REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO THE PROGRAM OF APPLIANCES FOR DISABLED PEOPLE

Uncorrected proof

———

At Sydney on Wednesday 24 October 2008

———

The Committee met at 9.30 a.m.

———

PRESENT

The Hon. R. M. Parker (Chair)
Mr I Cohen
The Hon. G. J. Donnelly
The Hon. M. A. Ficarra
The Hon. K. F. Griffin
The Hon. C. M. Robertson

CHAIR: This is the third public hearing of the inquiry into the Program of Appliances for Disabled People [PADP]. The Committee welcomes the return of representatives from New South Wales Health. The Committee has received evidence from a number of witnesses since the representatives from New South Wales Health last gave evidence before it and requires clarification on some matters.

The Committee has resolved to authorise the media to broadcast by sound and video but there are guidelines as to be observed. Committee members and witnesses may be filmed or recorded but the people in public gallery should not be the primary focus of filming or photographs. The media must take responsibility for what they publish and what interpretation they place on anything that is said before the Committee. If anyone has messages for Committee members they can pass them through the Secretariat staff or the attendants. All mobile phones are to be turned off. Would anyone with a data-receiving device please keep it away from the microphones because of the interference with the electrical equipment.

DR RICHARD MATTHEWS, Deputy Director General of Strategic Development, NSW Department of Health, and

MS CATHERINE LYNCH, Director of Primary Health and Community Partnerships, NSW Department of Health, on former oath:

CHAIR: Dr Matthews, do you wish to make any brief comments before we begin with questioning?

Dr MATTHEWS: Thank you for the second opportunity to appear before the Committee. I am sure by now the Committee has had a chance to review the audit of the area health service PADP lodgement centres report produced by Oakton. As I mentioned last time, the results have only recently been finalised. We are pleased that the report supports the key recommendations of the review of PADP including consolidation into a single statewide service. We have noted that the auditor has identified significant inconsistency in the quality, efficiency and accountability of service delivery amongst the various lodgement centres. We are very keen, as part of the Enable process, to remove those inconsistencies. Small discrepancies in budget allocation have been identified and will be addressed. All these issues will be addressed through the reforms currently being implemented through Enable NSW.

Throughout that period we will continue to consult with clinicians, consumers and advocacy organisations and suppliers to ensure that services are not disrupted. It is also important to highlight that in metropolitan and rural areas clinical services are not being centralised as part of PADP. Clients will continue to see local health workers, equipment repairs and maintenance will continue to be done locally, and equipment loan pools will continue to operate from local hospital and community health centres. The program needs to be improved to make it better, fairer and simpler, and we believe that the partnership with clinical services and clients will enable us to do this. We have read through the transcripts of evidence and we have noted that there are a few points that require clarification. With the permission of the Committee I would like to table this document that relates to a number of questions that have been asked and adds clarification in writing for the Committee's benefit.

Document tabled.

CHAIR: Without seeing the clarifications, the Committee may ask questions that relate to those. My first question to you is one that I should have asked in the first instance. From a lot of the witnesses before the Committee there has been support for the centralisation of the lodgement centres of Enable NSW. I know there is a need for consultation but I do not understand why there is such a long drawn out process when there is agreement that this should happen. The length of time seems quite extraordinary. Would you please explain that?

Dr MATTHEWS: You have heard in evidence how many lodgement centres there are currently and their location. There are a number of things that need to happen with each centre in order for this to take so long. In each of the 22 centres we have to write letters to clients regarding the changes. We need to hold information and education sessions for clinicians regarding the new service. We have to talk to non-government organisations, general practitioners, and all the service providers regarding the changes. We need to standardise the supply guidelines, the business processes and application procedures. We need to process and relocate the existing file—there are a total of about 150,000 existing client files that need to be gone through and relocated. There are multiple databases, and we are implementing a new single information technology system—phase one is due in April 2009. This system has been specified and designed specifically for this purpose. We will need to

extract the client data from the existing databases and transfer it to the new system. We need to allocate stock equipment to clients, equipment loan pools and web recycling. We need to deal with the issues of relocation and redeployment of staff—employees of area health services who may need to be relocated in other jobs within the area.

The clinician training around the new processes is going to take two staff a period of two to four weeks to plan, prepare and implement, which is 32 weeks across all the area health services and non-government organisations. We are going to have a designated team that will move from centre to centre to do this. The process will commence in January with the first centre and will take a period of time because of all those complex issues of existing files, databases and changes in management processes. We want to be certain that we get it right.

CHAIR: Do you have a break down of how the $11 million top-up funding received was disbursed?

Dr MATTHEWS: I think we do. As at 30 June the total waitlist, in dollar terms, was $7,454,817 to the best of our knowledge from available data. So despite the fact that obviously the waiting list gets added to on a daily basis and will continue to do so, already there are signs emerging, because there has been a fairly broad announcement that there is additional money, that the rate of new additions to the waiting list is actually increasing.

We have allocated, or we are allocating, money to area health services in quarterly allotments, in addition to the usual budget, to allow lodgement centres to manage the workflow related to these waiting lists. So $2,861,480 was allocated in August. There will be a further allocation of $2,043,983 at the beginning of November. Following the August allocation, because of some of the issues raised in the audit, the lodgement centres are now being asked to provide line item acquittal for all expenditure.

CHAIR: I guess what I am wanting to get to the bottom of—and perhaps you can take this on notice—is just how much is being disbursed and how much is being used in administration and other costs. I want to know how much actually gets to the point of the objective, which is to reduce the waiting list. How much in dollar terms gets to that specific practical position of providing equipment to people?

Dr MATTHEWS: It should be all of it. We are certainly not keeping any of it centrally for administration.

CHAIR: Thank you.

Dr MATTHEWS: In terms of the administration locally, that administration is in place. Clearly over time, if the volume of work increases, at some point you have to have additional administrative staff, but at this stage all of that additional money should go to equipment.

CHAIR: If you could take that on notice and give us a breakdown, that would be helpful.

Dr MATTHEWS: We will give you a breakdown by area health service.

CHAIR: Thank you. One the question I have, and I know everybody has lots of questions in terms of the actual cases that came before us and some of the examples, is that I know that people who live under the care of the Department of Ageing, Disability and Home Care [DADHC] in a group home are not under the Program of Appliances for Disabled People [PADP], and they have a budget of something like $2.6 million across group homes and residential services to provide equipment, such as the same sort of equipment that is provided by the Program of Appliances for Disabled People.

They do not have a waiting list like the Program of Appliances for Disabled People has. How do you justify the difference between those who are being cared for outside the Department of Ageing, Disability and Home Care provision and who would be cared for by carers in their own community or through self-sufficiency, who have a huge waiting lists for all sorts of things and who have to go through all types of hoops with occupational therapists and backwards and forwards for treatment, compared with those who are in a group home or are receiving residential care and who do not have any waiting lists for any of those provisions? How do you justify that difference?

Dr MATTHEWS: The first thing is the separation: we do the broad community and the Department of Ageing, Disability and Home Care provides services for those in group homes. That is a historical separation. You could argue that the Department of Ageing, Disability and Home Care has a level of responsibility for those people who are in its full-time care, which is similar to the level of responsibility that we have for people in hospital, but their cohort in a sense, is a finite one, albeit potentially a growing one. The demand for appliances in the broader community is a much deeper, longer, broader and more varied one. I guess the real question you are asking me, if I may be so bold, is: Why is there a waiting list at all for the community?

CHAIR: It is that. The comparison is between a 10-year-old in a group home situation who has no issue in terms of waiting for a wheelchair for months and months and months and having to go back to the manufacturer because a footrest is broken and experiences no difficulty in getting new equipment, whereas another 10-year-old child in exactly similar circumstances who is being cared for in a home, according to the evidence we have been given, is in a completely different situation. They have the same needs, they may have exactly the same issues and perhaps they were born with the same genetic issues or problems, yet there is a vast difference in terms of their ability to get appliances. How do you justify that difference?

Dr MATTHEWS: In the broader sense, I guess I cannot justify it. I think we would all agree that people with disability should receive the aids and appliances they need in as timely a manner as is possible. There are two aspects to our waiting lists. I have suggested, and the team has agreed, that if we are enabled, we will change the waiting list to two parts. Those who are waiting to be seen and assessed will be one group, and there is a group on our waiting list who have been seen and assessed, but are waiting for sometimes fairly complex pieces of equipment to be manufactured and fitted. In all honesty, I cannot provide a justification for people waiting.

The only justification I can provide is that we have a budget, as indeed we have for the whole of the Health endeavour. The budget comes from appropriation from government. We have to make some decisions about relative location across the $12.5 billion of that budget. It is not the case that there is money held back somewhere. All the money is spent. As is well known from the press, in fact last year the money was overspent. It is actually a question of the relative allocation of resources.

CHAIR: You can see the point, can you not, of the parent caring for their child who is on a waiting list for incontinence pads and is having all sorts of difficulty trying to get those things, as opposed to a child in a group home situation where that difficulty does not exist?

Dr MATTHEWS: Absolutely.

CHAIR: That does not seem fair, and that cannot be a reasonable situation under any circumstances, can it?

Dr MATTHEWS: And that is why we argued, and were successful, for that fairly large allocation of $11 million, albeit one off, from two Ministers—to attempt, as far as is possible, to clear the waiting list. As I said at the last hearing, the gap between funding and demand will be partly picked up by our efficiencies—I have no doubt about that—and some of the waiting times will be improved purely by efficiencies. There will then emerge the difference between the budget and the demand, and that will need to be the subject of growth funding applications in the same way that the rest of Health is.

The Hon. MARIE FICARRA: I will take up the point about the $11 million top-up. I know it is being rolled out in proportion, but how is it being prioritised? Is it purely by time on the waiting list, or are you looking at each case in terms of its urgency? How are they rolling out the money?

Dr MATTHEWS: The money for the equipment will be rolled out in the usual way. This simply adds to the available amount of money. This additional amount of money will be treated no differently to the existing budget. The area health services and the lodgement centres will attempt to work their way through the waiting list using the usual processes of prioritisation. It is no different, if you like, except for the change to enable business as usual with additional funds.

The Hon. MARIE FICARRA: You mentioned the usual process of prioritisation. Are there clear guidelines for how you determine this prioritisation method? The only reason I ask is that we heard from many witnesses that different interpretations, on advice, were given out to clients by lodgement centres. I am just wondering what process you have for prioritisation. Is it documented?

Dr MATTHEWS: It is. It is fair to say that the review found that because each area health service—and you will remember that until recently we had 17 and they have been amalgamated to 8 geographic areas—had developed somewhat different processes. We found that in some areas the waiting list and waiting times were quite short and in other areas they were much, much longer. Much of that was historically based and, to some extent, due to the relative resource-rich versus resource-poor areas and to the tyranny of distance geography. We have looked at a study to devise a specific prioritisation tool for PADP as a whole with the new system. We cannot really develop a single tool until we have the standard prescription processes worked out and identified. We have found through the review and through a review conducted by some occupational therapists and published in their journal that there is a fairly significant level of what is known as equipment abandonment because people get equipment and for various reasons it just does not suit. There are many reasons for that and it has to do with the relative skills of clinicians, the varying prescription processes.

So the first step is to improve clinical skills, to standardise prescription processes and then to progressively implement a standard single tool for prioritisation. So, broadly speaking, what that will mean is that people requiring life-sustaining equipment will receive it immediately, for obvious reasons. Examples of that are around the ventilator-dependent quadriplegia initiative, certain people requiring enteral nutrition. They will obviously receive it immediately. The next priority is people who require equipment that prevents injury or illness to themselves or carers. Equipment that is required for daily living will be funded next, followed by duplicate equipment when clinically appropriate. Over this process we will have the whole rollout, consolidation and standardisation completed by the middle of 2011. We will give a very transparent process of prioritisation and a very transparent process around the acquittal of all the available funds.

The Hon. MARIE FICARRA: You did not mean 2011, did you?

Dr MATTHEWS: That is the time when the final one of the existing lodgement centres, the existing 22, will be consolidated into the centre. That is the time frame for the final process. The standard prescription process and the prioritisation standardisation will be finished well before that.

Ms LYNCH: If I could add to that, a trial of those new prescription processes has already been completed and we have been working with lifetime care and support around the appropriate prescription and the appropriate level of skill needed by the prescribers for different pieces of equipment as well. We think that will also minimise some of the wastage by stopping inappropriate prescription. Within that as well, we ask that clinicians engage quite closely with the clients. One of the reasons why equipment is abandoned is because clients were not consulted adequately enough. That would be addressed as well. The other thing is the training of people and carers in the use of equipment will be part of that process, as well as evaluations. So going back and seeing did our processes, our prescription, our training, our engagement with the clients work as well.

The Hon. MARIE FICARRA: As the rollout continues, as you said, because of the publicity and communication involved, a lot of people perhaps were not approaching the program before for whatever reason—giving up, not knowing about it, being frustrated. Will you be reporting back as to the adequacy of the $11 million? It could be as you roll out you will get many more on the waiting list. There must be an incredible unmet need out there that we still have not tapped into. Is there going to be a process for evaluating, coming back and reporting and perhaps asking for additional funding? This $11 million may be just a stopgap to deal with what we think is out there, but it may not be adequate.

Dr MATTHEWS: That is absolutely right. As I have said, with the efficiencies there will be an increase in the amount of the budget that is actually spent on equipment and a decrease of the amount that is spent on administration. But you are absolutely correct: there is no doubt that there will still be a gap between funding and supply. In terms of the unmet demand out there, I think it has got a number of features, some of which are very worrying. Firstly, there are clearly people who are potentially eligible who are currently purchasing their own equipment. How big is that group? There is no way of knowing. Secondly, there are continual improvements in the quality and hence generally the expense of the sorts of equipment that assist people with disability. It is what I call the Stephen Hawking syndrome where you can have someone with a very, very profound disability who is assisted in being a highly productive member of the community contributing to scientific endeavour at an extremely large cost. So between unmet demand, the likelihood that the quality and cost of aids available will increase—and you only have to look at wheelchair technology, for instance, to see an example of that—and, of course, the fact that medical science means that many people with significant either catastrophic injury or disability from other reasons are now surviving who previously did not

survive, the future demand for this particular form of assistance is unquantifiable and will be a problem for every government at every level going into the future.

The Hon. MARIE FICARRA: In relation to enteral feeding tubes, we were alarmed to know how little was supplied on a daily or weekly basis from a hygienic, safety point of view. I think we were all left gobsmacked about what could happen if an infection occurred, let alone the health of individuals and the cost to the system because of the inadequate provision of enteral feeding tubes.

The Hon. CHRISTINE ROBERTSON: The question leads to whether there is uniformity in the provision of enteral equipment. We heard about one area. Is it just in one area that people are supplied with only one a week or one a fortnight, or whatever the dreadful story is? I am told it is three.

Dr MATTHEWS: It is the responsibility of the Therapeutic Goods Administration to determine standards for these sorts of pieces of equipment. So that their remit extends beyond drugs to things like cardiac catheters and to these disposable bags and feeding tubes. There are some items that are labelled single use only and there are others that are labelled single patient use only, which means that they can be used more than once by the same patient.

The centres have their own supply guidelines. They are not standard at the moment; they should be. There is also the issue that the Therapeutic Goods Administration [TGA] guidelines cover health workers but do not cover people using that equipment themselves. In other words, if one of our clinicians goes into a home and connects something, that particular endeavour is covered by the rules of the Therapeutic Goods Administration. If I am at home and I am doing that myself, or my carer is, then they are not. That is an issue that needs to be thought about by the Australian Government because, clearly, standards should be uniform. The Therapeutic Goods Administration is a Commonwealth responsibility, and that is an anomaly.

CHAIR: In terms of that, what representations are you making to fix that anomaly, because it is a pretty concerning situation? It has been identified; what is happening about it?

Dr MATTHEWS: We have made—"we" being the various jurisdictions—a number of representations about similar sorts of issues. There is great debate about cardiac catheters, and I do not want to digress, but all the clinicians argue that they can be reused; the manufacturers stamp them "single use only". Where does the truth lie? Nobody wants to do the trial. So in many cases it is not absolutely clear-cut where the safety issues begin and end in terms of reusing and how they might be cleaned and sterilised, so we obviously have to rely on TGA guidelines. But we have made submissions and we will make a submission on the basis of this anomaly. We have not done so as yet but we will.

CHAIR: I think our Committee is very interested in this issue in particular.

Mr IAN COHEN: Dr Matthews, at your last appearance you stated an openness and willingness to return to the Committee and I thank you for that. It is not an easy task and it is appreciated. Following on Ms Ficarra's question about the application prioritisation process, is it not correct that there has been a policy directive in place since 2001? Why is this not being followed and why cannot the area health service follow this document?

The Hon. CHRISTINE ROBERTSON: Have you got any more details about the policy?

Mr IAN COHEN: Not in front of me now, but perhaps we could come back to it or perhaps Dr Matthews could take it on notice.

Dr MATTHEWS: I will have to take it on notice. I am afraid NSW Health has a large number of policies and I cannot keep them all in my head.

Mr IAN COHEN: Ms Bronwyn Scott gave evidence that hospital administrators work with local PADP lodgement centre staff. Can you outline how this works, when the evidence of a number of people before this inquiry has stated they have difficulty contacting PADP lodgement centres?

Dr MATTHEWS: The lodgement centres should be easy to contact.

Ms LYNCH: I can answer. I cannot specifically address Bronwyn's link between the hospital administrators and the PADP admin staff. We are also aware that there are some problems contacting individual lodgement centres, and one of the things that is being done in the centralisation is that they will be that single point of contact. And, as we said, we will have extended hours on that as well. Some of the lodgement centres at this point in time have low levels of staffing, which we want to bring to that central level. We do have a 1800 number that can be used centrally, which is already set up in Enable, and if there are particular problems with individual lodgement centres then at this point in time they are centrally working with triage or working with those calls to make sure that those people are linked to services.

Dr MATTHEWS: I take that sort of thing quite seriously and I understand that in some places at some times we can be difficult to contact in all sorts of ways. We have a very clear complaints handling policy and we are happy to table what that is, but each area health service has a process that if anyone has a concern or a complaint they have to get a response within, I think, three days and a resolution within 30 days of whatever the issue is. So if there are any individual instances then we are very happy to take them and take them up with individual areas.

Mr IAN COHEN: In terms of the cost of developing the new prioritisation tool, I understand about $100,000 was paid to Wollongong University to develop the prioritisation tool about three or four years ago and I understand this was aimed at the local area health services there but is not used. Would you have any comment on that?

Dr MATTHEWS: I do not have any specific knowledge on that particular contract but I will be happy to take that on notice.

Mr IAN COHEN: In the Oakton report, page four, it states clearly that oxygen expenditure was not treated correctly. How did certain area health services spend PADP funding on the home oxygen program without EnableNSW or the Department of Health becoming aware of this "incorrect" treatment, if that is a fair way of stating it?

Dr MATTHEWS: I think the first thing is that the level of departmental scrutiny on area health services does not, as a matter of routine, extend to line items in individual journal lines down to this level of detail. We expect that these sorts of things are, for obvious reasons, managed locally. However, it is because of this sort of concern and because of the recommendation of the review that we conducted the audit, and from time to time—as is the case with all public organisations—we conduct audits, both planned and random, of activity to check the compliance. The audit found that there were potential anomalies within an amount of budget equal to 2.9 per cent, which is not a significant amount but, nevertheless, a concerning amount. Some of it was in relation to things such as the Bathurst Seating clinic and the home oxygen, which some people might have legitimately argued were to assist with disability, and there may have been some confusion locally.

Mr IAN COHEN: Is that not clearly a health department prerogative? There may be that misinterpretation but is it not a health department responsibility?

Dr MATTHEWS: Absolutely. That is why, as a result of the audit, I have written to all the chief executives with what you might call a please explain letter, and unless the chief executives can demonstrate that what is in the audit is incorrect, then they will be directed to return that money to the PADP. That has been very clear.

Mr IAN COHEN: Does that request to check and, if necessary, return the money to the PADP, go back to 2001? Because I understand that is the point when the original directive was made. Is that not correct?

Dr MATTHEWS: Again, I cannot remember when the directive was made. But I would note that the home oxygen service expenditure against PADP has decreased considerably so that in 2006-07 it was only $47,000. There has been communication saying that that is contrary to the previous directives and that it must cease. For the period of the audit, unless chief executives can demonstrate that what has been found is incorrect, there will be a directive to return that money to the PADP budget.

Mr IAN COHEN: Given that and your additional recent understanding of the situation as a result of the debate we have had in this inquiry process, is it not fair to say that Enable NSW's supervision of PADP lodgement centres has been lacklustre?

Dr MATTHEWS: No, I think that would be a little unfair given that Enable NSW has only recently been set up and the specific purpose of doing the sorts of things that it does has led to this inquiry having the information that it does. I would argue quite the reverse: That Enable NSW is on the road—I accept that it is a road of a little length—to resolving the majority of these issues. It will not be able to resolve the overall resourcing issue because in the end that is a matter for government. But it will resolve the issue of these irregularities, which, after all, we have uncovered and we are addressing. The issues relate to consistency of the prescription, the equity of provision within existing resources and all the things that you are concerned about. I think it has actually done a very good job in setting this process in motion in the short period it has been in existence. Prior to Enable NSW, essentially we had a large number of separate fiefdoms.

Mr IAN COHEN: I appreciate that. You mentioned it doing a good job, but do you think it is good practice to acknowledge significant underfunding of programs such as PADP, which the Government by implication has done, and then fail to collect adequate data on efficiency costs? Am I mistaken?

Dr MATTHEWS: Your question is whether Enable NSW should be blamed for all of that. We can talk about it and apportion blame if you wish. However, I certainly would not be blaming Enable NSW because it is setting about in a very professional manner to sort out the problem.

Mr IAN COHEN: I refer back to the Health Care Complaints Commission. Has it received any complaints about PADP lodgement centres?

Dr MATTHEWS: I would have to take that question on notice. I would be surprise if it had not, but I cannot say for certain that it has.

Mr IAN COHEN: Last time the department appeared before the inquiry it was stated that 98 per cent of PAPD applicants are in dire financial straits and are, to a large degree, welfare dependent. The Oakton report at page four states that co-payments were not properly managed. Does that mean the Department of Health is charging people who cannot afford to pay or people who are exempt from payment due to grandfathering arrangements?

The Hon. CHRISTINE ROBERTSON: Or not collecting payment.

Dr MATTHEWS: As you know, there are no charges for children. However, there is a process of co-payment for people over 16 years of age for some items. Is that fair and reasonable?

Mr IAN COHEN: It depends. Is there any means testing or acknowledgment of what is obviously a very difficult life path for these people?

Dr MATTHEWS: There is a system of what are called salary or income bands—not all of it is salary. There is a 20 per cent payment for those in salary band four. I stand corrected, that also applies to children to a maximum of $100. I will have to take on notice the details about salary band four.

Mr IAN COHEN: I am sure we will work that one out. Have there been situations in which the Department of Health is imposing a co-payment whereby the cost of collection is higher than the actual co-payment?

Dr MATTHEWS: I would not have thought so. I would be interested if you had any evidence of that. The cost of collection is, of course, within the percentage that we previously quoted, which is the overall administrative cost of the program.

Mr IAN COHEN: Would it be too onerous to ask the department to provide the total amount of co-payments and the total administration costs from 2004 to date? I do not want to ask for something that would take an unreasonable amount of effort to provide. I am not looking to do that, but if it is doable I would appreciate it.

Dr MATTHEWS: We will take the question on notice and look at the information we have from the audit process. As to the ease of collection, I am not certain, so I will have to get back to you.

Mr IAN COHEN: I appreciate that. As I said, I do not want to ask for anything unreasonable from the department. You mentioned discrepancies, and you called them small discrepancies. Can you explain the

following discrepancies outlined in the Oakton report relating to the following funds that the auditor cannot attribute to any particular costs? An amount of $54,454 for Sydney South West Area Health Service in 2005-06 and 2006-07; $100,000 for the South Eastern Sydney and Illawarra Health Service in 2005-06; $132,000 for the Greater Southern Area Health Service in 2005-06 and 2006-07; $1.14 million for the North Coast Area Health Service. Do you consider that to be relatively small discrepancies in the scheme of things?

Dr MATTHEWS: I said that the percentage, which was 2.9 per cent of the total budget, was relatively small. I think I also said it was significant. Some of it, for instance, the spending on the Bathurst seating clinic was for a clinic that provided services for people which a disability. However, because the other seating clinics were not using PAPD funding and because it was outside the guidelines, it has been directed to return that money to PAPD. I think you used the phrase "the auditor was unable to determine", and there are some cases—

Mr IAN COHEN: I said, "cannot attribute".

Dr MATTHEWS: The reason for that technically is that there is a journal line item in the area health services' chart of account that includes a broad range of equipment, some of which is PAPD equipment and some of which is other sorts of equipment that area health services purchase. So there has not been a specific journal line and that has made the process of sorting it out somewhat difficult. Some of the data is a little scanty. At the margin of that 2.9 per cent there are some that we have been clear are inappropriate, such as the seating clinic, and some of the Sydney west spend. There are some that are still the subject of voluminous correspondence between myself and chief executives. However, between now and the end of this calendar year we will sort it out. As I said, where the moneys are clearly demonstrated to have been spent on purposes other than those strictly allowed by the rules, they will be directed to repay the money to the budget.

Mr IAN COHEN: According to the Oakton report many other financial costs have been written in to PADP, including other administration costs of $29,680, North Sydney Central Coast; average wage costs increasing by 21 per cent in a one-year period; Greater Southern, $12,000 in costs charged to PADP, and support to Children's Hospital Westmead. Does your ongoing inquiry include those?

Dr MATTHEWS: My inquiries include all of the issues raised by the auditor. As I say, we have resolved some and we are still having discussions about the balance. But we will finalise it and it will be paid back where it is shown that it has been inappropriate.

Mr IAN COHEN: I refer you to section 3.1.1 in the Oakton report, on pages 22, 23 and 24. Taking into account the broad range of PADP policy breaches, is it a fair statement that neither Enable New South Wales nor the Department of Health is taking an active role in ensuring PADP policy compliance at AHS and PADP lodgement centre level?

Dr MATTHEWS: No. I think that is a little unfair. The very fact that the audit is done and has revealed these things suggests that we are taking a very active role. If we were passive we would not have done the audit.

Mr IAN COHEN: How will centralisation in a practical way ensure PADP policy compliance across the board? As well, perhaps, what alternative models to Enable New South Wales has the department considered?

Dr MATTHEWS: The answer to your first question, I think, has been partly covered by Ms Lynch. It is by engagement with the clinicians and the clients to determine the most appropriate ways. It is the standardisation of the prescription and the standardisation of the prioritisation. That is really Enable's job to make certain that those things are standard across the system. It will continue to do spot audits from time to time at random to make certain that is the case. The second part of Enable's job is to procure the aids for the clients at the best possible cost so that the maximum amount of the budget can go towards aids. The clinical interactions that provide the treatment and determine the need will still have to be managed locally at both an operational and a clinical supervision way.

The Hon. GREG DONNELLY: Dr Matthews, one of the many complaints we heard from various witnesses about PADP has been that where you live geographically throughout New South Wales has an impact on your access to equipment and aids, and also how long it takes for you to get that equipment and aids. Can you explain to the Committee, in the context of the changes that are going on, what is being done to address this issue?

Dr MATTHEWS: I will ask Ms Lynch to answer that.

Ms LYNCH: It is correct what you say at the moment. Where a person lives can make a significant difference to the type and the amount of assistance that they receive. This can result in an unfair outcome for those clients. If I can talk about incontinence, for example, in some areas you can receive assistance of up to $1,200 a year with incontinence products while in other areas you receive only $500, with the person funding the difference. With powered mobility, some lodgement centres only provide electric wheelchairs to children of school age, when the evidence suggests that children who are younger can benefit significantly from powered mobility.

Another area that makes people disadvantaged depending on where they live is repairs and maintenance. Some people experience getting repairs in a timely manner as being quite difficult. At this time all centres have their own individual policies about how often they will repair, when they will repair it and the speed of that response. Some centres at this time require clients to pay for the hire of alternative equipment. In repairs, Enable is developing a database, an IT system, which will have flags for routine repairs, so routine repairs will be flagged in and there will be a process for managing urgent repairs as well.

There is a variation, as we said, on how long people wait on waiting lists. Each area health service has its own allocation at this time. By pulling that in centrally we can apply the prioritisation across the State rather than depending on local funding. I think Ms Scott mentioned at the last hearing that in rural areas, because the population is smaller the amount of funding to that area is smaller. So, if there are a couple of high-cost items it can impact that budget. So, by centralising that we can get greater control as well. So, the goal of Enable is to provide fair and equitable access to assistance for people with a disability no matter where they live. So, centralising the back office functions will mean that all clients, regardless of where they live, will have their access to assistance from the program.

Consolidating the lodgement centres will ameliorate the impact of one or two high-cost items, as I said, and uniform application of processes will support fairer prioritisation as well as more efficient processing and more timely advice to clients about their applications as well. Consistent policies regarding the type and amount of assistance available are currently being drafted, and they will be out for broader consultation. They will be based on evidence rather than local knowledge. One example again is the prescription of power wheelchairs for young children. We will go back to the evidence and use expert panels to look at that rather than just relying on local knowledge.

Repairs and maintenance policies will be developed which are consistent and do not impose further unfair financial hardship on clients and their families. As I said, we will provide repairs and maintenance, we hope, in a more timely manner. If we do any of our centralised procurements as well we will make sure that part of that incorporates not just cost effectiveness but also the timeliness of repair and support and access to service and backup. Enable is also working quite closely with area health services to facilitate an effective interface between equipment loan pools. You will be aware that a lot of hospitals or area health services run their own equipment loan pools, usually for short term, while equipment is being ordered or when a person only requires that equipment for a short time. That will be part of this centralised process as well, which we hope will decrease some of that wait time for people as well.

Something we mentioned last time but which I would like to re-highlight is the pilot we are doing of pre-approval, in which equipment trial funding is applied but equipment occurs concurrently. The anticipated benefits of this will be that this will reduce clients' and clinicians' apply time for reassessment and requoting. This process is one of the greatest benefits, we think, when replacement equipment is required. You already have an idea of what is required for that person and their condition is stabilised, so I guess that centralisation will also help us with our planning around our budgetary requirements into the future too.

(Short adjournment)

The Hon. GREG DONNELLY: One thing that struck me when we had the witnesses from the various non-government organisations representing disabled people is the intellectual capital they had about the needs of particular groups they represented, particularly their understanding of the equipment and aids best suited to them, and looking into the future, keeping abreast of the new aids and equipment that will be of assistance to these people. Can you provide the Committee with some understanding of how the Government, through Health

and Enable, will relate to the non-government organisations to maximise the transfer of information and knowledge from them to you to enable best practice to assist people with disabilities?

Dr MATTHEWS: At the peak level in relation to the department and Enable, there is an advisory council on which many of the peak organisations and the non-government organisations are represented. That group comes together to discuss this and other related issues on a regular basis. Many of the changes and improvements involve a partnership between the non-government organisations that you mentioned, which have particular knowledge and expertise about the groups they represent—the clinicians, who are continually investigating ways of improving care, and the group, for want of a better word that I would probably call the boffins, who are scientists and others developing improved technologies across a spectrum to include care.

We would all be familiar with the debates that have raged around stem cells, for instance, and their possible applicability to spinal cord and other injuries. There is a partnership there, but in answer to your specific question, it happens at a peak level at the department through that advisory Council and it should happen at a local level as well to use that expertise.

The Hon. GREG DONNELLY: The 2011 endpoint was a cause of criticism from various witnesses, as you probably gathered from reading *Hansard* with respect to the time it will take to fully implement these changes. Do you see any way at all as to how that can be brought forward other than what has been laid out before us as the process?

Dr MATTHEWS: I answered this question in part before about the details of the process, so I will not go through all that again. The plan is to have a specific implementation team to move from centre to centre with a fixed time frame in each one to do those tasks. The only way I can see that conceivably it could be brought forward would be to consider the idea of running two teams to try to double the process. I think there are some concerns about doing that, but what I will do is undertake to go away and have a look at that.

We are hopeful that we will be able to improve on that timetable because we think that the first centre and its transition will be a learning process. What they learn from the first one or two will hopefully shorten the process and shorten the timetable. I do not want to become known as the caveat man at these inquiries, but there is a balance here between making certain that you get it right and you do not lose a lot of data or lose a lot of files or make a lot of mistakes, so having a good process and having a process which is as quick as possible. I do not know that is one where there is a right answer. I think we will do the first centre early in the New Year and based on what we learn from that, we may then be able to revise the time frame and make it shorter and we may be able to consider whether it is possible to run parallel teams.

The Hon. KAYEE GRIFFIN: You spoke earlier about concerns that have been highlighted about inappropriate equipment prescriptions and/or perhaps adequate clinical supervision. Is there anything further you want to add?

Dr MATTHEWS: Ms Lynch is actually an occupational therapist by profession so I will ask her to answer that.

Ms LYNCH: First up, it is important to note that responsibility for professional development, clinical experience and clinical supervision is the responsibility of the service providers and professional organisations. In that respect, Enable and other funders have limited capacity to make changing clinical practice. The PADP reviewers noted their concerns about the skills of prescribers of PADP equipment and since the commencement of Enable New South Wales one year ago, we have collected a significant amount of anecdotal information, which supports that concern as well. Indeed, Ms Scott and myself, as occupational therapists, have had several conversations about that as well.

Examples include inaccurate prescription of equipment resulting in the need for the equipment to be replaced, prescription of discretionary features that are not really essential to the core prescription and funding of items that people only need for a relatively short period of time and are then discarded. This is further supported by a recent study that Dr Matthews mentioned before in the *Occupational Therapy Journal*, which found abandonment rates of some equipment of between 30 and 59 per cent. I did mention some of the reasons for that were inappropriate prescription, a lack of engagement with the clients in the process and the lack of training and ongoing support for them as well.

These issues are not only add to the PADP rating list but they also cause significant inconvenience for clients and their families, who are without the appropriate equipment to meet their needs for longer than is necessary. The common prescription guidelines project addresses many of these issues and it is one that we are working with the Lifetime Care and Support Authority. You can actually look at those on the Web as well if you want to look at how they will look in practice.

The first phase of the project has involved the development of new prescription processes, the introduction of minimum qualifications and experience for providers, clients' sign-off on equipment prescribed, the requirements for training and follow-up with clients and the evaluation. I think I mentioned earlier that one of the important points is to evaluate how the client is finding that piece of equipment and whether it is meeting their goals. These processes were developed following wide consultation with expert clinical groups and professional organisations and have been piloted at two of the PADP lodgement centres so far, as well as through the specialised equipment set-up program, and Ms Scott mentioned that particular program at the first hearing.

Importantly, the pilot sites included both the metropolitan centre and a regional and rural centre to ensure that the specific needs of rural clinicians and clients were considered. Preliminary results from those pilots indicate that the quality of the prescriptions was improved, as was the ease and speed of processing for PADP staff. What happens sometimes is that if a prescription is inaccurate, it comes to the lodgement centre. It then needs to be sent back to the clinician to clarify. We found through this process that this was speeded up because the accuracy of prescriptions was much better.

In response to recommendation 15 of the PAPD review, Enable has employed expert statewide occupational therapy advisers, who are providing high-level support and advice to clinicians and staff. Sometimes a new graduate on the ground has to suddenly prescribe a very complex wheelchair can feel totally overwhelmed. We are working to put processes in place to support that person to make it quite clear to their managers what needs to be done in order to do that prescription appropriately. This includes information resources for clinicians regarding professional development opportunities in the area of equipment prescription, networks of clinicians experienced in specific equipment categories so that clinicians requiring assistance can be provided with information on who to contact. You do not provide some pieces of equipment frequently and if you would have not done it before, you lack the skills to do it properly, so that network will support that work.

Phase two of that pilot project has also commenced, and will produce equipment-specific guidelines for prescribers to assist in clinical reasoning behind their equipment choice. A key focus of this work will be on the main areas of concern identified by the clinical advisers in pressure care, seating, and seated mobility, which are the areas that we had the most problems with at the start. Early on, phase two has commenced with collaborative work and to identify the evidence base for the prescription of specific areas of equipment, which is what you spoke about as well. Enable will continue to closely liaise with clinical groups and the professional associations to address the concerns that have been raised regarding prescriber skill.

The Hon. CHRISTINE ROBERTSON: The other issue in relation to prescription consistency and equity that has come up quite a lot in the inquiry is the geographic cover of occupational therapists. We have been told that in certain towns there is a visiting occupational therapist every couple of months—I cannot remember the time factor, but not very often—which caused a long extension to waiting times. This was not necessarily related to access to equipment but to the skill base required for the ordering of the equipment.

Dr MATTHEWS: You have raised part of a very broad issue of rural workforce and isolated towns. I cannot begin to say that I have the answer to the question of appropriate equitable access to all health services, whether it be skilled occupational therapists, general practitioners, specialists or hospitals, in rural New South Wales. There is no doubt that a lot of the smaller towns and villages will need to rely on a visiting service of some sort in order to receive the service they need.

The Hon. CHRISTINE ROBERTSON: Most of these places have a regional centre that carries responsibility for the expertise. Some specialties and facilities have changed the structure so that they are delivering to those places. Is there thought during this PADP review process that it is somehow being ensured that these regional centres know that they are responsible for the places—not that, by accident, they are inside their geographic boundary? Am I being clear here?

Ms LYNCH: I think you are being clear, but I do not think it is in the scope of this piece of work. It does speak to access to staff and clinical expertise within those area health services. I guess the separation point

happens with PAD supplying the equipment. You are right: we have also moved, with the prescription guidelines, to make sure that those things are done properly so that we get appropriate prescription and less wastage, but we have not moved into the clinical domain which is its separate from the PAD.

Dr MATTHEWS: One of my other areas of responsibility is the Rural Institute. We have been giving out a very large number of rural allied health scholarships in order to attract allied health professionals into rural areas, and there has been a net increase, although nowhere near enough. I am happy to table for you our endeavours through the Rural Institute.

CHAIR: Dr Matthews, I want to ask you about repairs, an issue that has been raised with the Committee by witnesses. People often go to charitable organisations for expensive equipment if they are unable to supply it themselves or get it through PADP. Then there is a problem in terms of repairs, and the evidence we have heard is that PADP will not pay for repairs. Do have any plans in place to do something about that?

Dr MATTHEWS: Yes. Because of the considerable concerns that have been raised about repairs and maintenance, we have what is called a business processes working group which is particularly looking at the issue. It is developing a process for both routine maintenance and unscheduled repairs. In many ways, a wheelchair is no different to a motor vehicle: if you have it routinely serviced on a regular basis, you will have less need for unexpected repairs. The new IT system will have an asset management module which will trigger routine maintenance needs. In other words, it will tell us when a particular piece of complex equipment is due for routine maintenance so that we can make that arrangement, and it will keep a record of unscheduled repairs. We will attempt to develop a process for unscheduled repairs to address the need for urgent repairs to be arranged quickly and, if necessary, out of hours, because an unexpected breakdown can mean a complete loss of mobility for some people.

CHAIR: We have certainly had evidence of a number of examples of that. One witness told us about a wheelchair footplate, and about having to go back to the occupational therapist to get a report on it. There was a bizarre process of letters backwards and forwards, weeks later when it was obvious that the footplate was broken and had to be fixed. Do you intend to address that situation?

Ms LYNCH: Yes, that will be part of it. Repairs will be kind initiated; they do not need to go back to the prescriber. Where there is a change in the equipment because the child has grown, or something like that, it will need to go back to the therapist. But for routine matters, no.

CHAIR: Why does it have to wait until the rollout in 2011? Why can you not do that now?

Dr MATTHEWS: The IT system is scheduled to be in place in April next year. As soon as we have that system—which has been specifically designed for these and other purposes—up and running, we will be able to start that maintenance schedule. So that part of it will not need to remain until the end. The end is really the last lodgement centre coming in; most of the other things will be complete.

CHAIR: I understand. But current repairs having to wait until April is still a long time.

Dr MATTHEWS: We are moving from the nineteenth century into the twenty-first century and skipping the twentieth in terms of our IT, I think.

The Hon. MARIE FICARRA: Has the department considered, or will it consider, funding a scheme similar to the one in Victoria, which provides for the modification of motor vehicles for disability access?

Dr MATTHEWS: Can I ask about the Victorian system scheme? Is it funded through the Department of Human Services, or is it funded through the Motor Transport Authority?

The Hon. MARIE FICARRA: I do not have that at hand. Perhaps if you could take the question on notice. It would be good to get speedier access to these vehicle modifications. I note that Reverend the Hon. Dr Gordon Moyes is not present, but during the inquiry he brought up the topic of low vision or no vision access to PADP information. It was stated during the inquiry that it is not available in alternative forms such as braille, or even electronically online, that application forms are still very much based, depending on where the lodgement centre is. How do people access the information if they have no vision or low vision?

Dr MATTHEWS: That is a very good question. All I can say in response is that it is technically possible to attach an audio version to a website. I will go away and ask the question as to whether we can do that reasonably.

The Hon. MARIE FICARRA: We also heard about email addresses and clearer points of contact. There was criticism about the lodgement centres now with a centralised model. Will that now be clearer and more efficient, so people know where the email address is and how to contact an agent?

Dr MATTHEWS: I think the email-single, telephone-single, facsimile-single website will enable that. But there is already, as Ms Lynch previously said, an 1800 number which has been in existence since October 2007—

CHAIR: With all due respect, not enough people know about that. That is a bit of an issue, I think. I am sorry to interrupt you.

The Hon. CHRISTINE ROBERTSON: May I extend that question in relation to communications? Is there any way that the prescription staff and the first contact staff who are referring people to the PAD system can personally provide people with the 1800 number immediately—not when all the problems are fixed? At the moment we are all saying there is an 1800 number. The special interest groups certainly have it, and the workers have it, but the community members do not have this number. The other thing people could be provided with is the complaints handling procedure.

Dr MATTHEWS: I think that is an excellent idea and, I will go out on a limb here and say, I will ask the team to develop a simple business card or something that can be distributed to all the relevant clinicians that contains the contact details for Enable and the website and the single 1800 number and try and get it disseminated and distributed as widely as possible.

The Hon. MARIE FICARRA: Are we going to have a statewide loan pool scheme with the centralised model of the loan pool or is still going to be based on the area health service? How will it operate?

Dr MATTHEWS: The answer to that is both. The pools will remain local but they will be coordinated centrally so that there is an overall understanding of what there is and where it is and who currently has it. Part of the work is to coordinate the loan pools across the areas. In line with recommendation 28, an interface is being developed with PADP so that people receiving equipment through equipment loan pools who require it permanently can keep it without disruption. So if you get equipment from a loan pool and you do need to have permanently it will flip, if you like, out of the loan pool into a PADP item. We are looking at donated low- cost PADP equipment that is returned by clients from time to time to equipment loan pools for re-use and recycling—the returned equipment will be registered with a website recycling page to be available for use in recycling across the State where such recycling is appropriate. We are also looking at the placement of complex PADP equipment for longer trials in equipment loan pools, and the provision of some specialist PADP equipment for medium-term loans through equipment loan pools in place of permanent provision, for example, young children's loan equipment. Local provision with central coordination.

CHAIR: We were talking before about a group that is looking at repairs. Suppliers are a valuable source of information as well and a number of them have concerns about their interaction with PADP. I appreciate that sometimes they might have a conflict of interests but I wonder if your group that is looking at repairs has suppliers as part of that group? How are you interacting and consulting with suppliers when they have such a huge wealth of information?

Dr MATTHEWS: Certainly we have a strategy to engage the suppliers around procurement. You have raised the interesting question of repairs and I think we will need to add that into our consultation strategy so that we can balance again our obvious requirement to get things as cheaply as possible for clients with the need to deal, particularly in regional and rural areas, with suppliers who are often the sole agents available in particular places. We need to balance those two things.

CHAIR: Is there an opportunity for your group that is reviewing the repairs to have a supplier representative on that group? I am not sure who constitutes that group?

Dr MATTHEWS: We will certainly consider doing that. I am uncertain as to whether the suppliers have a peek group.

CHAIR: I am not sure either. I understand those issues might be complicated.

Dr MATTHEWS: Normally our process of engagement is through some sort of peak otherwise you get obvious conflicts.

CHAIR: I understand that. Earlier you mentioned something about the Bathurst Seating Clinic. That it had been asked to return monies and the operation has been inappropriate—I think that was the word that you used. What do you mean by "inappropriate" and how long has that issue been going on?

Dr MATTHEWS: I think "inappropriate" is a bit strong because the Bathurst Seating Clinic does provide a service to people with disability. But using PADP funds for that particular purpose is technically outside the rules. So what we have said to that area is two things: firstly, the Bathurst Seating Clinic has to continue—because it is a valuable service—but it has to be funded from sources other than PADP funds; and secondly, that component has to be returned to the budget.

The Hon. MARIE FICARRA: When devices or equipment are returned to loan pools are they inspected for maintenance and so forth?

Ms LYNCH: Yes.

The Hon. MARIE FICARRA: Does that go on regularly?
Ms LYNCH: Yes.

The Hon. MARIE FICARRA: Before they are given out on loan again?

Ms LYNCH: That is absolutely correct. You have really outlined the answer in your question. Complex equipment in good order will be returned but it will be subject to cleaning and maintenance checks before being placed on recycling. Obviously we have a duty of care for that equipment.

Mr IAN COHEN: Continuing on with the Bathurst issue that was touched on by other Committee members. Clause 19.5 of the PADP policy directive requires that prior to approval a local advisory committee consider high cost items over $800. I refer to finding 2.3 in the Oakton audit of the Bathurst lodgement centre that states that the acting manager was approving, as I understand it, items up to the value of $3,000. When I put this to Ms Tobin, the PADP manager for Bathurst, she stated:

> We present all applications over $800 to the high cost allocation committee.

How can we have the auditor stating the acting manager in August 2007 was approving applications for equipment up to the value of $3,000 on the one hand, when Ms Tobin stated all applications over $800 are sent to the high cost allocation committee? Can you indicate more broadly how many PADP lodgement centres were found to be diverging from clause 19.5 of the PADP policy directive?

Dr MATTHEWS: All the ones that were found to be doing it are detailed in the audit report. That report you have in its entirety, so you have all the information that we have. I am not certain about that individual case. You mentioned an acting manager. It may have been that the acting manager was not aware completely of all the delegations but I will look into that.

Mr IAN COHEN: Thank you. I understand it to be the PADP manager for Bathurst, not an acting manager.

Dr MATTHEWS: Okay.

Mr IAN COHEN: Does the department think that the Bathurst model of the specialist-seating clinic would be appropriate and cost-effective to roll out to other PADP lodgement centres? We did receive some interesting information in terms of the way they were operating?

Dr MATTHEWS: My memory, which may be faulty, tells me that there are five seating clinics across the State. We will provide on notice the sites of the others. That attempts to give a reasonable geographic cover. Again, my memory tells me that there are two metropolitan that we run, and some are run by non-government

organisations, but the majority of those clinics have an outreach component which takes them to many other sites in rural and regional areas. We will give you a list of the clinics and the outreach services.

Mr IAN COHEN: You stated that Enable would split the waiting list into two sections of criteria: one, waiting for assessment and, two, waiting for manufacture of complex equipment. Does this not omit the major reason for delay, which is waiting for funding, and should that be a criteria included in the overall assessment?

Dr MATTHEWS: Yes. There will be key performance indicators [KPIs] that will cover all those things within the combined Enable process. I have to say that the splitting of the waiting list was a bright idea that I had this morning at half past six when I was reading the papers.

Mr IAN COHEN: We can add those as an amendment, perhaps.

Dr MATTHEWS: In reading the papers and trying to again understand the waiting list, it became clear to me that it had those components, that is, I am waiting to be assessed or I have been assessed and I am now waiting for a piece of equipment to be made. To better understand the waiting list it would be useful to divide it into those two components because the former, to some extent, would define the funding.

Mr IAN COHEN: Perhaps so, but the funding process is in itself a period of time to go through the proper channels. Would you accept that is part of the problem in relation to the time taken and it is perhaps worthy of your attention?

Dr MATTHEWS: Yes. The authorisation of funding for any item within public sector funds has a process that is laid down. One of the aims of Enable is to speed that process because there has been variability across the different centres; I acknowledge that.

Mr IAN COHEN: I take it with centralisation as an overall process there would be an increased bulk-purchasing power for equipment and the like, which will be of assistance. There has been a quite a bit of discussion in this Committee about the provision of clinically appropriate equipment. Given that you would be buying in bulk, do you envisage there will be problems with the provision of appropriate equipment if a bulk-buying regime is followed? How would you deal with that as a department?

Dr MATTHEWS: I think bulk buying would apply to items that were very standard. Continence aids would be a good example of that. Clearly, pieces of equipment or aids that need to be designed for an individual, because of that individual's unique needs, cannot be the subject of bulk purchase.

Mr IAN COHEN: Dr Matthews, could you explain why the Oakton report at page 44 describes the PADPIS as being of limited capacity? Could you tell the Committee the cost of the PADPIS and why it does not have a function for equipment management? Surely that would be a core requirement of any management software for an equipment program?

Dr MATTHEWS: Apart from it being an unfortunate acronym, it is an old database that is no longer supported. It was developed quite some time ago. I can find the data development. I think it is essentially an adoption of an Excel spreadsheet. Because of the way it is designed, the individual databases of the lodgement centres cannot be consolidated. With one merger that has already taken place that resulted in one office having three separate databases, which is obviously inefficient. That is why we are waiting with bated breath for our new system in April next year, which will give us the twenty-first century.

Mr IAN COHEN: In the South Eastern Sydney and Illawarra Area Health Service I understand that 306 clients have waited longer than 12 months for equipment as at 30 June 2008. What would be the ballpark cost of occupational therapy [OT] reassessment for these clients, and what would be the cost if some of these clients occupied acute hospital beds?

Dr MATTHEWS: Obviously each one of those people would be different and so calculating the occupational therapy [OT] reassessment cost or even determining whether in this particular case reassessment was necessary would be a lengthy exercise.

Mr IAN COHEN: Is there a possibility you could take the question on notice and provide a percentage or estimate of additional costs for that situation?

Dr MATTHEWS: We will attempt to do so. We will do our best.

Mr IAN COHEN: I appreciate the difficulties but it is a point of frustration for people who are users of the system, as you might appreciate.

Dr MATTHEWS: I do.

Mr IAN COHEN: I refer to page 38 of the Oakton report, which sets out the auditor's recommended responses to deficiencies and risks in PADP administration. How long would it take to roll out these recommendations? Do you expect that the PADP will adopt a standard format for waiting list data? I think you have answered much of that.

Dr MATTHEWS: I think we have covered that.

The Hon. CHRISTINE ROBERTSON: In some areas home modification comes under the Home and Community Care [HACC] program rather than a PADP program. Because of the closeness of the work of the two programs, they often work in conjunction in the area health services. The changes are looking important for PADP. With these two services working in conjunction, is there a risk in dividing them off and creating a hotchpotch of services for the individuals who need the services?

Dr MATTHEWS: The Home and Community Care [HACC] funded initiatives, with the exception of the clinical nursing component, are supplied by the Department of Ageing, Disability and Home Care [DADHC], a different government department, and they employ their own therapists. So they are separately funded in that way. There are discussions, I think I can say, at a national level through the Council of Australian Governments [COAG] process about all those aspects of care and there will be decisions made about that whenever COAG now takes place, so it may be that there are changes. But at the moment Community PADP is NSW Health and the HACC-funded program, including home modification, is a DADHC responsibility. The two need clearly to work in partnership and there are many areas and many client needs where the clinical needs and the disability needs are blended and merged and we need to work with DADHC.

The Hon. CHRISTINE ROBERTSON: An issue came up in the inquiry, which you have touched on in your answers today, about communication technology and the definitions as to which groups were appropriate for communication technology by PADP. You have told us that the Department Of Education and Training and workplace people usually fund this, but there are many people requiring communication technology outside either of those spectrums, particularly the very young. Is this being addressed in any way by the expert panels? The issue was brought to us a couple of times during the original hearings.

Dr MATTHEWS: Some communication devices are funded through PADP and there are, as in all the other areas, inconsistencies in the prioritisation given to those devices. Anecdotally it appears that applications are not always made to PADP. There are waiting lists for specialised technology clinics, and for some clients difficulties in obtaining communication devices may be due to limited access to assessment—again, particularly in regional and rural New South Wales. So I think it is one of the issues that we will need to take up as part of the ongoing review of need and supply and funding.

The Hon. CHRISTINE ROBERTSON: So your expert review panel, which will be a central expert review panel rather than bits of panels all over the place, would this be the sort of question that they would be dealing with on an individual basis?

Dr MATTHEWS: There is a technical advisory group looking specifically at communication devices, and in the short term the appeals process that we are setting up for consideration of special needs which are outside the rules will pick up this. In the medium term, particularly with the fairly rapid changes in technology in this particular area, we will need to consider it as a priority for increased applicability.

The Hon. CHRISTINE ROBERTSON: Just one last question—not a nice question—in relation to the funds that have been moved around in a fascinating way from PADP within the area health services. I think this inquiry requires a commitment that these funds, when recovered back into the program, will go to patient services and not into general funds somewhere.

Dr MATTHEWS: You absolutely have that commitment. As soon as we are satisfied, as we already have been in some cases, that there are funds applied to other areas, the area chief executives are subject to the direction and control of the director general and they will be getting that direction.

The Hon. GREG DONNELLY: Dr Matthews, in terms of what other jurisdictions do in other States and Territories, what is the process in which New South Wales liaises with those other jurisdictions to understand what they are doing in this whole area and, I suppose, cross fertilise ideas and best practice which seems to be working to the best advantage of those who are in most need?

Dr MATTHEWS: The general way in which the States and Territories and the Commonwealth get together in all these matters is through the Australian Health Ministers Council, which has an advisory council underneath it consisting of all the chief executives and, under that, a number of principal committees and then a number of committees, which consider the full range of services. So somewhere within that committee structure there would be an appropriate committee that is considering these things. For the very high level of equipment there is a national process called the Medical Services Advisory Committee [MSAC], which considers the applicability, safety and cost efficiency of very high level new treatments being developed around the planet. Its focus is mainly clinical rather than this area, but there is a processing that overall health Ministers structure to deal with these things.

The Hon. GREG DONNELLY: Just on this issue, and you may not be able to speak about it in specific detail but perhaps just for information, in terms of looking into the future. Beyond the issue of more sophisticated pieces of equipment such as electric wheelchairs that have a whole range of functions and what have you, what are specific areas that are new boundaries that are going to be pushed out that are going to be quite challenging for us to look at?

Dr MATTHEWS: One that we have recently dealt with where the clinical and the disability merge is in the area of ventilator dependent neonates. These have a variety of causes. There is a group of premature babies who have poorly developed chest muscles and need to be ventilated for something like three years until they develop. There is another group who have hypoplastic hearts, who have normal cognition but will be ventilator dependent for life. Until fairly recently, children with those conditions died, and two or three years ago we found ourselves at the Children's Hospital at Westmead having the stepdown unit of the neonatal intensive care completely full of long-term ventilated neonates and we had to develop a program to enable these children to go home.

For all the obvious reasons, that is a very expensive program that can cost up to half a million dollars a year per child. Sitting behind that is a very complex series of ethical issues that I do not really want to go into now, but that is an example of modern medical technology enabling survival of a child—and there are others with various genetic disorders who until a very short period ago would not have survived. And where such technology enables longevity approaching the normal, you have got a very long period of significant disability support, and clearly this is an area where, in terms of numbers and in terms of cost, there is going to be a significant growth. That is one example. I guess I could give you some others.

The Hon. GREG DONNELLY: Just one final question on the issue of criticism that arose during the hearing. With respect to the dispensing and the supply of the equipment, and I think the examples that were given were specifically complex pieces of equipment such as electric wheelchairs, there was some concern expressed about the way in which the handover takes place; in other words, the delivery to the individual. If my memory serves me correctly, I think there were some examples given of wheelchairs arriving at people's homes and being pretty much left there on a pallet, so to speak. They may well be rare examples. I think the criticism was directed at the courier company, but is that something that both Health and Enable are mindful of and, in particular, is some attention given to that handing over of particularly complex pieces of equipment?

Ms LYNCH: It does. The prescriber guidelines that I spoke about earlier have a requirement that the clinician also articulate an implantation plan that would include, obviously, training in the piece of equipment, that I mentioned earlier, and then the evaluation of how that is going as well. Obviously we will have some benchmarking around some of those things as well.

Dr MATTHEWS: Obviously that sort of thing should not happen.

Ms LYNCH: No, it should not.

CHAIR: I will just conclude and note that in terms of clarification of some of the issues that have been raised we may come back to you in the process of writing our report, if that is all right. I know you have taken some things on notice that may take a bit of time to prepare, but we are on a fairly tight timetable with this, so we are looking forward to getting that extra information back to help us with our report. Thank you so much for coming back to clarify a range of issues that have been brought to us by witnesses and thank you for your positive and encouraging responses. We are certainly all working towards getting better outcomes for people with a disability and high complex health needs in the community.

(The witnesses withdrew)

(The Committee adjourned at 11.30 a.m.)