Thank you for the opportunity to provide comment on the Productivity Commission's draft report, "a better way to support veterans".

We are occupational therapists providing home visiting services to veterans and their dependents under the DVA RAP program.

I have been providing services to veterans since 1997, over a 21 year period.

During this time I have also provided occupational therapy services to other government and on government organisations and client groups.

My colleague Lisa who contributed to the Submission, has been providing occupational therapy services to veterans since 2007.

- We would like to

  1. Provide a response to Information Requests from the Productivity Commission.

  2. Provide our opinion and experiences as health professionals involved in the delivery and management of veteran health support services, in particular occupational therapy services. Our feedback relates to the Key Points and findings and recommendations formed by the Productivity Commission relevant to the DVA RAP program.

  3. We have also attached our Analysis of the DVA Allied Health Reform Package V3 and Accompanying Key Message, which contains supporting evidence and relevant data related to the DVA and Health Service Delivery.

DVA's Rehabilitation Appliance Program (RAP) "provides eligible DVA clients (Gold or White Card holders) with aids and appliances to be as independent and self-reliant as possible at home and in the community.

As stated on the DVA website, the provision (i.e. objectives and principles) of the RAP program is to

1. Minimise the impact of disabilities, illnesses or injuries

2. Maximise quality of life,

3. Maximise independence and participation in the community."

INFORMATION REQUEST 15.1 - GOLD CARD

Given the Gold card runs counter to a number of key design principles, the Commission is seeking feedback on whether a future system should have a coloured health card system. If not, what are the other options?

In particular, the Commission is seeking feedback on the benefits and costs of providing the Gold Card to dependents, service pensioners and veterans with qualifying service at age 70.

Response: The Gold Card does not run counter to a number of key design principles; it is wellness focussed (on ability) and adopts a life time approach to supporting veterans and their families. This is the overarching objective of the new veteran support system.

A wellness model is a holistic model which allows a health practitioner to address all aspects of a person's life. A gold card allows treatment and care for all health conditions and this in essence allows for a holistic approach to caring for a veteran.

Gold card does not discourage wellness. In our experience, Veterans are truly grateful for the health care received and would be mortified if they thought the community thought they were 'cash grabbing from the government'.

The DVA gold card communicates lifetime support, care and an importance and value on and individual's wellbeing. A monetary benefit communicated by a lump sum payment does not support a lifetime wellness approach.

We can confirm that on the ground from the many hundreds/thousands of Veterans we have serviced, they absolutely do not view the gold card as money in the context of the RAP program, Veterans view the Gold Card as support and care following a life of service.

The benefits of the Gold Card are aligned with and fulfils the intention of the instruments of The *Veterans Entitlement Act 1986* and *Repatriation Private Patient Principles Legislation* enabling free and enhanced treatment to be provided to veterans and therefore promotes their right to health.

The Gold Card has a tremendous influence and positive outcome on wellbeing.

We believe the Gold card should continue to be provided to dependents.

Given the overarching objective of the veteran support system should be to improve the lives or wellbeing of veterans and their families, and that the commission's position that the veterans support system should be wellness focussed, the Gold card system should remain in place.

A future system should not reinvent the wheel and adopt different colours as it is likely to cause further confusion. Connotations will inevitably develop over time, just as they have with the current gold and white card system (albeit good, bad or otherwise).

Mainstream health services provide only very basic and essential health care. If at all possible, members of the community will seek to finance private health care cover which affirms the fact mainstream services are insufficient to achieve good/acceptable health outcomes, let alone wellness. It is on this basis that the gold card needs to be provided to veterans and their dependents for their entire life time, up to and including death.

INFORMATION REQUEST 15.2 – FEES

The Commission is seeking participants' views on fee-setting arrangements for veterans' health care that would promote accessible services while maintaining cost-effective system.

What would be the benefits and costs of separate fee-setting arrangements for Gold Card and White Card holders? To allow cardholders more choice of provider, should providers be allowed to charge co-payments? Should co-payments, if permitted, be restricted to treatment of non-service related conditions?

Occupational Therapists have been calling on DVA for the last decade (since October 2008) to review the schedule of fees and remuneration structure. The financial reimbursement for occupational therapy services is significantly below market rate and DVA continue to make no meaningful commitment to addressing this issue, despite the recent Review of dental and allied health arrangements. Due to this, we assert that veterans will no longer be able to access quality health services and in turn this will lead to an increase in hospitalisation costs and community care costs long term.

The level of reimbursement for occupational therapy equates to approximately 20% of current commonwealth and state funded hourly rates or approximately $40 per hour for occupational therapy services. Physiotherapy has a similar low remuneration rate and I believe this is a concern for other allied health professions.

Occupational Therapy providers working under ComCare scheme for active defence members are remunerated far more per hour ($194.75 per hour) than their counterparts providing a service to the DVA RAP veteran community.

In the Commission's report, reference is made to The Australian Medical Association suggestion that DVA's allied health arrangements do not sufficiently guard against high levels of service usage and that the current referral system may encourage treatment by an Allied Health Professional to persist beyond what is clinically indicated. In DVA's Final Report May 2018, Review of DVA Dental & Allied Health Arrangements, it was reported that DVA's expenditure on dental and allied health services equates to an average of 29 services and $2200 per year. What this means is that on average a veteran accessed one of nineteen available health services once per fortnight at a cost of $75.86 per service. It is our opinion that this is a very reasonable level of servicing for clients (veterans) who typically have chronic and co-morbid conditions and there is no evidence of over servicing as the AMA and the Commission elude to.

The average spend for medical services per veteran is $25,000.00.

Our recommendation is that an independent review is made into DVA's fee setting arrangements. Reimbursement rates and fee schedule items should be adjusted in line with contemporary and industry standards. DVA should consider commonwealth and state government schemes (ComCare, ICWA, NDIS, and WorkCover) fee settings arrangements in principle for all veterans and dependents and including all conditions. The rate should be consistent for treatment of all conditions as this is consistent with a wellness approach which is the overarching objective of the veteran support system.

We are of the belief it was inaccurate and misguiding to refer to the TAC rates in the Commission's report as it does not clearly illustrate hourly rates nor represent the majority of national State and Commonwealth rates.

The mean and common hourly rate for occupational therapy (and other allied health therapy services) is approximately $180. The NDIS hourly rate for therapy services is $179.26 and the ComCare, ICWA and Workcover rates for occupational therapy in WA is $194.75 per hour.

In the Commission's report, the following figures are quoted to provide a comparator of expenditure on allied health, however they are misleading and is a misrepresentation of the situation; "In 2016-17, DVA funded about $320 million in dental and allied health services for about 140 000 card holders (DVA 2018ag). DVA's average expenditure per patient was $2285. Medicare's expenditure on allied health services was $305 per patient in 2016-17 (DoH 2018).

The Medicare system and rebates for allied health services is very underdeveloped and limited and should not be used as a comparator in this situation. Very few allied health professionals/ providers participate in the Medicare schemes, e.g. Chronic Disease Management, because they are not workable, remuneration is abominable and they provide minimal therapy treatment for the participants. $25 is the approximate hourly remuneration rate for occupational therapy service delivery for this Medicare program, which is also capped at 5 sessions per year. As a consequence therapists do not participate in the program and therefore the public cannot access the program. Therefore this is how the low cost per patient is derived. This is likely to be the typical scenario for many of the poorly resourced and underdeveloped Medicare programs for allied health services.

It would be an improvement to utilise private health insurance costings for allied health service as a comparator, however this would still be misleading and a misrepresentation. When looking at the veteran cohort with gold and white cards, they are predominantly a population with comorbid and complex conditions hence their need for health care and services would be even greater than an average person or person with private health insurance who typically would not have comorbid and complex medical conditions.

It would perhaps be of greater relevance to utilise expenditure data on allied health for the motor vehicle accident compensation population. This is because they receive funding for all clinically necessary treatment related to their claim and typically have complex and comorbid conditions.

We will provide our feedback and comments relevant to the Productivity Commission's Report's Key points;

- ***The veterans' compensation and rehabilitation system is not fit-for-purpose — it requires fundamental reform. It is out-of-date and is not working in the interests of veterans and their families or the Australian community.***

We strongly affirm the RAP program's framework/ objective and principles is fit for purpose.

We strongly affirm however, the administration of the RAP program is not fit for purpose, and yes does require fundamental reform.

When allied health undertake services for the DVA RAP program we are all governed and directed by the following documents, which are also legally binding; the Acts, The Treatment Principles, Notes for Allied Health Providers and the relevant DVA schedule of fees.

These governing documents, as mentioned, are legally binding and set the expectations upon the way in which allied health services for the DVA RAP program are to be delivered to veterans. These documents however do not translate to a fair and workable day to day system and we therefore strongly assert poor administration by the DVA management and clinical advisors for decades.

As a consequence of this poor administration, it has led to and will continue to, result in a decrease in a veterans' ability to access allied health services in general, and in particular quality allied health services.

In the very near future with the Allied Health Reform which has commenced roll out it will not be financially viable for practitioners to continue to provide allied health services.

I can personally confirm with the planned implementation of the 12 treatment session cycle due for implementation July 2019 it will no longer be viable for my organisation to provide OT services to Veterans.

The NDIS commissioned an independent pricing review and following the release of the Report by McKinsey & Company, the NDIA stated they were "committed to ensure a vibrant market for disability supports that enables participants to achieve better outcomes. A vibrant and financially viable market is essential to the longer-term sustainability of the Scheme".

In order for DVA to ensure a long term sustainable allied health service to the veteran community they must also fully commit to ensuring a vibrant and financially viable market exists as per the NDIS.

The level of DVA reimbursement equates to approximately 20% of NDIS and all other current and state funded hourly rates for occupational therapy services. The DVA RAP program remuneration in accordance with their schedule of fess is approximately $40 per hour as compared to the NDIS at a rate of $180 per hour.

Despite continued, regular, frequent and 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 however DVA still show no commitment to address the issue in any meaningful way. We have compiled an Analysis of DVA's Allied Health Reform Package and will provide this with our written submission.

In summary, the objectives and principles of the RAP Program and the allied health practitioners delivering this service are working in the interests of veterans and their families. The DVA administration processes, management and clinical advisors are not.

The system fails to focus on the lifetime wellbeing of veterans. It is complex (legislatively and administratively), difficult to navigate, inequitable, and it is poorly administered (and has been for decades), which places unwarranted stress on claimants. Some supports are not wellness focused, some are not well targeted and others are archaic, dating back to the 1920s.

The DVA RAP program does focus on the life time wellbeing of veterans as it focusses on the health and wellbeing of eligible veterans and their dependants post service up to and including their death.

In terms of their health and related wellbeing the RAP program addresses this very well.

We strongly agree with The Productivity Commission that the administration of the DVA RAP program is poor. We advise with serious concern that the DVA Allied Health Reform package which commenced implementation November 2018 will place unwarranted stress on veterans as it will reduce their access to allied health services, especially quality and timely allied health services. It will also force the veteran back to the GP on a regular basis to purely request and gain consent for continuation and/or completion of clinically required allied health treatment.

This DVA reform package is part of the Veteran Centric Reform however the new 12 session Treatment Cycle Initiative component of the reform package certainly is not based on a wellness model and instead adopts an archaic and non-contemporary medical model of health care.

This model is a very disempowering form of health service delivery and does not support the Veteran's Entitlement Act and Repatriation Private Patient Principles Legislation which is designed to promote the Veterans' right to health. A gold card allows access to and funding for all clinically indicated health services. Furthermore the reform package does not support basic human rights to dignity and freedom. GPs are already thin on the ground: this reform will place further time demands on an already overloaded GP service as well as increasing red tape for DVA (which DVA was trying to lessen as part of the Veteran Centric Reform).

The Productivity Commission made comment regarding equitable access and a proposal to provide a lump sum payment instead of the gold card, however I affirm this does not support the overarching wellness approach for veteran care. The DVA gold card communicates lifetime support, care and an importance and value on and individual's wellbeing. A monetary befit communicated by a lump sum payment does not support a lifetime wellness approach.

- ***In 2017-18, the Department of Veterans' Affairs (DVA) spent $13.2 billion supporting about 166 000 veterans and 117 000 dependants (about $47 000 per client). And while the veteran support system is more generous overall than workers' compensation schemes for civilians, money alone does not mean it is an effective scheme.***

We can confirm that on the ground from the many hundreds of Veterans we have serviced that they absolutely do not view the gold card as money in the context of the RAP program, Veterans view the Gold Card as support and care following a life of service.

First hand we can say, the gold card, in terms of health provision, has had a tremendous influence and positive outcome on wellbeing. Our experience is that it has an exponential influence on veterans' and their dependants' health and wellbeing. It is very telling when you compare a veteran and/or their dependent to a public patient, their care, concern and commitment for their own wellbeing is considerably higher than an average public patient.

In our experience, Veterans are grateful for any care received and would be mortified if they thought the community thought they were 'cash grabbing from the government'. A common theme amongst our veteran community is that they are concerned about not wasting money and not wanting to receive anything they didn't need.

I am concerned by The Commission's comments regarding the Gold Card discouraging wellness on page 19 of The Overview, which I believe to be misleading and out of context. It appears that the comment made by RSL NSW referenced in the commission's report has been taken out of context. I believe that the 'view of the system as a contest to be won', is the view of the DVA, not the entitled veterans.

A wellness model is a holistic model which allows a health practitioner to address all aspects of a person's life. A gold card allows treatment and care for all health conditions and this is essence allows for a holistic approach to caring for a veteran.

The Gold card does not discourage wellness.

- ***The system needs to focus on the wellbeing of veterans over their lifetime. This means more attention to prevention, rehabilitation and transition support, which in turn will produce better outcomes for veterans, their families and the Australian community.***

We affirm the current system does focus on the wellbeing of veterans over their lifetime.

The RAP objectives and principles to minimise the impact of disabilities, illnesses or injuries, maximise quality of life and maximise independence and participation in the community allows for attention to both prevention and rehabilitation.

We affirm that a focus on well-being does produce better outcomes for veterans, their families and the Australian community.

This evidenced through assisting veterans to maintain their independence at home, reducing their dependence on home and self-care support services (e.g. cleaning and showering assistance) and assisting to avoid hospital admissions by providing at home rehabilitation or hospital type equipment such as a hospital bed and hoist so they can be cared for at home. Reducing home care services, hospital and residential care admission comes with a high cost saving for the community.

- ***To achieve this focus, the system needs to be redesigned based on the best practice features of workers' compensation and contemporary social insurance schemes.***

We affirm the value of the need to use best practice and again wish to highlight that DVA's Allied Health Reform Package is not based on best practice nor is contemporary. It was an internal review with a multitude of flaws in their terms of reference and methodology. There was no references to best practice or evidence base given to justify the proposed reforms.

Any reform or redesign must be carefully considered and as such we are calling for an independent review into the DVA Allied Health arrangements.

In The Commissions formation of their recommendations in their report, they make reference to best practice models it is not clear what exact models the commission is referring to in the draft. I believe the Commission needs to make known which models it bases recommendations upon.

When considering best practices, please consider the Insurance Commission of WA, after recognising the cost for effective clinically required health services and rehabilitation related to motorist injury, a significant increase was made to third party insurance premiums.

DVA needs to acknowledge and accept the cost of effective, contemporary and best practice health care delivery.

DVA could provide more evidence based practice information specific to veterans. Along with proposed and planned funding for medical research as discussed in the Productivity Commission Report, there should also be funding for allied health research for Australian veterans.

In order to support DVA's wellness approach Allied Health research is essential. I am of the understanding that in the USA clinical research is funded for and conducted for both medical and allied health professions.

- ***This will require new governance and funding arrangements.***
  - ***A single Ministry for Defence Personnel and Veterans should be established.***
  - ***A new independent statutory agency — the Veteran Services Commission — should be created to administer and oversee the performance of the veteran support system.***
  - ***DVA's policy responsibility should be transferred to the Department of Defence within a new Veterans Policy Group.***
  - ***An annual premium to fund the expected costs of future claims should be levied on Defence.***

We believe that the governance and funding arrangements for the RAP Program should remain with the Department of Veterans' Affairs.

Should a new Veteran Services Commission be established, the VSC and the Independent Board must contain highly qualified and suitably experienced health professionals.

- ***DVA's recent Veteran Centric Reform transformation program is showing early signs of success. It should continue to be rolled out to mid-2021 as planned, but adjusted where necessary to accommodate the proposed reforms.***

DVA's veteran centric reform transformation intention in their own words is to make sure veterans and their families can access the services they rely on more easily and faster.

The allied health reform package roll out should be immediately suspended. As Those (veterans) who need help will not receive it more easily.

The reform will result in reduced access to quality allied health services as previously explained above. It will not meet the intended goals of providing quality and effective allied health services.

In line with contemporary health care schemes such as the NDIS, DVA should establish an independent quality assessment team and system to review and ensure the quality and efficiency of services delivered by all health providers.

A suggested adjustment to the proposed allied health reform would be to remove the need for a GP referral to allied health services. This would improve ease of access to services and make the system easier for all parties. In contemporary practice an individual with private health cover is not required to seek GP permission to access allied health services. This suggestion is supported by RSLWA.

There does not appear to be a sound reason for the need for a GP to consent to allied health intervention.

Allied health practitioners are registered health professionals bound by a code of conduct set out by AHPRA in partnership with the relevant health professional board to provide ethical and clinically appropriate services.

- ***The way treatments and supports are commissioned and provided to veterans and their families also needs to change. There needs to be more proactive engagement with clients and providers and better oversight of outcomes.***

We concur with this key point.

The current system of a one year referral with the option of providing ongoing care with GP consent works effectively and provides a quality service to the veteran. Further improvement would be to remove the need for a veteran to seek GP consent.

Once again, establishing an independent quality assessment team and system would be a method to review services delivered by all health professionals.

Improving the rigour of intervention by requiring the use of standardised assessment and outcome measures by allied health professionals will provide better oversight of outcomes and accountability of the health professional and services delivered.

There appears to be an attitude within the DVA that proactive engagement between veterans and providers is not supported. There is lack of value and respect for allied health intervention communicated by the DVA clinical advisors and management. This is evidenced through the longstanding ignorance of addressing significant service delivery problems such as general remuneration rates, remuneration for travel to visit veterans and writing reports to referring medical practitioners. There have been anecdotal reports of comments made to allied health providers by DVA clinical advisors questioning why the therapist is visiting a veteran or stating the therapist cannot return for another visit without ascertaining all relevant information before providing clinical direction.