DisabilityCare Australia
Prosthetic Funding in Australia Overview

Background

Limbs 4 Life is the national body for amputees in Australia. We regularly undertake consultation with our stakeholders and are best placed to provide feedback (on behalf of the consumer) regarding the supply, manufacture and provision of prosthetics in Australia. Limbs 4 Life regularly engages with prosthetic and orthotic clinicians and currently co-shares with the Australian Prosthetic and Orthotic Association of Australia.

Funding streams

There is currently over twenty different funding streams for the provision of prosthetic equipment in Australia. These are made up of;

- State based motor vehicle and workplace insurance funding models
- Veterans Affairs (DVA)
- State based Health Department funding

In all states and territories of Australia funding for the provision of prosthetics is managed by an Artificial Limb Scheme (ALS) funding manager. There is no 'standard' funding scheme in Australia. Each of States and Territories has developed its own funding mechanism since taking over responsibility for delivery of the ALS, and they vary considerably.

The only exception to the above is in the state of Victoria. Funding for the provision of article limbs in Victoria is managed by each hospital facility. Funds are provided to the business unit of the hospital, for example Austin Health and then part of the funding allocation is distributed to the Prosthetic and Orthotic Head of Dept to manage (in the case of Austin Health the example of this would be Royal Talbot Rehabilitation Centre. There are currently twelve facilities in Victoria which have access to funding for the provision of artificial limbs to public patients; however this still remains a postcode lottery in that; it depends which facility an individual attends, on the kind of prosthetic equipment and suspension systems they receive.

Most jurisdictions fund the **actual cost** of parts and labour for a limb (up to some limit): actual component costs plus labour costs calculated according to a fixed schedule of hours for different types of work, multiplied by a rate per hour. The exception to this is Western Australia, which funds a fixed unit price for some typical limbs, regardless of the actual components used. Some challenges have been identified in implementing this system, namely that sub-standard components have been identified in some limb recipients, and a process of ongoing audit will be required to guard against this.

- Funding models are generally underpinned by some sort of maximum limit on what the scheme will pay. In WA this is explicit for some typical limbs – a fixed unit price is paid. In Queensland, a matrix is used to determine funding for each limb, which depends on limb type, client weight and mobility level.
- Many jurisdictions fund **silicone suspension** (the device which holds a prosthetic limb to the body) for some limb recipients, although the guidelines for who is eligible for funding vary widely. In South Australia, silicone liners are approved for 'probably more than half' of clients, compared to the alternative dated systems often provided everywhere else.
- Most jurisdictions have explicit guidelines on the timeframe they expect a limb to 'last' – typically this is three years, and funding approval may be required for replacement within this time.
- All States require that prostheses only be replaced when required, and not simply because the expected time period has past.

- Each state uses a list of approved componentry (as determined by the funding manager) however it is the policies which unpin the delivery of prosthetic equipment that outline what consumers can and cannot receive.

Several jurisdictions are investing in more expensive limbs and components for certain patients, to see if that improves value for money. For example, Queensland ALS has paid for more complex knees for younger, more active clients, as cheaper knees tended to wear out quite quickly (eg: 18 months) whereas they have been able to get up to 5 years out of the more expensive knees. A number of Victoria facilities indicate a reduced number of repairs and financial gains by investing in energy-storing feet, particularly for young people, and have recently started offering silicone suspension for interim (temporary) limbs, in order to get clients moving earlier and reduce the number of silicone liners (suspension systems) required in the interim phase.

In addition it is important to note that South Australia not only provides energy storing feet, they supply and manufacture multiple limbs (such as a shower/water leg) and in some cases recreational limbs. In all other states one only limb is supplied.

Equipment selection

Prosthetics are primarily determined using a grading system based on mobility and activity, for example;

- K1, Suitable for use on level surfaces at steady speeds. i.e. someone who only walks indoors.
- K2, Suitable for outdoor use but at a low activity level. Eg. Someone who manages steps and slopes but walks limited distances and may use a stick or other gait aid.
- K3, Suitable for general outdoor use, but not including sports and other high impact activities. i.e. someone who walks in most commonly encountered environments, at varying speeds, long distances when required and usually without a gait aid.
- K4, Suitable for high impact use. For those people who have unrestricted mobility and may impose higher than usual forces on their prosthesis, eg sports, manual work.

It is disappointing to note that some facilities will not provide components higher than a K2 rating leaving active amputees (and or potentially active amputees) often frustrated with the system due to continual breaking and snapping of feet, on-going repair work, regular time off work for maintenance and modifications.

Like many other areas of the disability community, funding for prosthetics has not been increased since 1998. The advances in technology have been outstanding over the past ten years, supporting on going health outcomes such as; fall prevention, energy storing and return, skin health and greater human biomechanical support. Considering the amount of energy amputees expend during the course of the day and or general ambulating, it is disappointing that only a handful of amputees can access this technology.

No areas of Prosthetics are covered by the private health system.

Aids and equipment

Currently aids and equipment which support outcomes of people living with limb loss can include partial funding for;

- Wheelchairs
- Mobility aids such as crutches and walking sticks
- Home modifications (grip bars in wet areas/shower stools)
- Vehicle modifications (left foot accelerators) and rarely hand controls

Like the provision of prosthetic equipment different states allocate different values of funding per item and delays in the provision of equipment is consistent across each state and territory, with the exception of South Australia.

In Victorian, delays in the provision of access to SWEP funding can directly impact an individual's health outcomes, leading to longer hospital bed stays, poor mental health outcomes and negative impact on physical health. While

SWEP indicate that the funding provided to hospitals (based on episode bed stays for amputees) have a small percentage (per bed stay) which should be allocated to the on-going purchase of assistive devices such as wheelchairs, to enable individuals to return home;

- there is rarely sufficient quantities of equipment
- discharge from rehabilitation to home is based on the individuals safety and hence lack of the provision of equipment can further impact patient based outcomes
- individuals must wait a minimum of 30 days post rehabilitation to apply for funding assistance
- requests for funding assistance can take up to 18 months
- if individuals chose to contribute total costs to each piece equipment SWEP cannot subsidize
- cheaper/inferior equipment products are purchased by individuals due to funding delays in an attempt to regain independence

The allocation of SWEP funding in Victoria has not been increased for decades.

Chronic Illness Comparison

Type 2 Diabetes and Vascular Disease (Chronic Illness) is the major cause of amputations in Australia. Nationally a limb is lost every three hours due to the impact of diabetic related foot disease.

In contrast the US Government allocates the following to reduce hospital bed stays, prevent the development of foot ulcers and additional health based complications caused by diabetic related foot disease.

- 2 x extra depth / extra width pairs of footwear per annum
- 2 x custom made orthotics per annum

This investment can save government additional costs on bed stays and diabetic related amputations and the cost of equipment such as wheelchairs etc.

In Australia the financial allocation on the public system for orthotics is minimal (approx. $200) and there is limited funding available for footwear.

Transitional funding

It will be imperative to have clear and concise guidelines regarding the transition from hospital based in-patient care and access to individual DisabilityCare funding. The main purpose behind this would be to ensure that individuals who are being treated an in-patients are not discharged from rehabilitation centres earlier than normally anticipated in order to activate individual DisabilityCare funding packages, and thus taking the financial onerous off the hospital based provider.

Current health based funding systems provide an interim (temporary limb) as part of their patient charter, access to physiotherapy and gait training, support from social work and occupational therapists. It is crucial that these services remain the financial responsibility of the health departments until such a time that the hospital discharge plan take effect. A clear line needs to be drawn in the sand outlining where hospital based funding ends and DisabilityCare funding commences.