Further responses to questions posed by Support at Home Team during meeting held 8th February 2023 with ATSA Suppliers

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Features of an assistive technology and home modifications scheme

What are your thoughts on this outline – what do you like, what concerns you, and what's missing?

Concerns raised in regard to the loan pool model in the outline:

ATSA members cannot support the proposed loan pool model given the significant negative impact it is likely to have the on the AT supply sector in Australia. These concerns are not new and have been previously raised by ATSA in the following written feedback to the Department:

- Response to Consultation Paper No 1 released September 2022
- ATSA Consultation input paper on GEAT Support at Home send 4th October 2022
- Summary of industry position on AGED Care AT Model sent 7th February 2023
- Response to Consultation paper on AT-HC released 22nd December 2022.

Key issues arising from the consultation on regional, rural and remote supply of GEAT.

- **Delay in the supply of AT**: This has been driven by the process and the time taken for an ACAT assessment to be completed and the time for the person's nominated package to become available. Once an item of AT is identified, regardless, if it is from a loan pool, hire or purchase, any delay in this point of the process, will be based on the fact if it is on the shelf ready to go or not, i.e., no relevance to the supplier source.
- **Delay in the supply of AT**: Delays in the supply of AT are largely driven by the lengthy process of obtaining a prerequisite ACAT assessment and then waiting for the older Australians nominated package to become available. Once an item of AT is identified, regardless if it is to be sourced from a loan pool, hire or purchase, any delay in the assessment process will result in a delay of receiving the AT.
- **Compliance with TGA**: There is a substantial risk around aged care funded reissued AT not being compliant with the Therapeutic Goods Act and Regulations. We understand that the TGA will be contacting Aged Care on this matter to ensure any reissued AT is compliant and safe for end-users.

  There is an elevated risk in a loan pool model in regard to the management of older AT. This is critical because repeated returns introduce risks of reliability over time. The consideration of the product life cycle for AT is also necessary for safe operational life of the AT and compliance with the TGA.
- **Impact on other Government Programs**: AT suppliers supply AT for multiple government programs with cross-subsidisation of funding between programs supporting sustainability. The removal of CHSP/HCP funded product sales for AT suppliers via the introduction of a loan scheme could foreseeably impact the sustainability of AT supply to other government programs. This does not appear to have been considered in the consultation documents to date.
- **Risk to SMEs and their clients**: Removing the sales and/or hire of AT from local suppliers, which in some cases contributes up to 25% or more of their overall business, could be the tipping point to closing a business. This would then result in loss of local services and introduce long delays for supply, maintenance/service of AT for older Australians and as noted above, NDIS participants. This is counter to the intent to speed up AT access.
- **Trial stock and service**: Thought needs to be given to the holding of trial stock to support quick delivery to the AT user to ensure it is cost effective. For example, would the supplier that provides the trial also be the provider if the AT is the correct one for the client and the price is

within the guidelines? As an example, will a supplier who travels for 2 hours from their base to trial say a $200 product have a guarantee of supply? Even if they are reimbursed for the time and travel costs to conduct the trial, smaller businesses still incur holding and other costs of the trial product, which are currently offset through a sale.

- **Supply of clinically safe AT**: A loans program will, in practice, provide clients only what is available rather than what is appropriate (this is the current approach that is applied by government state agencies), e.g.: Lift/recline chairs that are not the correct size for the client. The suppliers of AT already have AT available to hire and, if necessary, more equipment could become available if the government were to offer grants to smaller businesses to increase their hire fleets and storage facilities. It should be noted that sales made locally mean the supplier can manage repairs and maintenance for the end-user without the delay of waiting for a repairer to travel to the region, thereby reducing risk to the clinical outcome for older Australians. This also injects financial activity in local and regional areas.
- **Track record of loan pool schemes**: In Tasmania, the previous loan pool closed down and while there was an attempt to implement another system, it was not successful. The South Australian loan pool scheme also closed down and the private sector did not respond to the EOI to take over this scheme due to the risks with the business model not being sustainable.

  No scheme will be better able to serve local regional clients than the small businesses already in place, who have developed a sustainable business model that suits the local area which relies on a vested interest in providing good and ethical customer service pre and post-sale.

<u>Positive elements of the proposed outline:</u>

- **Wrap Around Services:** This are in already in place under the current CHSP and Home Care programs**.** Installations, delivery and set up in regional areas already occur without issue under the current system as does the maintenance of equipment.
- **Up-front Services**: We support the provision of up-front services which will provide the necessary AT for older Australians based on their needs and not whether they have saved enough in their package. This can still be provided by purchasing and/or renting from existing businesses – it does not require a new scheme or loan pool as it leverages on existing proven services.
- **Inclusions list:** We support the concept of an Inclusions List. This will provide businesses with information on which AT can be funded readily and is not limited to certain brands so that all suppliers can offer their products and services. Regional businesses purchase equipment based on local demand and what can be maintained through ready access to parts.

  The inclusions list needs to refer to The Australian Standard ISO 9999. Devices for people with sensory disabilities and communication needs should be covered in this list.

  It is noted that in the most recent edition of the Home Care Packages Program – Operations Manual (Version 1.3, January 2023) that section 9 – Inclusions and Exclusions has been revised significantly from the previous edition. There is much more detail on what may be included in a package and what may not be. On the supply of Assistive Technology in section 9.9, there is reference made to both the DVA Rehabilitation Appliances Program and the geat2GO program but only in reference to who may be suitable health professionals to prescribe different types of AT. Whilst this is a step in the right direction, there are several potential issues with making this reference to other programs.

  The DVA RAP requires that every piece of AT must be prescribed by a nominated health professional – each product category identifies health professionals that may prescribe the

equipment – some categories include a long list of professions, and some are very specific. The guidance on which profession may prescribe the AT is at the product category level – that is a good thing as it means that the prescriber is not restricted to a limited set of products. The point is that many low-risk items require prescription by a health professional when it could easily be self-prescribed by many people. Requiring a health professional to prescribe every single piece of AT would add significantly to the cost of providing the AT to the recipient and make it much more challenging to get it to them in regional and remote areas.

The DVA program then has 4 prime contractors, each have their own catalogue of products for those AT categories. The catalogues promote the prime contractor's own brands of AT at the expense of other brands. Theoretically it is possible for a smaller importer / manufacturer of AT to get their products added to those catalogues, but they first have to convince the prime contractor to add it and then it has to be approved by DVA which only happens once every 6 months. It is not conducive to making innovative AT available to people that may need it.

The geat2GO program also lists AT that can be prescribed by different health professionals but the list of AT is a very limited set of specific AT. It is limited to a relatively small number of very specific brand/models of AT – there is no scope to choose an item outside that list no matter how good it is and where it can be sourced from. The practice to date has been that for any single item of AT, only one of the geat2GO contractors will be approved to supply it even if all of them can supply it – it has been "first in, best dressed". It has resulted in situations where an assessor has prescribed 2 or 3 items of AT for an individual, but they are supplied by different contractors. This results in multiple delivery charges to the Department and also causes confusion for the recipient – it makes no sense to them that different items come from different suppliers.

Neither program allows for any form of self-prescription or prescription by anyone that is not a nominated health professional. There is opportunity for also allowing AT Mentors to be able to prescribe AT for recipient which would also improve the desirability of people getting the AT Mentor qualifications.

Any AT Inclusions and Exclusions list needs to take the best of these existing programs and ensure that it can be scaled to support the number of people that have the different Home Care Packages. Wherever possible, it must not be limited to a fixed range of AT products, and it must be easy for AT suppliers to have their products added to the range available for recipients.

At the AT-HM Consultation Sessions conducted in August 2022, a model for categorising risk of AT and HM was presented with 3 different levels of Low Risk, Under Advice and Prescribed. This model is certainly along the right lines and has the potential to address some of the issues identified above. However, so far, the Department has not provided any more detail on this model and it would seem prudent that this be reviewed in the near future by those organisations that will be working with it.

How could we ensure funding is targeted towards those with greatest need and minimise wasteful spending?

- **Other strategies to target those with greatest need and reduce waste**:
    - Any AT registered as a Class 1 medical device by the TGA should be scripted by an allied health professional to reduce the risk of waste by ensuring the correct AT is provided first time.
    - Communities of Practice will also be critical in minimising wasteful spending. Lessons learned in the NDIS have shown that where you have someone with a low level of

experience in recommending/scripting AT for their client/patient, they will tend to over order the amount of AT to be on the safe side and to mitigate any risk to the client or liability to themselves. Often this is done against the advice of the supplier who also has the experience to identify AT that is not a priority for that end-user.

- Refresher education and training on when AT is required and what type of AT is appropriate to meet certain needs. In our submission on the AT-HM Report issued by the Department on the 21st December 2022, ATSA outlined the training currently provided by ATSA and our members to allied health professionals, end-users and their families/carers.
- Innovation in AT can reduce the need for other services. For example, software for people who have dementia to remind them who to call, when to take medications etc can be a support to the older Australian and reduce the demand for 24 hour support services while creating a safe environment for the person.
- The process for the reissue and recycle of AT products no longer required by older Australians needs to be established. Across the country there are many AT suppliers who could collect this AT and return it to the originating supplier who then uses their skilled staff to make an assessment on whether it can be reissued or recycled. If it is the latter, then a number of AT suppliers already have existing agreements in place in the recycle sector. Financially, there could be a reimbursement formula to manage this process which would then minimise the risk of wasteful spending. Such a formula would consider the original supply price, depreciation of the device, cost to remove the device, cost of repairs/maintenance (if to be reissued) and transport costs plus income from re-sale/rental.
- Incentives for end-users to look after the AT they receive so that the device can be reissued with minimal repairs.
- Routine maintenance maximises the lifecycle of the product reduces waste and assist in the prevention of in use failure that could result in injury.
- To minimise waste, consideration of the option of government retaining ownership of AT with the suppliers providing the original supply, reissue and recycling services.
- It would be helpful to receive guidance on the volume and type of stock suppliers in area areas of smaller populations need to keep. For example, Tasmania has a small population of just over half a million people which presents some unique challenges.
- The inclusion of Telehealth would be beneficial to clients in areas of smaller or dispersed populations or where a person has difficulty leaving their home. There is a short supply of health professionals and a lack of experience and AT knowledge by some in regional and remote areas. Currently equipment suppliers provide training to experienced OTs so they can make an informed decision.
- Where an OT cannot travel to their client to do the assessment, local suppliers attend the client's home to assist the OT to remotely conduct the assessment with the client. This reduces the risk of clients receiving AT that doesn't meet their needs and ends up in storage in their home.

What are your views on fee for service, including with subscription, reimbursement and voucher options?

- **Reimbursement:** The guidelines would need to be clear, simple to understand and to follow with appropriate constraints to ensure the correct behaviours are achieved. There would be risk with reimbursements where older Australians buy AT not included in their plan or where an approved assessor/allied health professional has not assessed the suitability of that AT for the end-user. By using a registered supplier it would allow for appropriate governance of safe supply.

  It is to be noted that the ACCC is currently reviewing online platforms and one of the key areas of risk is the purchase of second-hand AT with a view to reimbursement by the Scheme. Where

the seller is an individual and not a registered business, there are no consumer guarantees for the purchaser. Additionally, the AT has had no safety check by an experienced technician and no infection control undertaken. We understand the TGA has/will raise this matter with the ACCC.

A program of reimbursement for small purchases by a package recipient could facilitate timely delivery of AT to those individuals – they can buy it as soon as they recognise they need it. It also fully supports the principle of Client Directed Care (CDC) – they get to choose what they want and who they get it from.

A challenge with reimbursement, of course, is that the recipient has to buy the item up front which may not be feasible for many people. They might be able to afford to buy an item worth $20 but not an item worth $200. Reimbursement should be an option for those people that can afford it but not a requirement for everyone with a HCP.

Vouchers: A Voucher scheme could also enable timely delivery and support CDC whist also addressing the issue of affordability for those with limited funds. Vouchers should also reduce the risk that people might buy inappropriate AT or non-approved AT because they should only be able to use them at approved suppliers. Many of the other issues raised above for reimbursement also apply to vouchers.

Subscription: Where the AT is a consumable item, then a subscription scheme would also support this. However, it is unlikely to be applicable to much of the AT supplied by ATSA members.

Can you provide examples where reimbursement would be a preferable funding option to support an older person?

Example 1: As noted above, Reimbursement to the end-user is best suitable when they can afford to buy the items up front. It should always be an option no matter what as someone may well need to urgently buy something when they are away from home, or an item unexpectedly breaks. It would disadvantage someone that had to suddenly replace their 4-wheel walker when they were away from home and not be able to claim reimbursement for the new one.

Example 2: Reimbursement to the supplier may be an option where AT has to be collected and reissued for another end-user or recycled and the supplier does not own the AT.

Under what circumstances would a supplementary grant be required?

- **Clarification on pricing in Central database**: When a supplementary grant is required may depend on what is included in the price on the proposed central database. If the intent is to have the price without transportation or any of the wrap around costs, then the grant would need to also cover those costs.
- **Travel**: Travel to clients living in rural and remote areas that exceed a certain agreed distance would need a supplementary grant.
- **Collection of AT**: When an item is collected for reissue on behalf of another supplier/recycler. This model needs to create incentives for suppliers to support each other thereby creating efficiencies wherever possible.
- **Expansion of stock/services:** Supplementary grants could support local businesses to extend their hire fleet, storage etc.

- **Equity:** The offer of supplementary grants should be equitable to all suppliers and not disadvantage small businesses.

Are there other services and circumstances that would be not be sufficiently supported through these funding mechanisms?

- **Flat packed AT**: The current geat2GO program requires suppliers to provide AT flat packed – there is a single delivery fee for every item no matter what size the item is, how heavy it is and how far it has to go to be delivered. Under this program, suppliers are paid the same delivery fee irrespective of whether it delivered is across the street or at the opposite end of the state. Currently there is no payment for any form of wrap around installation or adjustment service that should be provided with such equipment. The client is left with a flat packed piece of AT as well as the packaging. This practice is contrary to ATSA's code of practice for its members.

Reflecting on your experience

What examples can you share of how access to AT-HM has been improved in regional and remote areas?

Example 3: Suppliers provide education on AT to OTs working in regional, rural and remote areas.

Example 4: Suppliers work collaboratively to ensure correct equipment and a range of equipment is available for participants.

Example 5: Suppliers have showrooms with a range and variety of equipment. They also have delivery vans in which to take a range of AT to clients' homes if they cannot attend a showroom centre.

The AT Supply industry overall has been able to grow throughout Australia because of the expansion of programs such as the Home Care Packages. The CDC principle of allowing HCP recipients to choose who they want to be their third-party supplier has meant that there has been more market for the regional AT suppliers to grow. The sheer number of AT suppliers through Australia has grown in recent years. The number of suppliers importing products into Australia has also grown significantly which has introduced some innovative products. It is now feasible for some very small businesses to import a small range of products and distribute them throughout Australia. There has also been a significant maturity of many of the suppliers, including in regional areas, such that they are able to have showrooms that are both more welcoming and more accessible. It is now very common for AT supplier showrooms to be in retail precincts rather than in industrial precincts of cities and towns.

As noted at the start of this document, any changes to programs such as HCP that means that local suppliers are no longer involved has the potential to affect the viability of those suppliers and potentially means that they may cease to operate.

How could access to AT-HM be improved for people living regional and remote locations? How could the Government support this?

- **Education for consumers, assessors and prescribers:** It has always been a challenge for people who require AT to know what is available. It has also been challenging for assessors and prescribers to know what is available. There is an extensive range of AT available today and the range is growing all the time. Information on the range of AT would improve access.
  Many prescribers have little time or incentive to learn about AT that is available. Many prescribers settle on their "preferred" products and will not even consider alternatives that may be equally as good and/or accessible for their clients. It can easily end up with recipients getting fully scripted manual wheelchairs and high-end pressure care cushions when off-the-shelf options may well be quite appropriate for the recipient and far less expensive leaving more money in the package for other needs.

  Retailers that do not specialise in AT do not fully understand the risks they might be exposing both the clients, and themselves to if they do not understand the suitability and limitations of equipment that they supply. For example, general retailers that might sell adjustable beds or recline & lift chairs, are unlikely to have mattresses that satisfy the pressure care needs of all HCP clients; they may sell adjustable bed bases that cannot have rails safely fitted to them to provide ingress and egress; may not have recline & lift chairs providing tilt-in-space seating or that can properly accommodate pressure cushions to reduce the risk of pressure sores; or chairs that support the postural requirements of all users.

  Education is needed for the community on what is available and why/when they need to use specialist AT suppliers to ensure that HCP recipients get what they need and reduce the chance of wasted spending.

- **Provide more guidance to HCP managers:** The HCP program already requires HCP managers to support CDC and allow recipients to choose who their third-party suppliers might be. This could be enhanced by providing more guidance for the HCP managers to encourage (not dictate) supporting the local AT suppliers rather than just using the "big guys" in capital cities that can and do spend a lot of money on advertising in many different formats.

- **Utilise the skills, facilities and AT available from existing suppliers**: Access can be improved by supporting existing suppliers to grow their access in regional areas through an inclusive and competitive AT supply model that leverages off existing AT providers. This creates efficiencies and most effectively utilises existing resources. For example, AT suppliers have established networks, showrooms, trained staff and vehicles in regional, rural and remote locations and the capacity to visit older Australians in their homes. They also provide the wrap around services for older Australians and the maintenance and repair services to maximise the life-cycle of the AT.

  As AT suppliers form part of local communities they are also best placed to respond and adjust to the needs of older Australians in these areas.

  The Department of Health and Ageing also needs to address the issue of compliance to the TGA regulations in the supply of AT to older Australians. This has not been mentioned in the proposed model and is a complex area. ATSA's members have existing processes to ensure their new and reissued products are compliant with the TGA's regulations.

- **AT for trials:** Appropriate incentives for AT suppliers to participate in trials would ensure the sustainable provision of trials in regional, rural and remote areas. Existing AT suppliers are best placed to provide trial for equipment in more rural/remote areas where longer travel time is required from a regional or city centre. To create efficient use of time and travel, suppliers co-ordinate as many necessary visits to other clients, OTs and other agencies in the same area as

possible. Funding to cover the administration time in addition to the travel and staff costs, for pre-approved visits needs to be included as part of the cost for these trials. This could be through reimbursement of expenses or grant funding. The supplier selected to conduct the trial should also be the supplier of the AT if the trial is successful.

Some suppliers currently allow OTs to borrow smaller items for trial reducing the trial costs. Clarity on who has the liability for any damage or loss of such AT should be considered in the model. Note: Larger AT and more specialist equipment requires the AT supplier to do the set-up.

- **Safe processes to support older Australians and their families:** AT should not be delivered as a flat pack without a booking with the AT supplier to set the device up in a safe and timely manner. Note: Thought also needs to be given to who removes the packaging – this has been daunting for some older Australians and should be included in the planning for the set-up of the AT.

- **Improved communication and efficiencies through online portal**: Providing older Australians, AT suppliers, assessors and allied health professionals with access to an online portal to track requests for AT and the status of approvals. This would create transparency and enable suppliers to better manage stock levels and bookings with clients. Many suppliers do a round trip to see multiple clients, therefore, knowing where and what type of AT is required early in the process improves the planning logistics and timeframe of supply of AT for trials and longer-term use.

- **Supplier Certification needs to go to local level:** If any form of supplier certification is introduced, then it needs to go down to the local level. For example, a national AT Supplier can easily say on their web site, that they have service technicians fully trained and experienced in the most complex of products. However, their regional showroom may have never even seen that item and may not even have a regular service technician based there. Just because head office can service any product does not mean that a regional showroom can too.

- **AT Prescriber Certification:** Currently most AT is prescribed by Occupational Therapists. There currently no recognised specialty of AT Prescriber for an Occupational Therapist. In many professions there are education and experience requirements that must be fulfilled before someone can call themselves a professional. Particularly medical professionals – even being a GP Doctor requires specific training after graduating medical school. Today, as soon as an Occupational Therapist gets their AHPRA registration, they are deemed fully capable of prescribing any type of Assistive Technology or Home Modification.

What mechanisms should we introduce or maintain to support providers in regional areas?

- As previously stated removing the loan pool model from the scheme will ensure suppliers in regional areas are not forced to significantly reduce or close their business.
- The supplier selected to conduct the trial should also be the supplier of the AT if the trial is successful. This allows for the trial AT to remain with the older Australian and is more cost effective.
- The supply of AT is a competitive market, however consideration needs to be given to supports for smaller suppliers to provide the local showrooms and local wrap around supports to older Australians in their local area. Grants may be one mechanism.

Examples of issues raised in this response

Example 6 – relating to possible "loan pool"

A bed was delivered to a client in a regional area but not supplied by the local AT supplier. On a Friday afternoon before a public holiday weekend the bed handset stopped working. The client was quadriplegic and required for medical reasons to be lying flat throughout the night, with the adjustable bed used to assist with repositioning him through the night. This client only had his power wheelchair to spend the weekend in, if he wasn't able to be assisted to bed.

The local supplier was advised of the situation and attended the site with spare handsets – none of which were compatible with the bed supplied. The local supplier then removed the person's bed and put in a loan bed. Had the bed been supplied locally, the supplier would have had the right parts in stock to make the necessary repair.

This highlights the risk with loan pools as local suppliers may need to undertake the repairs and maintenance but are not likely to have the parts in stock.

Example 7 – relating to possible "voucher" system

A client chose to purchase a lift/recline chair from a major furniture retailer. The retailer's staff were not trained in how to size someone in a lift/recliner or what may be important for an older Australian or person with a disability in choosing this type of equipment.

When there was a power failure locally, the client was stuck in the full recline position and discovered that the lift/recliner had no battery back-up.

The carers called the local supplier as the client needed toileting and the local AT supplier was on site within 10 minutes with a loan hoist so the client could be lifted out of the chair.

This example shows the risk that need to be considered when implementing a voucher system and the need for registered AT suppliers to have skilled staff. It is important older Australians are provided with the appropriate assessment and skilled staff who understand AT inform the selection process.

Example 8

An Aged Care provider selected a hoist based on the cheapest of 3 quotes. This quote did not include the costs of the trial or wrap around services. The local supplier was the one who conducted the trial in a private area of the regional showroom to preserve the client's dignity and had the wrap around services for the client who requested the local supplier. These were not considered in the selection of the AT and placed the demonstrating supplier at a commercial disadvantage.

This highlights the need for clarity around trials and wrap around services as part of the overall service based on the needs of older Australians.