee was also told that Tasmania does not have tertiary training options for occupational therapists.

---

[157] DHHS, submission, pp. 28-29
[158] DHHS, submission, p. 29
[159] Sertori and Merry, transcript of evidence, 28 April 2008, p. 4
[160] Sertori and Merry, transcript of evidence, 28 April 2008, p. 5
[161] Sheppard, transcript of evidence, 20 May 2008, p. 39
[162] Neuro-Muscular Alliance Tasmania, submission, p. 2
[163] Information provided by DHHS, 23 September 2008, p. 5

According to OT Australia:

> *"The lack of staff to perform assessments slows the acquisition of required equipment and consequently clients and carers who are struggling and unable to cope may be going without required equipment or purchasing inappropriate or sub-standards [sic] to get by."*[164]

Peter Nute (CBS) said:

> *"There is about a four percent per annum increase in our client base at the same time as there is a decrease in the total work force."*[165]

He added that assistive technology devices and diet improvements are an alternative in light of human resource pressures in the sector.[166] He also said that a shortage of occupational therapists and physiotherapists in Tasmania was being exacerbated by an absence of tertiary training in the State:

> *"To get an occupational therapy school at the University of Tasmania is essential and it can't be left any longer. It has to be set up as soon as possible because we can't do these assessments without them."*[167]

Megan Morse (Calvary Health Centre) said recruiting and retaining speech pathologists has been particularly difficult, describing the shortage as "chronic, ongoing, unremitting… to the point where it starts to put pressure on our remaining members of staff."[168]

Christy Donward (CHC) explained further:

> *"There are two issues there. There is the recruitment and retention, which you were talking about, and the number of therapists per capita compared to the other States. We are about half of their national average. It's not just a matter of retention, it's looking at the other issue as well."*[169]

Robyn Sheppard (Australian Physiotherapists Association) said that there is a general shortage in Tasmania and Australia of therapists.[170] Ms Sheppard also said the CES has human resource issues. She said that while the permanent staff have a good knowledge, if some are on leave, temporary CES staff have "no idea and you are better off going down yourself." She also said that CES staffing levels has affected equipment maintenance and cleaning standards.[171]

ILC (Tas) submitted that Tasmania has proportionately fewer allied health professionals than other States. The following table, reproduced from information provided, gives an indication.

---

[164] OT Australia, submission, p. 17
[165] Nute and Guy, transcript of evidence, 20 May 2008, p. 2
[166] Nute and Guy, transcript of evidence, 20 May 2008, p. 2
[167] Nute and Guy, transcript of evidence, 20 May 2008, p. 10
[168] Morse and Donward, transcript of evidence, 20 May 2008, p. 31
[169] Morse and Donward, transcript of evidence, 20 May 2008, p. 31
[170] Sheppard, transcript of evidence, 20 May 2008, p. 36
[171] Sheppard, transcript of evidence, 20 May 2008, p. 43

Allied Health Professionals, by State/Territory[172] (Per 1,000 head of population, FTEs in public hospitals, 2006)			
State/Territory	**Allied health professional numbers (per capita)**	**State/Territory**	**Allied health professional numbers (per capita)**
NSW	1.5	SA	1
VIC	2.2	TAS	0.7
QLD	0.9	ACT	1.8
WA	1.5	NT	0.8
		Average	1.5

Pip Leedham (DHHS) commented to the Committee:

> *"You cannot just rock up to the scheme and say 'I want* x*'. You have to get a referral with a prescription from an authorised prescriber."* [173]

Members asked Ms Leedham if there are enough occupational therapists in Tasmania to properly service people. She replied:

> *"It is not just OTs that can prescribe the equipment, it is physios as well, but it depends on the type of equipment."*[174]

Members repeated their original question, to which Ms Leedham responded:

> *"The challenge we have is that we do not train OTs in this State. When you are talking about it from a workforce perspective, we only train social workers, pharmacists and psychologists in Tasmania so we are impacted by the fact that we have to attract graduates from interstate. … In some areas we are well serviced with allied health professionals. In other areas we could always do with more."*[175]

2.6 Future Resourcing

Ideally, resourcing for future equipment and assistive technology needs, with appropriate planning, should be possible to presently estimate, witnesses said. For individual cases, the Committee was told that case management and planning should also be possible.

Michael Sertori (St Giles) said that modelling could be carried out to forecast future requirements of the disability sector. He said, "we just do not bother" to apply modelling to the disability sector because "it has always been a low-priority area in this State."[176] Mr Sertori estimated, very approximately, that an extra $2 million to $3

[172] Additional information provided by ILC, May 2008, p. 3; see also OT Australia, submission, p. 17
[173] Leedham *et al*, transcript of evidence, 6 March 2008, p. 4
[174] Leedham *et al*, transcript of evidence, 6 March 2008, p. 5
[175] Leedham *et al*, transcript of evidence, 6 March 2008, p. 5. In its submission, DHHS also drew attention to recruitment and workforce retention issues (DHHS, submission, p. 34)
[176] Sertori and Merry, transcript of evidence, 28 April 2008, p. 11

million is needed for equipment and assistive technology for the broader Launceston region.[177]

Diane Ewington said forward planning should be possible from a person's childhood to adulthood; for instance anticipating the eventual need for a place at a group home. She commented:

> *"There is not even a waiting list. Disability Services refused to even have a list because if they had a list and it is written down then they might be held accountable."*[178]

Julia Butler-Ross and Tom Butler submitted:

> *"It is easy to predict that a child who depends on a wheelchair for mobility is going to grow and will need a new chair on a regular basis. It is also predictable that powered wheelchairs that have a recommended life of five to ten years are going to need replacing, or that people who lack mobility may put on weight and need larger equipment, or that equipment that fails or needs regular maintenance by qualified people… Prioritisation in these circumstances needs to be proactive rather than reactive."*[179]

Phillipa O'Connor (ILC) said that clients could acquire the primary item of equipment they were seeking, only to find that a secondary item is then required. A wheelchair, for example, would also require an electric hoist to lift it into a car.[180]

Robin Wilkinson commented on her experiences trying to choose a suitable wheelchair:

> *"I was also offered a trailer for the back of my car to put the chair on and they got this huge trailer. I don't know how they thought I would learn to back up with a trailer, because I have never done that, but I also had to be able to get the chair up onto this trailer with one hand, and even the therapists couldn't work out how to do it with both hands. So for me, it's those sorts of frustrations. I shouldn't lose my temper and I often do, but when you have it every day of the week, can you understand how it is?"*[181]

Members asked Robin Wilkinson if a caseworker had been allocated to her for future planning purposes. She replied:

> *"You take pot luck. You ring up and hope that somebody might be allocated to you."*[182]

---

[177] Sertori and Merry, transcript of evidence, 28 April 2008, p. 6
[178] Ewington and Patchin, transcript of evidence, 29 April 2008, p. 39
[179] Butler-Ross and Butler, submission, p. 4
[180] Frost, Bryg, O'Connor, transcript of evidence, 28 April 2008, p. 23
[181] Reynolds and Wilkinson, transcript of evidence, 20 May 2008, p. 16
[182] Reynolds and Wilkinson, transcript of evidence, 20 May 2008, p. 15

CHAPTER 3

CAPS ON CONTRIBUTIONS

The CES contributes a limited amount of financial assistance for equipment purchases to eligible clients, which is capped at $6,000 for non-standard equipment, $2,000 for communication devices, and 50% of costs to a maximum of $1,000 for continence aids. A number of witnesses criticised the present thresholds as too low relative to the cost of equipment items, especially powered wheelchairs and communication devices.

The CES Guidelines state:

> *"CES will contribute up to $6,000 for any individual item of equipment (excluding communication devices). If the cost of the required item is in excess of this, the clients are able to consider a range of options which may suit them and will be expected to meet the cost difference."*
>
> *"An upper limit of $2,000 in a 12-month period exists for assistance with communication devices."*[183]

These thresholds, as DHHS acknowledged in its submission, have not been increased since the inception of the CES in 1999.[184]

OT Australia (Tas) pointed out that the $6,000 cap, relative to the cost of some equipment items, "can leave a substantial gap for many clients and their family."[185]

Calvary Health Care submitted that with the difference between current CES contributions and the cost of powered wheelchairs, for example, "families can find themselves with a shortfall in excess of $14,000".[186]

In its submission, the ILC described caps as "dramatically too low". The submission commented further:

> *"Equipment has advanced in design and inflated in price. It is not uncommon for an electric wheelchair to cost $18,000. The amount that the CES can currently provide is capped at $6,000. This leaves a gap of $12,000 that needs to be sourced by clients from other funding bodies (virtually non-existent), charitable organisations or self-funding."*[187]

The submission also pointed out that questions of ownership would arise less often if caps were increased to enable full CES ownership of equipment, as well as clarifying responsibility for maintenance.[188]

---

[183] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 13 (provided by DHHS). Items costing less than $50 are not provided for hire or loan, excluding continence aids and appliances.
[184] DHHS, submission, p. 34
[185] OT Australia, submission, p. 8
[186] Calvary Health Care, submission, p. 3
[187] ILC, submission (revised), p. 5
[188] ILC, submission (revised), p. 6

In additional written information provided to the Committee, the ILC suggested:

> *"Funding should be reviewed at least annually and needs to reflect increases in the prices of equipment and the demand for AT, rather than just CPI, to ensure levels of equipment provided are not eroded."*[189]

Robyn Sheppard commented that the $2,000 cap on communication devices "does not go very far with $15,000 to $20,000 machines."[190]

Diane Ewington (Association for Children with Disabilities) said families who need continence aids would spend $2,000 to $3,000 per year.[191] Angela Dodd said she spends $8,000 per year on continence aids for her daughter.[192]

Pip Leedham (DHHS) said that while the CES would consider cases of hardship, the current subsidy is appropriate:

> *"In fact most clients do not ever access up to their $1,000 worth of aids and appliances. $1,000 seems to be a fair amount."*[193]

In its submission, however, DHHS expressed a different view on continence aids subsidies:

> *"The majority of clients in Tasmania who need continence aids use disposable continence pads. As disposables are the major item provided to clients, and many of the clients use more than the subsidised quota, it is clearly a highly valued programme."*[194]

[189] Additional information provided by ILC, May 2008, p. 2
[190] Sheppard, transcript of evidence, 20 May 2008, p. 38
[191] Ewington and Patchin, transcript of evidence, 29 April 2008, p. 31
[192] Dodd, transcript of evidence, 29 April 2008, pp. 3-4
[193] Leedham *et al*, transcript of evidence, 6 March 2008, p. 19. The available continence aids subsidy is 50% of cost to a $1,000 maximum threshold (i.e. $500). As Ms Leedham explained, "if the bill is $400 they [the client] will pay $200." See also Clauses 17.6 and 17.7 of the CES Guidelines.
[194] DHHS, submission, p. 32

CHAPTER 4

ELIGIBILITY CRITERIA

The Committee received a mixture of views in relation to current eligibility criteria. The criteria were criticised, *inter alia*, for being too restrictive and unfair on employed families. By contrast, DHHS and one non-government organisation submitted support for the criteria to remain unchanged. One submission also argued that changing the eligibility criteria to assist more people would be dependent on funding.

Eligibility to the CES for equipment loan is open to permanent Tasmanian residents, according to the Scheme's Guidelines, if:

> *"They are living at home in the community and have a disability of a long-term or indefinite duration; or, they require equipment as part of discharge planning from hospitals or nursing homes in order to be able to live at home in the community; and they are ineligible to receive equipment or home modifications from any other government-funded programme and have not received compensation or damages in respect of the disability for which the equipment has been prescribed; and they are a recipient of the following benefit card entitlements: Health Care Card, Pensioner Concession Card, [or] Health Benefit Card."*[195]

Some client groups are also specified as being ineligible. Nevertheless, the Guidelines provide for equipment to be hired to non-eligible, non-compensable clients for a monthly fee.[196]

OT Australia (Tas) expressed the view that eligibility criteria are appropriate for paediatric clients and people on low incomes. However, other client groups were described as being in a disadvantaged or complicated situation: clients who move to Tasmania from interstate have to wait three months until they are eligible to access the CES; clients without healthcare cards; residents of "low-level aged care facilities"; and clients who are also eligible for funding under other schemes.[197]

Robyn Sheppard said the eligibility criterion excluding people who have been Tasmanian residents for less than three months could be "quite difficult" for families with disabled children who move to the State. [198]

ILC pointed out that expanding the eligibility criteria "will not greatly assist these client groups unless there is also an increase in funding for the CES."[199]

NDS called for a "total re-write of the criteria for eligibility… with consumer participation".[200]

---

[195] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 8 (provided by DHHS)
[196] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 8 (provided by DHHS)
[197] OT Australia, submission, p. 12
[198] Sheppard, transcript of evidence, 20 May 2008, p. 38
[199] ILC, submission (revised), p. 7
[200] NDS, submission, p. 4

According to the APA, "sometimes there is difficulty knowing whether individuals are eligible for loan or hire status."[201]

Angela Dodd commented that restrictive eligibility criteria could be unfair on people who work:

> *"Is it because I work and I have a good income that I am ignored? I work hard just so that we can make ends meet. Is that what is wrong? Do I need to quit work and then, if I am on a pension and I am more of a burden to the Government, is that going to make a difference to all these things? That is how I feel sometimes because I do not know what to do. I am working my guts out."*[202]

Robyn Wilkinson said:

> *"You dare not have too much money either or else you have to buy your own equipment… So it is actually encouraging dependence and being on the welfare system, really."*[203]

Pip Leedham (DHHS) said that due to finite CES resources, non-Healthcare Card holders were being encouraged to hire items through the private market.[204] The Committee was provided with figures showing the proportion of concession card holders and non-concession card holders accessing CES services.

CES Clients Concession Status[205]	
Concession card holders	
North[206]	1,602
North West	658
South	2,277
Tasmania	4,537 (72.2%)
Non-concession card holders	
North	439
North West	324
South	984
Tasmania	1,747 (27.8%)
Concession/Non-Concession	**Total:** 6,284 (100%)

DHHS' submission explained

> *"The reason, in part, for the increase in numbers of non-eligible clients, is that fees charged by the Department for hire of equipment have not been raised since 1999 and are now out of step with commercial rates."*[207]

---

[201] APA, submission, p. 3
[202] Dodd, transcript of evidence, 29 April 2008, pp. 12-13
[203] Reynolds and Wilkinson, transcript of evidence, 20 May 2008, p. 17
[204] Leedham *et al*, transcript of evidence, 6 March 2008, p. 6
[205] Information provided by DHHS, 12 May 2008, p. 2
[206] In information DHHS provided (12 May 2008, p. 2), it was noted that figures for the north region are "unreliable due to earlier non-recording of card status."
[207] DHHS, submission, p. 8

In relation to the current eligibility criteria overall, DHHS expressed the view that they are "largely appropriate". Additionally, it commented:

> *"There will always be a core group of clients who have failed, but only just, to qualify for a Health Care card or another equivalent. The Department recognises that such clients can be financially burdened by the costs of hiring equipment and intends to further investigate extension of the Hardship Policy to such clients."*[208]

Community Based Support South recommended in its submission that the eligibility criteria remain unchanged.[209]

[208] DHHS, submission, p. 34
[209] CBS, submission, p. 3

CHAPTER 5

PRIORITISATION METHOD

5.1 Introduction

The Committee received two types of responses to this term of reference, which could possibly have been due to varying interpretations of its meaning. Some witnesses and submissions commented on the methodology, or approach, which is used to prioritise CES equipment purchases. Others, however, commented on the method, or process applied, to prioritise CES equipment purchases according to the Scheme's procedures. Some witnesses also drew the Committee's attention to equipment items that are not included under the CES or which they believed are prioritised too low.

5.2 Prioritisation Methodology

The current prioritisation methodology was widely criticised as having an undue emphasis on clinical or medical factors rather than on a client's social needs or human rights. DHHS explained that the Guidelines are not always firmly applied and suggested the current priority ratings could be reviewed.

The three regional CES committees apply the CES priority ratings scale to prioritise applications for assistance. Priority 1 represents the highest priority and priority 5 represents the lowest.[210] The criteria for priority 1 rating, for example, are as follows:

> *"Priority 1: discharge home from hospital is essential for the client to live at home and: discharge home from hospital is dependent upon supply; skin has broken down, or is at high risk of breaking down and there is no access to pressure care equipment; safety risk(s) for client/family/carers prevents care or prevents client living at home or puts home care situation of significant risk of breaking down; significant growth/deterioration in condition/pain completely inhibits use of existing equipment within the home or there is no equipment; client is unable to communicate their basic needs; existing equipment has significantly deteriorated and requires immediate replacement or upgrading; [and] reduces frequent falling."*[211]

NDS submitted:

> *"The current priority ratings seem only to include the medical model to determine access and need. However if the Government is really serious about community inclusion, then a new community assistive technology scheme needs to work on a socio-economic model for assessing needs."*[212]

---

[210] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 21 (provided by DHHS)

[211] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 21 (provided by DHHS)

[212] NDS, submission, p. 5

Prof Christopher Newell (School of Medicine, UTAS) submitted:

> *"There is a need for a review of these ratings. My suggestion is that there is need for a values process whereby the human rights of people with disabilities are upheld in accordance with the State's anti-discrimination legislation."*[213]

Calvary Health Care Tasmania submitted that scope exists for changes to the current application prioritisation approach:

> *"At present, the highest priority is given to applications that facilitate discharge from acute care. Whilst acknowledging the inherent value of achieving a successful discharge, it could be argued that applicants who are currently admitted to hospital are not in the community: their exclusion from the CES would create a far more 'level playing field' and would mirror the approach that has been adopted in a number of other States."*[214]

The ILC explained that a current tendency to fund only high priority cases has been at the expense of prevention. Its submission stated:

> *"This results in many people not obtaining funding until their condition deteriorates (sometimes as a result of not obtaining equipment) to a stage that requires urgent intervention or being admitted to hospital (also sometimes as a result of not having adequate access to AT).*[215]

Ms Dodd agreed that if clients could influence the order of equipment priority, this would be useful.[216] She said:

> *"Something that is really important to us is not always important to someone else. [If] it is not a priority one so it does not get looked at… we had to go and buy it ourselves".*[217]

Pip Leedham (DHHS) said application of CES guidelines is not always rigid:

> *"It depends on what their needs are because you have to look at the total circumstances for the client and work out what is going to make the biggest difference for the client. They really try to take a holistic approach to what is going on rather than it being absolutely black and white. The guidelines are there to guide but in all fairness, what they are trying to do is look at what the needs are of the client to best meet them."*[218]

DHHS acknowledged that the priority ratings for non-standard equipment are "based on clinical urgency". The Department also suggested:

---

[213] Newell, submission, p. 3
[214] Calvary Health Care Tasmania, submission, p. 4
[215] ILC, submission (revised), p. 7
[216] Dodd, transcript of evidence, 29 April 2008, pp. 8-9
[217] Dodd, transcript of evidence, 29 April 2008, p. 8
[218] Leedham *et al*, transcript of evidence, 6 March 2008, p. 7

"A revision of the current priority ratings may be required to ensure that due consideration is given to quality of life, rather than the current principles with their emphasis on clinical factors."[219]

For standard items of equipment, a priority ratings system does not apply, DHHS informed the Committee.[220]

5.3 Prioritisation Method

Some NGOs deemed that the process of prioritising equipment purchases has been applied in a consistent and ethical manner. One witness, speaking from experience as a member of a regional CES committee, said deciding how funds should be expended is difficult. Also, some witnesses raised objections to the apparent concealment of the priority ratings from CES clients. Under questioning from Members, DHHS representatives conceded that clients might not necessarily be informed of their application's priority status.

OT Australia (Tas) submitted that as equipment in the non-standard category is very expensive, obtaining limited available funding is a "highly competitive" process.[221] When equipment is issued, however, regional committees are "consistent and ethical in their application of the priorities and funding", according to its submission.[222] Calvary Health Care's submission also stated that the process followed to allocate funding "is consistent and ethical". [223]

Karen Frost (ILC) noted the tight budget of $69,000 for non-standard equipment in the northern region of the State, and commented how difficult this would be for regional management committees:

"I give the panel full marks for how they make those decisions. I would hate to be in that position, it must be very awful for them to know that there are a number of people who are not going to get funded for some time, even though they have high needs, and some who will never get funded under the current funding arrangements that the CES has."[224]

Catherine Merry (Allied Health Manager, St Giles) said:

"I sit on the northern community equipment scheme panel and we have approximately $6,000 per month for the entire region to disburse. New applications could be up to $100,000 for that month, but we have $6,000 to distribute, and that is for the entire region and it includes children, people with disabilities in the community plus people who need to be discharged from hospital."[225]

She added:

---

[219] DHHS, submission, p. 35
[220] Information provided by DHHS, 11 July 2008, p. 4
[221] OT Australia, submission, p. 4
[222] OT Australia, submission, p. 5
[223] Calvary Health Care Tasmania, submission, p. 7
[224] Frost, Bryg, O'Connor, transcript of evidence, 28 April 2008, p. 22
[225] Sertori and Merry, transcript of evidence, 28 April 2008, p. 3

"On an annual basis, if you look at the northern region, with $6,000 being distributed amongst the entire region you just about need a stiff drink after trying to split that up. Even four times that amount of money per month would not cover all of the needs but would certainly go a lot further."[226]

Community Based Support South Inc submitted that the prioritisation method should remain unchanged.[227] By contrast, a submission from Speech Pathology Australia (Tas) stated that the priority ratings method should be revised; to more clearly describe how communication devices are prioritised, and be made readily available to equipment prescribers.[228]

Angela Dodd said, in response to questions from Members, that the priority ratings are concealed from clients.[229] Steve Daley (Executive Director, Devon Industries), also commented, "we have been unable to find out the criteria for determining the order of priority." He added:

"We all think that the client we are supporting at the time is the number-one priority. But it would be nice to say that these are the criteria you need to assess against to determine where you fit in the priority scale."[230]

Members asked why he thought the priority ratings were not revealed. Mr Daley replied:

"Because then we might be able to mount an argument to show that the client we have on support at the moment is the number-one priority and they would have great difficulty in arguing against that. We do not know what they have based their decision on, so it makes it very hard for us to come back and argue against that. That makes it frustrating. The person making that decision has very limited dollars so you can understand their not supporting it and why they do not want to make it too obvious what the criteria are."[231]

Pip Leedham (DHHS) said clients are informed of their status:

"They are told whether they are being placed on a waiting list. In some cases they would be given some indication of time; whether they are high priority or not."[232]

Members asked what happens to applications that are allocated the lowest priority. Ms Leedham said, "At the moment it is very hard to fund priority five because we have a finite bucket of funds." She also added that the CES has to "focus on those with greatest need".[233]

---

[226] Sertori and Merry, transcript of evidence, 28 April 2008, p. 6
[227] CBS, submission, p. 3
[228] Speech Pathology Australia (Tas), submission, p. 2
[229] Dodd, transcript of evidence, 29 April 2008, pp. 8-9
[230] Daley and Subonj, transcript of evidence, 29 April 2008, p. 23
[231] Daley and Subonj, transcript of evidence, 29 April 2008, p. 24
[232] Leedham *et al*, transcript of evidence, 6 March 2008, p. 6
[233] Leedham *et al*, transcript of evidence, 6 March 2008, p. 7

Members then specifically asked DHHS representatives whether clients are told which priority level their application is given. Linda Osborne (SCES Principal Occupational Therapist, DHHS) said that the "clinician who was making the request" would be informed and "they may well inform the client." Members asked whether the client necessarily receives this information. Ms Osborne replied: "not necessarily."[234]

5.4 Communication Devices

Communication devices, witnesses told the Committee, are often given a low priority under the CES. Speech pathology and communication organisations, among others, criticised this tendency due to the importance of communication devices for the everyday needs of people who are unable to otherwise communicate.

Felicity Lovatt (Speech Pathologist, Burnie and Devonport Special Schools) said that on 25 occasions she has requested communication devices from the CES and been rejected each time:

> *"I have seen a great incompatibility with the current Community Equipment Scheme and the way electronic communication devices fit into that. I have worked in the field for about 10 years and I have not had any success, not one single occasion, where I have had a successful submission for a voice-out communication device being granted a client by the community equipment scheme."*[235]

Megan Morse (Calvary Health Care) said communication devices are "a very fundamental human right" and the priority attributed to these devices should be reconsidered.[236]

Speech Pathology Australia (Tas Branch) submitted:

> *"The CES continues to give low priority to communication devices and is therefore ineffective [sic] addressing the communication needs of eligible Tasmanians with disabilities."*[237]

Christopher Newell (UTAS) submitted that communication devices "in general are under-recognised" though he also wrote:

> *"In identifying this however there is a need to ensure that it is not just a device by itself which is obtained but one that suits the requirements of a person and that person's life choices, social milieu and projected future."*[238]

AGOSCI (Australian Group on Severe Communication Impairment) submitted that under the present system, "communication devices are generally prioritised lower

[234] Leedham *et al*, transcript of evidence, 6 March 2008, p. 9
[235] Lovatt and Brown, transcript of evidence, 29 April 2008, p. 14
[236] Morse and Donward, transcript of evidence, 20 May 2008, p. 33
[237] Speech Pathology Australia, submission, p. 1
[238] Newell, submission, p. 4

than other equipment." It recommended establishing a separate budget and priority system for communication devices.[239]

A submission from DHHS acknowledged the situation in relation to communication devices:

> *"Use of the rating scale will usually result in the allocation of a low priority rating for communication devices, and due to budget constraints, it is unlikely that the client will eventually be provided with the device. … At present applications for these items compete directly with all other non-standard items such as mobility aids."*[240]

5.5 Equipment Categorisation and Coverage

The Committee was informed that some items of equipment are not covered under the CES as either standard or non-standard equipment. Additionally, one submission viewed the current categorisation of equipment as either standard or non-standard as inappropriate.

The CES Guidelines describe in detail the types of items provided under the scheme (clause 9). Broadly, these include mobility aids, specialised seating, transfer/lifting devices, positioning equipment, self-care aids (for toileting and showering), seating and sleeping items, surgical footwear, continence aids, communication devices, home modifications (labour costs only), and respiratory aids. Individual items and clusters of items are classified as being standard or non-standard.[241] The Guidelines define standard and non-standard as follows:

> *"Standard: basic items of equipment that are kept in stock and frequently requested for loans which are non-specialised, or off the shelf, or inexpensive (<$500).*
>
> *"Non standard: equipment not kept in stock that has to be ordered and which is specialised, or customised, or expensive (>$500). Regional CES committees require applications from authorised prescribers prior to purchase."*[242]

OT Australia (Tas) commented in its submission that definitions of 'standard' and 'non-standard' are inappropriate:

> *"The delineation between standard and non-standard equipment is flawed. As more clients with complex needs are supported in the community… equipment such as bariatric equipment, hoists, seating, standing frames, pressure care cushions and so forth has become standard."*[243]

---

[239] AGOSCI, submission, p. 1

[240] DHHS, submission, p. 35. The submission also noted the capacity of communication devices to "significantly improve the quality of life for those with a major communication impairment."

[241] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, pp. 10-11 (provided by DHHS)

[242] DHHS, 'Statewide Community Equipment Scheme (CES) Guidelines', April 2004, p. 10 (provided by DHHS)

[243] OT Australia, submission, p. 4

The Committee heard that some items are not covered as either standard or non-standard, such as special footwear.[244] According the ILC, some areas of assistive technology as "not well addressed by the CES". These include home modifications, computer access, environmental control units, car modifications, and scooters.[245] Submissions from TasCOSS and Anglicare asserted that smoke alarms for hearing impaired people are not covered within the CES.[246] The APA called for wider equipment coverage and "more bariatric equipment".[247]

Pip Leedham (DHHS) agreed that there has been increasing demand for this type of equipment, due to a prevalence of obesity among the population. [248]

[244] Ewington and Patchin, transcript of evidence, 29 April 2008, p. 37
[245] ILC, submission (revised), p. 15
[246] TasCOSS, submission, p. 3; Anglicare, submission, p. 7
[247] APA, submission, p. 2
[248] Leedham *et al*, transcript of evidence, 6 March 2008, p. 4

CHAPTER 6

ACCESSING FUNDS FOR EQUIPMENT AND ASSISTIVE TECHNOLOGY IN THE COMMUNITY

6.1 Introduction

Accessing funds is stressful for families and individuals who urgently require equipment though cannot afford the equipment they need, with items such as customised wheelchairs costing tens of thousands of dollars. This, evidence suggests, leads to people with disabilities approaching charities; bearing with delays; seeking personal loans; and has also led to situations where equipment purchased by the CES has been withheld from the client until the difference between the Scheme's contribution threshold and the actual item cost can be finalised.

The issue of access to funds is a problem for CES and non-CES clientele alike. As well as considering the significant role of the CES, this chapter also examines the issue of how the broader community members access funds for equipment.

This chapter is concerned with issues pertaining to access to funding and sources of funding. An earlier chapter in this report has been dedicated to the appropriateness of funding levels.

6.2 High Cost of Equipment and Assistive Technology

The Committee was provided with information from various sources highlighting the expensive cost of equipment and assistive technology. Customised wheelchairs, in particular, cost tens of thousands of dollars. One Tasmanian supplier explained to the Committee that the economies of scale and specialised nature of items ensures prices remain high for both suppliers and end-users, despite strong demand. For an individual who has had a catastrophic event, the Committee was informed that purchasing important equipment items could collectively amount to up to $80,000.

Specialised wheelchairs can cost over $20,000, witnesses and submissions estimated. Steve Daley and Millicent Subonj estimated that wheelchairs can cost up to $24,000, though average around $9,000 to $12,000.[249] Anglicare, through its research, estimated the cost of a customised wheelchair could be up to $21,000.[250] OT Australia (Tas) estimated the price of a powered wheelchair to be up to $20,000.[251] Likewise, the APA stated that wheelchairs now cost $20,000.[252]

Communication devices can cost up to $20,000, though mostly in the range of $4,500 to $14,000, Felicity Lovatt informed the Committee.[253] Speech Pathology Australia (Tas Branch) estimated the range of cost to be "from a few hundred dollars to $15,000."[254]

---

[249] Daley and Subonj, transcript of evidence, 29 April 2008, p. 21
[250] Anglicare, submission, p. 4
[251] OT Australia, submission, p. 12
[252] APA, submission, p. 3
[253] Brown and Lovatt, transcript of evidence, 29 April 2008, p. 15
[254] Speech Pathology Australia, submission, p. 1

The following information was provided by DHHS to show equipment cost increases since the mid-1990s.

Equipment Item Costs: increases over time[255] 1996 and 2006		
Item	**Avg price 1996-97**	**Avg price 2006**
Jay cushion	$185	$660
Self-propelled commode	$1,166	$1,530
Sheepskin	$46	$110
Air mattress	$1,995	$3,975
Manual wheelchair	$2,000	$3,650
Powered wheelchair (basic)	$6,900	$8,000 to $9,000
Powered wheelchair (specialised)	-	$12,000 to $20,000

DHHS also provided the committee with an approximate breakdown of the items required, and costs involved, if the CES (or other financier) were assisting a client who has suffered a catastrophic event. In addition, home modifications may be required.[256]

Equipment Item Costs: assisting a high-support needs client[257]	
Item	**Approximate cost**
Electric bed	$3,000 to $4,000
Customised motorised wheelchair	$12,000 to $20,000
Hoist	$2,000 to $3,000
Commode/shower chairs	$100 to $1,000
Assistive communication aids	$8,000 to $12,000
Environmental controls	$20,000 to $40,000
	Total approximate cost: $45,100 to $80,000

Michael Sertori (St Giles) said:

> *"Most equipment is relatively expensive due to the fact that it has to be customised and specialised and there are low production levels."*[258]

St Giles explained in its submission:

> *"Unfortunately, much of the required equipment is produced in small quantities and/or is adapted or produced to meet individual circumstances adding to the overall expense. Where possible, equipment is recycled to achieve economies but some individualised components can't be recycled due their one-off nature or due to general wear and tear."*[259]

In its submission, KW McCulloch explained how prices remain high:

[255] DHHS, submission, p. 30
[256] Information provided by DHHS, 12 May 2008, p. 6
[257] Information provided by DHHS, 12 May 2008, p. 6
[258] Sertori and Merry, transcript of evidence, 28 April 2008, p. 3
[259] St Giles, submission, p. 3

"Despite demand for such products being at a high level, a lack of available funding has meant that the usual market pressures and demand for product development and evolution have not occurred, as happens in mainstream markets. … The price drop that usually ensues after some time of product presence in the marketplace has not occurred in the disability sector and the technology remains expensive. It remains expensive not only for the end user, but also for suppliers. As a result, this technology is rarely applied to the disability sector."[260]

Megan Morse (Allied Health Manager, Calvary Health Care) said that children have ever-changing needs, which can require continual equipment changes:

"I guess the issue for us is that it's not a situation where you set that child up and then walk away and say, 'You'll be right', because kids grow and develop. … So the children's needs continue to change over a period of time; they are not a population where you can set them up and realistically expect, as you might with an adult client, that they will be right for x *number of years."*[261]

6.3 Service Fragmentation

Some witnesses explained that finding the appropriate service provider could be a confusing process for individuals and their families due to service fragmentation and a minefield-type environment.

The Neuro-Muscular Alliance Tasmania submitted that one issue, among others of concern, relates to the "fragmentation and confusion caused through multiple service providers – this is a minefield for those trying to assist let alone clients and their families."[262] Jane Wardlaw commented: "There is no one-stop shop that provides efficient and fast assessment service."[263] Kellie Ashman submitted that the CES is a "minefield" and not widely known about in the community.[264]

The ILC stated in its submission:

"The number and variety of different funding agencies can be confusing for clients. Consumers may not be aware of the appropriate funding body or that other funding sources may exist."[265]

Robyn Sheppard (APA) said:

"For every one hour of face-to-face we spend with a child, we end up spending about six hours chasing up equipment and other things."[266]

[260] KW McCulloch, submission, p. 4
[261] Morse and Donward, transcript of evidence, 20 May 2008, p. 27
[262] Neuro-Muscular Alliance of Tasmania, submission, p. 2.
[263] Wardlaw, transcript of evidence, 28 April 2008, p. 30
[264] Ashman, submission, p. 1
[265] ILC, submission (revised), p. 11
[266] Sheppard, transcript of evidence, 20 May 2008, p. 36

6.4 Funding Urgency and Timing

Clients can require equipment items urgently. The Committee was told that non-CES sources of funding for individuals and families in the community might deny assistance until the CES has also denied the same request, leaving people waiting and at risk of their condition degenerating.

Megan Morse (Calvary Health Care) said that as well as waiting for funding requests to be approved, families could be waiting to hear that funding will be denied. She explained:

> *"The fact that the timelines are very nebulous at the moment is a source of frustration perhaps for therapists as much as families because they are in that limbo of whether to pursue other options but you cannot pursue any other options until the CES categorically says, 'No, the money will not be forthcoming'. The family are stuck in a holding pattern until something happens."*[267]

The Equipment and Technology Library also noted in its submission that charities remain on hold waiting for a CES decision:

> *"Organisations… are put in a difficult position as they do not wish to purchase items that are the responsibility of the CES or have already been approved by them."*[268]

Similarly, OT Australia (Tas) made a similar observation:

> *"Clients with a lower priority are placed on a wait list rather than being refused despite the fact that they are unlikely to have funding allocated. This can make seeking funding from other agencies more difficult as the client cannot state that they are ineligible for funding under CES, although in reality funding is unlikely or is years away."*[269]

OT Australia (Tas) explained in its submission that CES approval for standard equipment and non-standard equipment (available for re-issue) is relatively easy. [270] However, the provision of non-standard equipment that needs to be purchased "is a more complex process," the submission stated, with a process involving *inter alia* prescription, research, applications for funding, and equipment trial. [271] In relation to the expediency of the CES to approve non-standard application for equipment purchase, the submission commented:

> *"Meetings of the committee overseeing the CES to consider applications for non-standard equipment are held fortnightly. While this is adequate for most applications, it can be inappropriate for some client needs which arise quickly and require urgent attention."* [272]

---

[267] Morse and Donward, transcript of evidence, 20 May 2008, p. 29
[268] Equipment and Technology Library, submission, p. 4
[269] OT Australia, submission, p. 8
[270] OT Australia, submission, p. 8
[271] OT Australia, submission, p. 8
[272] OT Australia, submission, p. 8

Millicent Subonj (Multicap) said people would degenerate in hospital waiting for equipment without a rapid response:

> *"There needs to be a quick response, because the quick response keeps them motivated, moving forward and wanting and able to develop their abilities, because once you lose that muscle tone lying in hospital waiting for a wheelchair, then you have lost it; it has gone."*[273]

6.5 Sources of Funding

The CES has been the main source of financial assistance in Tasmania for equipment and assistive technology purchases. In addition, charities have been a source of funding for some individuals and families; however witnesses maintained that the public's generosity could be limited, that people prefer not to rely on these sources, and that certain organisations might be less than genuine. Concern was also expressed to the Committee that people have had to resort to personal loans to pay for equipment or purchase sub-standard items. One witness suggested the creation of a lottery scheme to raise funds for equipment.

The Independent Living Centre (ILC) commented in its submission:

> *"Due to the CES having insufficient funds, many clients have resorted to purchasing inappropriate equipment or unsafe equipment. Some clients have resorted to buying equipment from Eco-Salve (the local tip shop). There are reports of clients taking out substantial loans and family members dipping into savings to pay for equipment. Charities and service organisations (such as Rotary, Lions) are also commonly approached to assist with funding or top-up funding."*[274]

Charities can be a source of funding for families and individuals who cannot meet expenses related to their equipment and assistive technology requirements. As Felicity Lovatt pointed out, however, ongoing requests for funds may leave community generosity "exhausted"; particularly for children who outgrow devices, "it is hard to go back in a couple of years and do it all over again for the same child."[275]

Angela Dodd, who has a young daughter with Aicardi syndrome, told the Committee of the personal difficulty seeking help publicly:

> *"You feel, when you bring a child into the world, it is your responsibility and you feel a huge failure because you cannot meet all of your child's needs. It is a big thing. I was brought up to be independent and it is a really huge thing for me to ask for help. Among the things that I have done, going to the media was the hardest thing I have ever done in my life. I just opened myself up to that. It was something that I just do not cope with very well at all."*[276]

---

[273] Daley and Subonj, transcript of evidence, 29 April 2008, p. 25
[274] ILC, submission (revised), p. 3
[275] Brown and Lovatt, transcript of evidence, 29 April 2008, p. 19
[276] Dodd, transcript of evidence, 29 April 2008, p. 7

Depending on charities could be "humiliating" for some people, Julia Butler-Ross and Tom Butler submitted.[277]

St Giles' submission stated that some people are "resorting to personal loans" to fund equipment purchases.[278]

Assoc Prof Christopher Newell explained that charities could be genuine though others could also less than genuine too:

> *"Some charities have people at their heart and all their outcomes and management structures reflect this. Indeed some would see it as an obscenity to pay management structures any more than their clients. Others have become extremely large businesses with wealth and privilege accruing for those who are supposedly seeking to selflessly benefit the poor and oppressed. There are some significant challenges and at times hypocrisy involved. … There are some excellent practices in Australia and some appalling practice."*[279]

He also commented that some charities "portray people with a disability in pathetic ways in order to maximise donations." [280]

Felicity Lovatt (Speech Pathologist, Burnie and Devonport Special Schools) commented that people self-funding their equipment through *ad hoc* sources is an inefficient approach. She said that when equipment items are no longer used, "they are left gathering dust and all of that resource and time and effort from the community for fundraising is wasted."[281]

Jane Wardlaw suggested that a no-interest loan scheme should be established for people to use for carrying out home modifications and purchasing equipment. She also proposed tax incentives to encourage investment into equipment and assistive technology, and the introduction of a lottery scheme modelled on Lotterywest in Western Australia.[282]

In its submission, the Equipment and Technology Library noted that if families and individuals do not receive assistance through the CES, "pressure is then put on other services, such as ours, which are seen to provide items more easily."[283]

6.6 Hardship

The Committee was made aware that some people with disabilities are struggling to raise money to pay for equipment. DHHS representatives said they recognised this issue and referred the Committee to hardship provisions in the CES' Guidelines. According to one submission, the CES hardship provisions are a drawn out process.

---

[277] Butler-Ross and Butler, submission, p. 4
[278] St Giles, submission, p. 4
[279] Newell, submission, p. 8
[280] Newell, submission, p. 8
[281] Lovatt and Brown, transcript of evidence, 29 April 2008, p. 15
[282] Wardlaw, transcript of evidence, 28 April 2008, p. 32; Michael Sertori also made this suggestion, Sertori and Merry, transcript of evidence, 28 April 2008, p. 5
[283] Equipment and Technology Library, submission, p. 4

Felicity Lovatt (Speech Pathologist, Burnie and Devonport Special Schools) commented that some families do not have the ability to raise funds:

> *"There are families who have the resources and advocacy to pursue funding through a variety club or service club or fundraising for themselves but there are so many who do not have those resources or capacity and therefore their loved one is discriminated against."*[284]

Anglicare submitted that as the cost of items can be a "huge expense", subsidies for people on low incomes as having a reduced capacity to "meet all their needs for aids and equipment".[285]

According to the APA, CES hardship provisions are cumbersome:

> *"Trying to access hardship funding for those in true need (and not otherwise eligible) is a lengthy, cumbersome process."*[286]

Diane Ewington commented that some families might decline assistance on the presumption others are worse off.[287]

Gordon Patchin said:

> *"We do not feel that we should be asking for more because we know there is such a limit out there and there are other people that need it. We feel certain amount of guilt in asking for more funding."*[288]

Pip Leedham (DHHS) said putting in place a "fair and equitable hardship policy is a challenge"[289] and also noted that the Department of Health and Human Services is currently reviewing its hardship policy.[290] She said that assessing hardship is a "value judgement" as "people choose to expend their income in certain ways."[291] Clients can also access the DHHS Board of Exceptional Needs (BEN), for clients who have high support needs and a complex response from the Department is required.[292] Ms Leedham said that since 2002, eight clients have been before the BEN.[293]

6.7 Client Age

Witnesses informed the Committee that accessing funds for children with disabilities is easier than for adults. The Committee was also told that children could have access to equipment while at school, which, however, cannot be used at home.

---

[284] Brown and Lovatt, transcript of evidence, 29 April 2008, p. 15
[285] Anglicare, submission, p. 4
[286] APA, submission, p. 3
[287] Ewington and Patchin, transcript of evidence, 29 April 2008, p. 37
[288] Ewington and Patchin, transcript of evidence, 29 April 2008, p. 37
[289] Leedham *et al*, transcript of evidence, 6 March 2008, p. 9. The Hardship Provision of the CES Guidelines is reproduced in part earlier in the report in relation to fees and charges.
[290] Leedham *et al*, transcript of evidence, 6 March 2008, p. 7
[291] Leedham *et al*, transcript of evidence, 6 March 2008, p. 7
[292] Information provided by DHHS, 12 May 2008, p. 5
[293] Leedham *et al*, transcript of evidence, 6 March 2008, p. 15

Diane Ewington (Association for Children with Disabilities) said families attempt to "get as much done as you can while they [their children] are still at school or while they are under 18" as the cost to access certain services for adults is "so much higher".[294]

The Committee was informed that children (under 18) could have access to equipment through schools, however, outside school hours, upon leaving school, or attaining 18 equipment would be taken away. Diane Ewington spoke of one instance:

> *"I have another family who had access to equipment while their daughter was at school. … Once the child leaves school it has to go back to the Community Equipment Scheme. Now that she has turned 18 she goes to a day-service program and she cannot take that piece of equipment with her because it is specifically for 18s and under and it is for school. … it is not available for anybody else because it has been made to her body shape… it is in their storeroom."*[295]

Gordon Patchin said that during school holidays, "equipment they can use at school they are not allowed to take home and use".[296]

According to Robyn Sheppard (APA), fundraising for equipment to give to children is relatively easy "because they're young and cute."[297] However, for adults the task is harder:

> *"It is a lot easier to fundraise for children but if you're trying to get a motorised wheelchair for an adult then that could be something like $20,000 and the Government puts in $6,000. Where do you get the rest? We used to go through Disability Services and they were great, but they don't have any money. So it is now getting back to going through all the charitable trusts. Some people just don't want to do that and you have to respect their wishes. It can mean that trying to get a piece of equipment for someone can take two to three years."*[298]

[294] Ewington and Patchin, transcript of evidence, 29 April 2008, p.
[295] Ewington and Patchin, transcript of evidence, 29 April 2008, p. 33
[296] Ewington and Patchin, transcript of evidence, 29 April 2008, p. 34
[297] Sheppard, transcript of evidence, 20 May 2008, p. 38
[298] Sheppard, transcript of evidence, 20 May 2008, p. 38

CHAPTER 7

ESTABLISHING A CENTRALISED SYSTEM TO TRACK AND AUDIT AVAILABLE EQUIPMENT AND ASSISTIVE TECHNOLOGY

7.1 Introduction

With anecdotal evidence that items are abandoned or sold at garage sales, witnesses and submissions generally supported in-principle having a centralised system for tracking and auditing equipment and assistive technology, particularly for the CES. DHHS informed the Committee that the CES relies on manual methods of data gathering and information management.

7.2 Current Information Management and Data Capabilities

In evidence it provided to the Committee, DHHS recognised the limitations of its information management systems. This has prevented CES administrators from identifying trends and ensuring equipment is duly returned to the Scheme.

Pip Leedham (DHHS) said that the CES currently operates under "three separate information systems" for each region. She commented:

> *"The actual tracking of the equipment is not as streamlined as it could be and we are doing some work internally to get a statewide information system for the scheme."*[299]

In its submission, DHHS stated:

> *"The current information system used to manage the Community Equipment Schemes is made up of three stand-alone Access databases used in the three regions. While these databases adequately manage individual client information regarding assessment status and equipment, more detailed data regarding the client base as a whole is unable to be extracted."*[300]

The submission elaborated further:

> *"Information required has to be extracted through a time-consuming, manual process. This impacts on the ability to provide accurate data on numbers of clients, numbers of applications for equipment, trends in demand and other data essential for effective management of the service.*
>
> *"Significant benefits would be realised if the scheme were able to establish and maintain one statewide database. Such an information*

[299] Leedham *et al*, transcript of evidence, 6 March 2008, p. 4
[300] DHHS, submission, p. 16

system would allow analysis of service trends; the ability to view equipment inventories in each region and would promote the sharing of equipment where practicable. The current databases are not always able to track the equipment that is on loan and hire to clients. The consequences of this are that a significant number of items are effectively 'lost', representing an expense to the DHHS with the consequent need to purchase new equipment."[301]

Michael Sertori (St Giles) said there is inefficiency inherent in current data-gathering systems:

"A lot of the data is collected but there is some vacuum that it goes into… and it just disappears into the black hole. Then when there is a crisis you are asked to provide the data again. So there is something missing in the system to properly analyse that data and work with it. I just conclude that no one wants to look at it because they are fearful of what it might mean."[302]

He said data is available, and could be utilised, if a system existed to collect it:

"The information is there… …if someone can develop an appropriate system to collect it. Then we can make forward projections by using that data."[303]

7.3 The Need for a Centralised System of Data Management

The Committee heard that a quantity of equipment has probably been abandoned, and in the absence of a system to track equipment status, these items have effectively become lost. A centralised system would create greater efficiencies and better utilisation of existing equipment, witnesses said.

DHHS' submission stated that if a tracking system was introduced through equipment barcodes, more items would be returned to the CES and a programme of scheduled maintenance could be administered effectively.[304]

OT Australia (Tas) submitted that the inadequacy of equipment tracking, as well as inadequate training for CES staff, results in items being "unused when in fact it could be reissued if therapists were aware of its existence" and ultimately requires therapists to "physically search stores for required items."[305] Its submission also listed numerous potential advantages of having a system to maintain and track equipment and assistive technology, noting *inter alia*: improved reporting; improved monitoring of equipment maintenance; increased cost efficiency; more expedient equipment re-allocation; more equitable distribution; standardised processes; and having multiple points of lending and return.[306]

Calvary Health Care Tasmania indicated its support for a centralised system:

---

[301] DHHS, submission, p. 33
[302] Sertori and Merry, transcript of evidence, 28 April 2008, p. 7
[303] Sertori and Merry, transcript of evidence, 28 April 2008, p. 7
[304] DHHS, submission, p. 33
[305] OT Australia, submission, p. 3
[306] OT Australia, submission, p. 13

"Assuming it was well-managed and maintained, further centralisation of equipment provision would be welcomed if it offered efficiency gains for therapists, who would relish the simplicity of lodging 'one application with one place'. It may also enable better data collection as to the utilisation and durability of equipment; provide greater scope for equipment trials (leading to better prescription) and, potentially, increase the scheme's leverage with suppliers."[307]

The ILC also noted the advantages of a central system in its submission, similar to the comments submitted by OT Australia and Calvary Health Care.[308] Whilst presenting verbal evidence, representatives of the ILC (Tas) commented that about one-third of equipment is abandoned.[309] Pip Leedham (DHHS) said that "part of the challenge" is equipment left sitting in garages.[310]

The Australian Physiotherapy Association (APA) submitted:

"Equipment out in the community is often not returned to the scheme promptly when no longer used; some nursing homes are not returning equipment when clients are admitted to high care."[311]

Millicent Subonj (Executive Director, Multicap) said:

"The equipment that is fully funded needs to be kept in a library; some record of what that equipment is and to whom it was supplied. When that person passes on, that equipment needs to go back into that library and be reallocated. Unfortunately at this point in time it is not. We tend to sit on equipment that is no longer suitable to us but nobody collects it, nobody wants it."[312]

Peta Raison said she was aware significant quantities of equipment is disposed of when people no longer need it:

"The amount of equipment that is thrown away, the amount of equipment that you will find in garage sales is amazing."[313]

She said people in possession of publicly funded equipment should be accountable for it, similar to how a public library operates; though she suggested an amnesty period. Ms Raison also said that a proper database would create efficiencies in the future, but commented that if a centralised regime of storage and information collection were established, the system would need skilled operators. [314]

Speech Pathology Australia (Tas Branch) indicated in its submission support for "a centralised system which owns, maintains, and tracks communication devices in the

[307] Calvary Health Care Tasmania, submission, p. 6
[308] ILC, submission (revised), pp. 10-11
[309] Frost, Bryg, O'Connor, transcript of evidence, 28 April 2008, p. 26
[310] Leedham *et al*, transcript of evidence, 6 March 2008, p. 16
[311] APA, submission, p. 2
[312] Daley and Subonj, transcript of evidence, 29 April 2008, p. 22
[313] Raison, transcript of evidence, 20 May 2008, p. 49
[314] Raison, transcript of evidence, 20 May 2008, pp. 49-52

community." Nevertheless, three potential limitations or advantages of the *status quo* were noted:

> *"Potential loss of responsiveness to local needs; reduces local representation if not factored into a centralised system; [and] local stores enable easier access for community and prescribers."*[315]

[315] Speech Pathology Australia, submission, p. 4

CHAPTER 8

EQUIPMENT SCHEMES OPERATING IN OTHER JURISDICTIONS AND POSSIBLE ALTERNATIVE MODELS FOR TASMANIA

8.1 Introduction

Some witnesses and submissions argued that the provision of equipment and assistive technology in Tasmania should be restructured and completely overhauled, including by replicating aspects of models from interstate. While not comprehensive, this chapter contains a description of how selected schemes and programmes interstate operate.

On the other hand, other witnesses and submissions did not seek fundamental changes to the CES except for addressing funding and other incidental concerns. The suggestion of transferring the State's equipment and assistive technology scheme to the non-government sector drew a mixture of qualified support and outright disapproval. Some witnesses and submissions impressed upon the Committee a desire to have people with disabilities included among the managers and administrators of any revised model.

8.2 Interstate Schemes

All Australian jurisdictions operate and administer schemes or programmes with the broad objective of providing equipment principally to people with disabilities in the community. There are, however, some operational differences between these schemes and programmes; for this reason direct comparisons could be misleading. Except for a submission from DHHS, information the Committee received on interstate equipment schemes and programmes from witnesses and submissions tended to be limited in detail.

Equipment Schemes in Australia, overview

Jurisdiction	**Scheme**
New South Wales	Programme of Appliances for Disabled People
Queensland	Medical Aids Subsidy Scheme
Western Australia	Community Aids and Equipment Programme
South Australia	Independent Living Equipment Programme
Victoria	Aids and Equipment Program
ACT	Equipment Scheme
Northern Territory	Territory Independence and Mobility Equipment

During the course of the inquiry, some witnesses said there were aspects of schemes in Victoria and Western Australia that are best practice, or otherwise

perform well, among Australian jurisdictions.[316] St Giles submission claimed that the CES is the "least effective" equipment scheme in Australia.[317] Pip Leedham (Director of Primary Health, DHHS) said, however, that all equipment schemes in Australia are currently experiencing the same problems:

> *"Right across the country all equipment schemes are experiencing similar sorts of challenges to those which are being experienced here."*[318]

The Victorian and NSW programmes have recently been reviewed. Key issues identified in the Victorian review were as follows: policy context (the range of clients seeking assistance); 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.[319] The NSW review cited four areas of challenge:

> *"The challenge of managing expectations from consumers applying to an eligibility program (where not all of the eligible persons can be provided with services) in the belief that they are accessing an entitlement program (where all those who meet the entitlement are provided with the services).*
>
> *"The challenge to accurately match the available budget to the numbers of persons who meet the eligibility criteria.*
>
> *"The challenges in delivering a consistent and reliable statewide program within a delegated geographical management structure that has only minimal statewide administration.*
>
> *"The challenge of creating the appropriate management and policy framework for the program in the future, as it is apparent the program has outgrown the current arrangements."*[320]

The following table outlines key characteristics of selected equipment schemes and programmes in Australia.

[316] Lovatt, transcript of evidence, 29 April 2008, p. 16; Sertori and Merry, transcript of evidence, 28 April 2008, p. 5; and Wardlaw, transcript of evidence, 28 April 2008, p. 31
[317] St Giles, submission, p. 4
[318] Leedham *et al*, transcript of evidence, 6 March 2008, p. 1
[319] KPMG/Victorian Department of Human Services, 'Final Report of the Review of the Aids and Equipment Program', 2006, p. 80
[320] Price Waterhouse Coopers/NSW Health 'Review of the Programme of Appliances for Disabled People', June 2006, p. 16

Equipment Schemes in Australia, comparative[321] Victoria, NSW, Queensland, and Western Australia				
	Victoria A&EP[322]	**NSW** PADP[323]	**Queensland** MASS[324]	**Western Australia** CAEP[325]
Aim	The Victorian 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.	PADP is designed to provide appropriate equipment, aids and appliances to assist eligible residents of NSW who have a disability of a permanent or indefinite nature to live and participate within their community. Items provided should address a client's equipment needs, independence and quality of life, and promote long-term functioning.	MASS provides access to subsidy funding for the provision of MASS endorsed aids and equipment to eligible Queensland residents with permanent and stabilised conditions or disabilities. The range of MASS aids and equipment is selected to assist people to live at home and avoid premature or inappropriate residential care or hospitalisation.	The core purpose of CAEP is to provide equipment for people with a long-term physical disability who meet the eligibility criteria. In particular, the Programme is targeted at people with disabilities who wish to remain in their homes and as community members.
Eligible Persons	Persons who are permanent Victorian residents, hold a 785 Visa, asylum seeker Bridging Visa A or E, have a permanent long-term disability or are frail-aged, and require aids and equipment on a permanent basis.	Persons living in the community, with an indefinite disability, permanent resident of Area Health Service, residents of State group homes, ineligible for other compensation or equipment loan service, discharged from hospital for one month, and not receiving assistance from another programme.	Persons who are permanent Queensland residents, hold a concession card, and have a permanent condition.	Persons who have an indefinite disability; hold a concession card, and are living in a residential situation.
Prioriti-sation	There are three categories of priority: no waiting and immediate approval; high urgency (safety and functioning is compromised); and low urgency. Item provision is dependent upon application priority; availability of suitable re-issue aids and equipment; and the availability of funds.	All children under 16 have universal access. Adults on lower income "bands" are given higher priority. Health Services prioritises available items "according to local demand and budgetary constraints."	There are two categories of priority: category 1 (hospitalisation and safety risks) and Category 2 ("all other" circumstances)	Equipment is provided according to "essential criteria". Items should support independent func-tioning, be for individual usage at home and is needed for safety reasons,[326] and be "the most basic model/type that meets the clinical need".

[321] Some information has been drawn from DHHS, submission, pp. 41-42, and Price Waterhouse Coopers/NSW Health 'Review of the Programme of Appliances for Disabled People', June 2006, pp. 48 to 55. Information in relation to South Australia, Northern Territory, and ACT schemes can be found in Appendix C of that Review.

[322] Department of Human Services, Disability Services, 'Victorian Aids and Equipment Program (A&EP)Guidelines', April 2008, at <http://www.dhs.vic.gov.au/disability/publications-library/aids-and-equipment-program-guidelines> [Accessed August 2008]

[323] NSW Health, 'Policy Directive: Programme of Aids and Appliances for Disabled People', 22 March 2005, at <http://www.health.nsw.gov.au/policies/pd/2005/PD2005_563.html> [Accessed August 2008]

[324] Queensland Health, 'Medical Aids Subsidy Scheme (MASS) Statewide Prescriber Procedures Manual', June 2008, at <http://www.health.qld.gov.au/mass/eligibility.asp> [Accessed August 2008]

[325] WA Disability Services Commission, 'Community Aids and Equipment Program: Referrer's Information Kit', June 2006; brochure 'CAEP: Community Aids and Equipment Programme for People with Long-Term Disability', [undated] at <http://www.disability.wa.gov.au/forindividuals/disabilityservices/aidsequipment.html> [Accessed August 2008]

[326] The safety criterion does not apply for all equipment.

	Victoria: A&EP	NSW: PADP	Queensland: MASS	WA: CAEP
Contri-butions	Maximum "ceiling" prices apply. These vary item to item and are specified in the A&EP Guidelines. Client pays additional cost.	PADP meets cost of the most "economically clinically appropriate" item. Clients make a contribution of $100 per annum. Higher income clients must contribute 20% of purchase cost.	MASS provides a limited subsidy. If this subsidy is exceeded, MASS and the client enter into a "co-payment arrangement".	Maximum thresholds apply. Clients may be requested to assist with funding.
Equipment Coverage	The A&EP Guidelines specify the individual items covered by the Programme; generally mobility aids, communication and continence aids, and various personal use items.	PADP Policy Directive lists the equipment covered; localised Advisory Committees may add items (but not remove them).	There is a list of approved items, which can be reviewed at the discretion of MASS. Items covered are categorised as: communication aids, continence aids, daily living aids, footwear, mobility aids, orthoses, oxygen, and spectacles.	Bed equipment, communication aids, daily living items, home modifications, personal care items, mobility aids, and others.
Ownership	Programme retains ownership where A&EP has contributed > 50% and item is reusable; if the client has majority ownership, items can be retained or transferred to the Scheme.[327]	Items remain the property of PADP.	MASS has full ownership of items.[328] Transfer of ownership can be arranged "under certain circumstances"	Ownership rests with CAEP.
Other Comments	Following the completion of a review in 2006, NSW Government intends to re-brand PADP as EnableNSW. This scheme will be an amalgamation of the PADP and other smaller schemes. Financial eligibility criteria may also be modified.[329] Also as a result of a review, the Victorian Government intends to develop a new service model, find consistent ways to prioritise and assess people's needs, and introduce a vehicle modification subsidy.[330] Schemes and programmes generally do not assist persons who have received compensation, live in nursing homes, are DVA clients, or have to access to other Federally funded sources of assistance.[331] South Australia's ILEP usually funds the full cost of an item purchases and home modifications.[332] The Federal Government has in place a national Continence Aids Assistance Scheme.[333]			

In its submission, DHHS listed various differences among equipment schemes and programmes in Australia. Its submission stated that "it is difficult to make direct comparisons" due to the varying characteristics, processes, and scope of schemes.[334] Particular points of difference included:

- The eligibility of persons who have recently been discharged from hospital;
- Some categories or items, such as oxygen, are under stand-alone schemes;

[327] This does not apply to home modifications or personal use items.
[328] Some selected items are deemed to be in the client's ownership.
[329] NSW Department of Health, 'PADP Review: Frequently Asked Questions', at <http://www.health.nsw.gov.au/Initiatives/DisabilityEquipment/faqs.asp> [Accessed August 2008]
[330] Victorian Department of Human Services, Disability Services, 'Statement on the Review of the Aids and Equipment Program', 9 November 2007, at <http://www.dhs.vic.gov.au/disability/supports_for_people/living_in_my_home/aids_and_equipment_program/whats_new> [Accessed August 2008]
[331] DHHS, submission, p. 44
[332] DHHS, submission, p. 46
[333] Refer to <http://www.health.gov.au/internet/main/publishing.nsf/Content/continence-caas.htm> [Accessed August 2008]
[334] DHHS, submission, p. 44

- Variances of subsidy thresholds;[335] and

- Terms and conditions of eligibility for continence aids supply.[336]

8.3 Possible Alternative Models for Tasmania

The Committee was presented with a variety of ideas for reforming equipment and technology provision in Tasmania. This included having separate schemes for hospital clients and community clients, bringing equipment under Medicare, and having separate schemes for adults and children. Opinion was divided as to whether the CES should be placed in to non-government sector control.

Margaret Reynolds (State Manager, National Disability Services (NDS) (Tas.)) said a "totally new" equipment scheme is required. [337] As the NDS submission explained, the new scheme should be a "Community Assistive Technology Scheme". Specifically:

> *"A restructured programme would retain a hospital-based equipment service, but would initiate a community-based assistive technology scheme properly resourced to provide professional assessment and technical services suited to individual clients."*[338]

Michael Sertori (CEO, St Giles Society) suggested that equipment should be placed under the aegis of Medicare:

> *"If we could adopt the practice in Australia of being able to claim under our national health scheme it might provide people with disabilities a more dignified pathway to funding their needs against the current system that sometimes requires somewhat innovative and undignified fund-raising pathways."*[339]

He also recommended a new approach to allocating funding:

> *"Overall funding should be assessed against population needs planning, both globally and regionally, and allocation should be governed by regional committee structures consisting of non-government organisation representatives, and perhaps government representatives, charged with the duty to ensure objective allocation of funds."*[340]

Felicity Lovatt recommended having a separate scheme for communication devices, as occurs in Victoria. Since communication devices cannot compete against mobility equipment, she said, "I think there is a lot of incompatibility in having all of the equipment addressed in one single scheme."[341]

---

[335] DHHS' submission also commented that having multiple thresholds, as is the case in Victoria, is more complex to administer than a flat-rate regime. DHHS, submission, p. 45
[336] DHHS, submission, pp. 44-46
[337] Reynolds and Wilkinson, transcript of evidence, 20 May 2008, p. 12
[338] NDS, submission, p. 2
[339] Sertori and Merry, transcript of evidence, 28 April 2008, p. 2
[340] Sertori and Merry, transcript of evidence, 28 April 2008, p. 5
[341] Lovatt and Brown, transcript of evidence, 29 April 2008, p. 16

Transferring control of the CES into the non-government sector received a mixture of responses, some urging caution and others mildly supportive.

St Giles submitted:

> *"There is some debate over the relative cost effectiveness of Government and NGO administration. Most evidence demonstrates that the non-government sector is generally more cost-effective in fulfilling an equivalent role with Government but there are exceptions. St Giles would support outsourcing management, if cost effectiveness can be identified and resulting savings are committed to CES funding. … We therefore support the concept as a matter of principle but would ultimately adopt our position based on the proposal being presented."*[342]

ParaQuad Tas submitted:

> *"ParaQuad Tas strongly believes that the CES should not be tendered to the non-government sector at any stage. It is a government programme that should remain 'neutral' when consideration is given to providing equipment so every application received is perceived to be without prejudice. It could be seen, by many people, that conflict of interest could arise should the programme be administered by a non-government agency."*[343]

NDS supported the notion of a non-government equipment scheme:

> *"NDS considers that a community assistive technology scheme could be run more effectively by the non-government sector which is close to local communities."*[344]

The APA suggested having separate equipment schemes for children and adults:

> *"Some consideration should be given to splitting the funding for equipment provision for children from that made available to adults. Charitable organisations provide a lot of funding for one-off equipment for children… This may lead to scope for government to look at the capacity for equipment for children to be managed and also funding provided by a charitable organisation."*[345]

DHHS representatives indicated that having one equipment scheme rather than several is more effective for Tasmania:

> *"Because we are a small State I think having all of the things in the one scheme is effective because we have the capacity to buy at better prices, by everything coming together."*[346]

---

[342] St Giles, submission, p. 8
[343] ParaQuad Tas, submission, p. 3
[344] NDS, submission, p. 6
[345] APA, submission, p. 4
[346] Leedham *et al*, transcript of evidence, 6 March 2008, p. 17

The Department's submission also outlined fifteen "options for consideration" in relation to the CES, which in summary suggested:

- Merging the CES and Spinal Account, and their separate continence aids schemes, to create a "Tasmanian Equipment Scheme";
- Increasing the recurrent budget allocation to the Tasmanian Equipment Scheme;
- Creating a separate "set-up fund" for clients who have been discharged from hospital;
- Increasing contribution thresholds for item purchases;
- Clarifying and simplifying the lines of accountability and financial management across the three regions and ensure budget equity across the regions;
- Gradually increasing loan and hire fees, without creating disincentives or hardship;
- Utilising an Agency-wide hardship policy;
- Reviewing the application process, such as by seeking more clinical information from therapists;
- Creating a separate budget and priority rating scale for communication devices;
- Implementing a statewide information management system;
- Establishing a website;
- Developing and providing information in a variety of formats; and
- Reviewing how and where equipment is stored and maintained.[347]

8.4 Rehabilitation Appliances Program

The Department of Veterans Affairs (DVA) operates an appliances programme (RAP), which according the DVA's 2007-08 Annual Report "provides aids and appliances to eligible members of the veteran community for self-help and rehabilitation purposes." The following table outlines the context of the RAP.

[347] DHHS, submission, p. 49

DVA Rehabilitation Appliances Program[348]	
Aim	To "achieve or maintain functional independence and/or minimise disability"; items for personal use only.
Eligible Persons	Holders of a Repatriation Health Card – For All Conditions (Gold Card) or – For Specific Conditions (White Card). Veterans from allied countries may receive some support.
Prioritisation	Provision of equipment is based on assessed clinical need and assist with managing the overall healthcare of the entitled person.
Access	Need is assessed by a GP, Local Medical Officer, or occupational therapist. A written referral is made and then sent to either the DVA or the appropriate supplier for issue.
Equipment Coverage	Six product groups: continence, mobility function and support, oxygen, diabetes, personal response systems, and continuous positive airway pressure. Household/domestic equipment is not supplied.
Ownership	Items must be returned when no longer needed.
Other Comments	The DVA will not necessarily provide items to veterans living in institutions.

Peta Raison (OT Australia) said that logistics could be arranged "very much like DVA do" in Tasmania, with a central point of dispatch:

> *"All of our DVA equipment comes out of MacLaines in Launceston. Down here in Hobart, if we have a DVA client, we fax DVA what we need and the numbers that correlate with the book they have given us and we tell them what we want. … …We make an order and then their courier delivers it. They will either deliver it if we specify to deliver it to us and then we will go out and fit it, or they will deliver it to the house and someone will do it."*[349]

8.5 Client Input

Some witnesses told the Committee that among any changes to equipment and technology provision in Tasmania, a necessary change should be the inclusion of people with disabilities among the administrators of any revised scheme.

Robin Wilkinson said people with disabilities should be involved in any new equipment scheme and included in policy-making decisions:

> *"Whatever you come up with in a new scheme, I would like to see people with disabilities themselves involved in the process. It is absolutely vital because we can bring a different perspective which relates to our personal lives. For me that is really important. I would like to see a scheme that has some policy around it that people with disabilities have had input into and, however it is run, also that input, if you like, from the consumer perspective. And with great respect to occupational therapists who seem to be the main gatekeepers of this stuff, I hope I am not*

[348] Dept of Veterans Affairs, 'Rehabilitation Appliances Program', 19 June 2007, RAP Factsheet HSV107; Dept of Veterans Affairs, 'Rehabilitation Appliances Program (RAP): National Guidelines', July 2007;see also <http://www.dva.gov.au/health/rap/rap_index.htm>

[349] Raison, transcript of evidence, 20 May 2008, p. 48

offending anybody… I have a great deal of respect for their profession but they do not live with the stuff that we do."[350]

Assoc Prof Christopher Newell (School of Medicine, UTAS) said people with disabilities should be included on the boards of NGOs providing related services. However, he said this has been slow to occur:

"From my conversations with a couple of CEOs, I think they are sympathetic to the idea but somehow it never happens and, again, it is about building capacity. If you do not want to have people on boards you have them on advisory committees with requirements that those particular committees be given due weight. There needs to be something in funding agreements that you do that."[351]

[350] Reynolds and Wilkinson, transcript of evidence, 20 May 2008, p. 13
[351] Newell, transcript of evidence, 20 May 2008, p. 64

CHAPTER 9

OTHER RELEVANT MATTERS

9.1 Introduction

The report contains four other relevant or incidental matters that were raised during the course of the inquiry. These relate to: other equipment schemes in Tasmania, research and development, the role of the environment, and prescriber "error".

9.2 Other Equipment Schemes in Tasmania

The CES is one source of assistance, among others, providing financial subsidies for equipment and assistive technology in Tasmania. This inquiry has had a strong focus upon the CES, though other sources of assistance also exist. Some individuals and families may also be eligible for assistance from the Federal Government, for example through the Department of Veterans' Affairs or the Continence Aids Assistance Scheme.

A report produced by Anglicare in 2007 surveyed the sources of assistance available in Tasmania, listing the following apart from the CES:[352]

- Equipment and Technology Library, which assists children aged 0 to 18 years who need equipment to access educational programmes and is funded jointly by DHHS and the Department of Education;[353]
- Facilities Services Branch, Department of Education;
- Disability Services, which provides slippage funds for CES purchases on an *ad hoc* basis;[354]
- Australian Hearing Services;
- Orthotic Prosthetic Services; and
- St Giles Society.[355]

The Committee itself received submissions from a number of other organisations assisting with equipment and technology or providing other in-kind support on a volunteer basis.[356]

DHHS administers numerous other smaller schemes in addition to the CES, namely the:

- Spectacles and Intra-Ocular Assistance Scheme;
- Palliative Care Equipment Scheme;
- Home Oxygen Equipment Scheme;
- Non-Invasive Ventilation Equipment Scheme (CPAP);
- Statewide Lymphoedema Garment Scheme;

[352] Hinton, Teresa, *Forgotten Families: Raising Children with Disabilities in Tasmania* (Anglicare, Hobart, 2007), pp. 78-79
[353] Equipment and Technology Library, submission, p. 2; DHHS submission, p. 27
[354] \DHHS, submission, p. 23
[355] See also St Giles, submission, pp. 2-3
[356] Refer, for example, to TADTAS, submission; Variety, submission

- Statewide Breast Prothesis Scheme;
- Wigs Scheme;[357] and
- Spinal Account, for people who have had a traumatic spinal cord injury. Though comprising a "small group in terms of numbers", the need for aids is strong in this area, according to DHHS.[358]

DHHS stated in its submission:

> *"These [schemes] are managed by the Primary Health business unit, by the acute hospitals and by service agreements with non-government organisations."*[359]

DHHS provided the Committee with details of expenditure for some of these schemes in recent years, reproduced below.

DHHS Expenditure, miscellaneous schemes[360]
2004-2007, statewide ($)

Scheme	**2004-05**	**2005-06**	**2006-07**
Spectacles and Intra-Ocular	681,558	682,372	677,710
Lymphoedema Garment[361]	22,000 (north only)	50,000 (north and north west only)	84,000
Breast Prosthesis[362]	32,748	33,992, plus an additional 27,000	63,432
Wigs	-	-	42,660
Spinal Account	-	221,526	285,216

In its submission, DHHS also drew attention to an inequity between the CES and the Spinal Account in the area of continence aids, with clients of the latter having "unlimited, free access" to these aids and appliances. It also noted the existence of operational differences between Accounts in each region of Tasmania and the absence of statewide guidelines.[363]

9.3 Research and Development

The Committee was informed that research and development into equipment and assistive technology in Tasmania has been insufficient. The Committee was told that this situation is creating disincentive for private suppliers to participate in the Tasmanian market, possibly leading to a situation where some equipment has to be imported from interstate.

According to KW McCulloch, a technology supplier in Tasmania, funding for healthcare development has not been sufficiently directed into the disability sector:

[357] DHHS, submission, pp. 24-27
[358] DHHS, submission, pp. 21-23
[359] DHHS, submission, p. 24. Disability Services managed the Spinal Account until 2004-05.
[360] DHHS, submission, pp. 24-27 and Appendix D
[361] Figures for some regions/years were not available.
[362] Plus GST
[363] DHHS, submission, pp. 31-32

"As a result, concepts which have a community focus tend to be left behind; left out of the economic development 'machine', with private sector organisations left to bear the brunt of development costs. … With little or no government assistance available, there is barely any incentive for private sector organisations to conduct vital research and development into products and systems that can vastly improve the lives of people living with disabilities."

Catherine Merry (Allied Health Manager, St Giles) expressed concern that decreasing demand caused by funding shortages has impacted negatively on suppliers in Tasmania:

"There is a very small number of medical equipment suppliers in Tasmania and I know that in recent times some of those have been putting off staff. If we lose those suppliers and those agencies in Tasmania, we are dealing across Bass Strait in order to get equipment. To get equipment to trial with people, to get our back-up in service, it is a huge issue, so the lack of equipment funding has impacted on our suppliers as well."[364]

Pip Leedham (DHHS) said there had been an emergence of development of private equipment providers in Tasmania in response to demand.[365] She said that private operators are providing equipment to articulate clients who avoid the CES and look elsewhere for the products they need:

"There is a whole client group up there that is quite articulate and quite capable of sourcing out other sorts of things to support themselves. I do not think it is just the issue to do with the availability of the equipment scheme, I think it is the opportunity and the developments in technology as well."[366]

9.4 The Role of the Environment, Technology and Design

Some witnesses highlighted how environmental factors can unnecessarily disable individuals. One witness said the concept of disability is a reflection of our social values.

In a 2003 report on aids and the environment, the Australian Institute of Health and Welfare (AIHW) explained how disability and the environment are linked:

"Recognition of the environment as having a direct impact on the experience of disability is an important conceptual and practical step on the road to improving participation and the quality of life for people with disabilities. The provision of affordable aids and equipment, support arrangements in educational and workplace settings, mainstream education, accessible public transport and personal assistance all act to facilitate opportunities individuals to participate in the economic and

[364] Sertori and Merry, transcript of evidence, 28 April 2008, p. 15
[365] Leedham *et al*, transcript of evidence, 6 March 2008, p. 3
[366] Leedham *et al*, transcript of evidence, 6 March 2008, p. 3

social world. … Nevertheless, features of the environment may still act as barriers for different people in different circumstances."[367]

Peta Raison said the way houses are built creates unnecessary complications:

"We have to be much smarter when we are building things in our community buildings and in our homes. … It is basic, basic stuff, basic things of how you have a wash and go to the toilet is what we need to have all this equipment and stuff for. And it is really, really hard. The equipment scheme try very hard to have as much standard equipment as possible. You can never get enough; you are always running out of shower stools or something."[368]

Assoc Prof Christopher Newell (School of Medicine, UTAS) told the Committee that technology and design are reflective of social values:

"It is the technologies that we have that reflect our social values. The technologies say what is nice, normal and natural. We have adaptive technology, special technology, largely because we have not gone in for universal design. … These days what is very fascinating to see is that, whilst a variety of players have adaptive technology, the technological approach that really wins is the approach that recognises that we need to design for everyone."[369]

9.5 Prescriber 'Error'

The Committee was informed that some equipment might be prescribed in error or incorrectly. One witness attributed this to the difficulties of trialling equipment, though DHHS linked the problem to mistakes and inexperience on the part of some prescribers.

Robyn Sheppard (Australian Physiotherapy Association) said about 20% of wheelchairs and other items are inappropriately prescribed:

"In Tasmania we have a number of suppliers but they have a limited range of equipment to trial. That is often quite difficult when you are looking at customised equipment. That has led to, I would say, probably about 20% of wheelchairs or commode chairs or some other sort of aid being inappropriately prescribed."[370]

DHHS submitted:

"The role of therapists in assessing the client's needs for aids and equipment is critical to the use of the resources of the CES and Spinal Account. The number of clinicians who are relatively inexperienced and may not have the required skill to prescribe high-cost or complex equipment is an issue in the regions where new practitioners tend to

[367] AIHW, 'Disability: The Use of Aids and the Role of the Environment', August 2003, p. xi
[368] Raison, transcript of evidence, 20 May 2008, p. 46
[369] Newell, transcript of evidence, 20 May 2008, p. 57
[370] Sheppard, transcript of evidence, 20 May 2008, p. 35

take up positions. In these regions there is less capacity for senior practitioners to perform a mentoring role for newer clinical staff, leading to prescriber error in some instances."[371]

The submission also stated that the regional CES committees have operated as a "checking process, guarding against prescriber error", which has resulted in a "noticeable reduction in expenditure on expensive items."[372]

HON KERRY FINCH MLC
CHAIRMAN

Wednesday 19, November 2008

[371] DHHS, submission, p. 36
[372] DHHS, submission, p. 36

Appendix 1

Submissions

Submissions received were as follows:

1. Kellie Ashman
2. Robert Appleby
3. Margaret Osborne
4. TADTAS
5. Community Based Support South Inc
6. The Equipment and Technology Library
7. Anglicare
8. St Giles Society
9. Speech Pathology Australia (Tas)
10. Neuro Muscular Alliance Tasmania
11. Assoc Prof Christopher Newell
12. Felicity Lovatt
13. Soroptimist International (Federation of the South West Pacific)
14. L Rowe
15. Australian Association of Occupational Therapists (Tas)
16. Variety
17. Tasmanian Association of People with Disabilities and Their Advocates
18. Calvary Health Care Tasmania
19. KW McCulloch
20. Julia Butler-Ross and Tom Butler
21. Department of Health and Human Services
22. Independent Living Centre (Tas) [April 2008 revised edition]
23. Australian Group on Severe Communication Impairment
24. National Disability Services (Tas)
25. Confidential
26. Fronterra Australia
27. TasCOSS
28. Paraquad Tas Inc
29. Australian Physiotherapy Association
30. Tom Butler

Appendix 2

Witnesses

Witnesses appearing before the Committee were as follows:

Tuesday 6 March 2008, Hobart

- Pip Leedham, Wendy Rowell, Linda Osborne, Lee Parker, and Ingrid Ganley (Dept of Health and Human Services)

Monday 28 April 2008, Launceston

- Michael Sertori and Catherine Merry (St Giles)
- Karen Frost, Christopher Bryg, and Phillipa O'Connor (Independent Living Centre)
- Jane Wardlaw
- Belinda Hanson and Robyn Hanson (New Horizons Club Inc)
- Clive Stott

Tuesday 29 April 2008, Burnie

- Angela Dodd
- Grace Brown and Felicity Lovatt (Burnie and Devonport Special Schools)
- Steve Daley (Devon Industries) and Millicent Subonj (Multicap)
- Diane Ewington (Association for Children with Disabilities) and Gordon Patchin

Tuesday 20 May 2008, Hobart

- Peter Nute (Community Based Support South Inc) and Mary Guy
- Margaret Reynolds and Robyn Wilkinson (National Disability Services)
- Paul Duncombe (TADTAS)
- Megan Morse and Christy Donward (Calvary Health Care)
- Robyn Sheppard (Australian Physiotherapy Association)
- Peta Raison (OT Australia/occupational therapist)
- Derrick Harnwell (Speak Out Association of Tasmania)
- Assoc Prof Christopher Newell (School of Medicine, UTAS)

Appendix 3

Documents Received

1. Media release entitled – Disabled Scheme Budget Imbalance – dated 6 December 2007. Tabled 28 April

2. Extract from Independent Living Centre magazine dated spring 2005. Tabled 28 April

3. Book entitled – New Horizons Club Inc. 20th Anniversary. Tabled 28 April

4. Paper entitled Principles of an Effective Electronic Communication Device Scheme. Tabled 29 April

5. Community Based Support South Inc Annual Report 2007. Tabled 20 May