Analysis of DVA Allied Health Reform Package

Key Message;

1. We are seriously concerned about the DVA Allied Health Reform Package proposal, in particular the 12 session treatment cycle due for roll out July 2019. The implementation of this reform will significantly reduce veteran access to allied health services and result in suboptimal health and wellbeing outcomes. This cap on veteran health services should be immediately suspended.

   Reasons for immediate suspension of the 12 session treatment cycle;

   a) It will create unnecessary stress on the veteran, partner and their family as well as the medical and allied health professions.

   b) Disrupts the timely delivery of allied health services as the veteran is required to return to the GP purely to seek a re-referral to continue with and/or complete therapy interventions.

   c) DVA reports a veteran will visit their GP 12 times per year and therefore draws a simplistic conclusion that a veteran will visit the GP once per month. However, in discussions with veterans they advise this is rarely the case. DVA propose that GPs will measure and manage allied health treatment during this established GP consultation time, however the GP will already be attending to the veteran's presenting medical concern. As a consequence, an extended medical consultation or an additional visit on a different day will be required to allow sufficient time for the GP to review the allied health treatment cycle. Given there are 17 different allied health professions accessed by veterans (dental and optical excluded), GP consultations will certainly increase in number or extend in duration placing extra unnecessary burden and cost on the health system and veteran.

   d) The Allied Health Professionals Association Submission to Productivity Commission (February 2019) questions *"the capacity and role of GPs in determining an appropriate amount of care by the treating allied health professional."*

   e) The proposed reform of a 12 treatment session cap was based on recommendations made by the AMA in their submission February 2016. The reform claims to address concerns held by the AMA that *allied health practitioners fail to effectively collaborate with GPs and that current referral arrangements fail to guard against high service usage levels.* There is no factual basis to these concerns with AMA incorrectly interpreting data provided by DVA in a background paper regarding service level usage (Review of DVA dental and allied health arrangements Background paper, undated).

   DVA *"expenditure on dental and allied health services equates to approx. $2200 per year", "the average spend for medical treatment was $25,000 per year."*

f) The 12 Session treatment cycle adopts an archaic and non- contemporary medical model of health care and will not deliver DVA's aspiration for "*21st Century specialised health care".* It is also a very disempowering form of health service delivery and does not support or align with the *Veterans' Entitlement Act 1986* and *Repatriation Private Patient Principles Legislation*, which is an instrument enabling free and enhanced treatment to be provided to veterans and therefore promotes their right to health.

g) The current schedule of fees and poor hourly remuneration rate lead to allied health consultations being shortened in time, resulting in more service occasions and a disruption to veteran experience and therapeutic outcomes. Should the treatment cycle be capped at 12 visits it will be likely the maximum number of sessions will be reached in a matter of week/s, resulting in a need for the veteran to return to the GP purely to seek re-referral to continue with/complete therapy.

2. DVA's Allied Health Reform package does not address concerns from the health industry and focus groups

a) Reform package does not address long held concerns from the allied health professions over the last decade and also those expressed in the working groups formed as part of the DVA allied health review. In particular, significantly low reimbursement rates in comparison to industry standard and other state and commonwealth funded therapy provision schemes. The level of reimbursement equates to approx. 20% of current commonwealth and state funded hourly rates or approx. $40 per hour for occupational therapy services.

Despite continued, regular, frequent & formal discussion since 2008 from our professional association, OT Australia; DVA have side stepped and delayed their promise to address our hourly remuneration rate and service structure. Most recently DVA said they would address the matter in DVA's Review of Dental and Allied Health Arrangements. DVA still show no commitment to address the issue in any meaningful way.

The Allied Health Professionals Association, Australian Physiotherapy Association and Exercise and Sports Science Australia also continue to express concern over low reimbursement rates.

b) The AMA, in its 2016 submission, recommended DVA introduce more formal reporting structures between the allied health practitioner and GP regarding the veteran's management and progress. Despite DVA stating in the reform package that the allied health practitioner must report back to the GP, DVA continues to not support this process by not amending the schedule of fees to allow health professionals to be remunerated for this service. Prior to 2006 the allied health professionals' schedule of fees allowed payment for report writing back to the referring practitioner/GP. However after 2006, this was amended, preventing remuneration for this basic and essential aspect of health service delivery.

c) In *DVA's Final Report, Review of DVA Dental & Allied Health Arrangements (May 2018*), the response from the Ex Service Organisation Round Table (ESORT) focus group regarding the treatment cycle was mixed; with concern expressed over the burden that might be placed on DVA clients or GPs.

3. The current allied health referral system supports optimal health and wellbeing for veterans. The allied health professional has a 12 month duration to deliver clinically required services. Should the veteran require ongoing allied health interventions the appropriateness of an ongoing referral is discussed in collaboration with the veterans' GP.

   If DVA are wanting better understanding of veteran health outcomes, there is no evidence to suggest that more interaction with GPs can provide this. AHPA reports in their February 2019 Productivity Commission submission that "*it is not the role of one profession to police another"*. The Australian Health Practitioner Regulation Agency (AHPRA) is responsible for setting standards for professional practice and conduct including acting with integrity at all times and provision of evidence based and clinically appropriate services.

   DVA should establish independent quality processes to review the quality and efficiency of health services provided to veterans. In addition, DVA could have better oversight over allied health outcomes by allied health practitioners forwarding a copy of their report sent to the referring practitioner. This report could be reviewed by the relevant DVA allied health clinical advisors.

   The Hon Dan Tehan MP August 2017 said *"if in a financial year, DVA needs to spend more money than had initially been budgeted for healthcare support to entitled veterans, then the excess is just 'written off' by government and we start the next year with a clean slate. This ensures that we can always meet the costs of all clinically necessary treatment for entitled veterans."*

4. Should the Allied Health Reform Package be implemented without suspension of the 12 treatment session cycle and substantial improvement to remuneration rates and service structure, there will be a rapid decrease in access to quality services for veterans as it will not be financially viable for practitioners to continue service provision.

Our recommendations;

1. Immediate suspension of the 12 session treatment cycle due for roll out July 2019.
2. An independent review of DVA's fee schedules and service provision.
   a. Adjustment to schedule items to better reflect contemporary practice and client needs to include payment for reports and travel time to visit veterans at home as clinically required.
   b. An increase in hourly rate in line with industry standards.
3. Establishment of independent quality processes to review the quality and efficiency of services delivered by all health providers.