

Introduction

Further to my initial submission there are some additional important points/facts I wish to raise.

I am doing so as I believe there is a lack of strong advocacy within the allied health industry.

We are a group of health professionals who typically just like to help and as a result can be vulnerable to unacceptable working conditions which in turn does impact on service quality and delivery.

We would like to raise 2 points with you.

1. Allied health Statistics and research within the Draft Report and subsequent conclusions drawn by the Commission.
2. Current Referral System/ Framework

1. In regards to Allied health Statistics and research within the Report, I believe some information, research and data provided to the Commission has not been suitably analysed or verified nor fairly or deeply considered.

In particular I wish to refer to:

- a) AMA Submission Feb 2016 –Review of Dental and Allied Health Arrangements
- b) DVA Statistics p 602 –(Rising number of dental and allied health services found to be unrelated to ageing)
- c) Medicare expenditure on allied health compared to DVA Allied Health Expenditure on Pg 565 of the report

I believe it is of great importance to discuss this information as it would appear the AMA and the Commission have concluded there are great inefficiencies in the provision of allied health services and a level of service provision that persists beyond what is clinically indicated.

- a) Regarding the AMA Submission to DVA – Review of Dental and Allied Health Arrangements, February 2016

On Page 602 of the Report, the commission directly references the AMA Submission.

The commission makes reference to the AMA's suggestion that *"DVA's allied health arrangements do not sufficiently guard against high levels of service usage"*.

The commission in their report continues by directly quoting from the AMA submission

"current referral arrangements do not encourage AHPs to report back to the GP and may, in some circumstances, encourage treatment by an AHP to persist beyond what is clinically indicated. (2016, p. 1)"

Furthermore, the AMA, in their 2016 submission, offer the following comment;

“We note with some concern, for example, that according to the background paper that shows that from July 2014 to June 2015 that of the average 25 services provided to DVA clients for dental and allied health almost 23 of those are for musculoskeletal services”.

We have obtained a copy of the Background Paper provided to the AMA by DVA and it appears the AMA have made an error in their interpretation of the facts within Table 2 – service utilisation 2014-15, pg6.

The data demonstrates that it is incorrect for the AMA to say that the proportion of musculoskeletal services equates to 23 out of the 25 average number of services (92%).

To determine the average number of dental and allied health services per client, the total number of services (3,947,495) is divided by the total number of clients (155,740), which results in an average of 25.

To determine what proportion of total allied health services is attributed to musculoskeletal services, the number of services for the musculoskeletal group (2,863,428) must be divided by the total number of services (3,947,495), which results in a proportion of 72%.

We wish to highlight that the musculoskeletal group includes 6 allied health disciplines – chiropractic, physiotherapy, occupational therapy, podiatry, exercise physiology and osteopathy. This is a large group of the most commonly accessed allied health providers. It is our opinion that the proportion of total services therefore is very reasonable. This proportion has remained stable with a 71% proportion of total allied health services in 2011-12 and 75% in 2016-17.

The correct interpretation of this data proves no evidence of over servicing or high usage of musculoskeletal services.

In 2016/17 DVA Statistics reveal the average number of dental and allied health services was 28.5 per veteran. This equates to roughly 1 service per fortnight from a group of 19 disciplines.

My professional experience tells me that this is a very reasonable and acceptable utilisation rate for the veteran population of which the majority, as reported by DVA, have co morbid and complex conditions.

In fact, I believe this service utilisation rate is on the low side and at a cost of \$2200 per veteran is a bargain.

Did you know the average cost for medical treatment is \$25,000.00 per veteran? This is the cost for GP and specialist consultations.

- b) I will move on now to the commission’s reference to some DVA stats and commentary relating to the rising number of dental and allied health services found to be unrelated to ageing

Page 602 of the report the Commissions references stats and commentary by DVA.

“There are other signs that suggest health service usage is not fully explained by ageing. Since 2010 the age profile has not changed much.... Yet from 2011-12 ..., the average number

of dental and allied health services per patient has increased by nearly 50 per cent (DVA 2018ag).”.

Whilst this commentary seems relatively innocuous, it does precede the AMA suggestion that DVA's allied health arrangements do not guard against high levels of service usage. The commission also offer no other explanation for the rising number of health services. A reader may draw the conclusion that the commission is eluding to the fact that rising levels of service usage is in fact attributed to over servicing.

Our health care system is much more advanced than it was 9 years ago. There is earlier detection of medical conditions and injuries, hence treatment and therapies are commenced earlier, emerging health disciplines such as psychology is generally more utilised now than it was 9 years ago along with exercise physiology which can account for the rise. New evidence around best practice may lead also to additional treatment sessions. Veterans just like the general public are better informed about health care, wellness and the role of allied health. This helps provide an explanation why an increase in allied health service usage does not have to be directly linked to ageing.

Furthermore, because there has been no meaningful rise in remuneration for DVA allied health providers in the last 10years, and at a remuneration rate of \$40 per hour, therapists have been forced to shorten their service sessions and do more of them to deliver the clinically required service in a financially viable way. Which can help explain the appearance of increased service use.

Im sure this trend in increase service usage would also be evident with the medical profession.

Why I draw your attention to this, is because it appears to affirm my concern the research and data related to allied health services has not been suitability analysed nor deeply considered.

c) I will move onto the Commission's commentary on Medicare expenditure on allied health vs DVA Allied Health Expenditure (p 565 Draft report)

“In 2016-17..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. Very few allied health providers participate in the Medicare schemes.

A published report in the Australian Health Review in 2011 affirms low uptake of the Medicare Allied Health services.

We as occupational therapists do not participate in the Medicare schemes such as the Chronic Disease Management Program because remuneration equals \$25 per hour. Because of this Allied health providers rarely participate in the programs and there is low uptake by the public.

It would be an improvement to utilise private health insurance costings for allied health service as a comparator, however 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 typically have complex and comorbid conditions and receive funding for all clinically necessary treatment related to their claim.

Finally, whilst the health care system has developed over the last 80 years, current mainstream health services still only provide very basic and essential health care. Generally the Australian population, if they can, will take out private health cover affirming that mainstream services are not enough to achieve good health outcomes and wellness.

It is on this basis that mainstream health services cannot be relied upon and the gold card needs to be provided to veterans and their dependents for their life time, up to and including death. The gold card supports wellness and communicates lifetime support which is are the overarching objectives of the future veteran support system.

2. Current referral system / framework

Whilst the current system of annual or continuing care referral supports a collaborative approach between the GP and allied health provider, it can interfere with veterans accessing timely allied health services of their choosing due the need to obtain GP consent. An example of this is a recent occupational referral received whereby the veteran reported discussing his request for a referral over a one year period. This veteran has PTSD and a number of orthopaedic conditions which has led to having difficulty mobilising around his home, getting in and out of his shower and on and off his toilet, having a genuine clinical need for occupational therapy services. The response from the GP had always been that he was unsure how an occupational therapist could help the veteran function better. As it turns out there were a number of interventions and ways we have been able to improve the veteran's functional mobility and well being in the home.

As a part of DVA's veteran centric reform, it is introducing in July 2019, a 12 session treatment cycle initiative for allied health services whereby the veteran must go back to the GP on a regular basis to purely request or gain consent for continuation and/or completion of clinically required allied health treatment. This reform does not support the commissions focus on wellness and instead adopts an archaic and non-contemporary model of health care. It is a very disempowering form of health service delivery and does not align with contemporary Australian models of health care such as the NDIS and My Aged Care which are based on choice and control.

The proposed DVA allied health reforms are removing choice and control for the veteran and runs counter to the Veterans' 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.

The allied health professional is the best person to determine a treatment plan and measure outcomes. This role does not lie with the GP. GPs are not rehabilitation consultants nor case managers and therefore not suitably qualified or resourced to determine treatment plans and outcomes of up to 17 different allied health professions (dental and optical excluded).

The anticipated result of this reform will be the veteran will not attend the GP to seek a referral as it is too cumbersome and will place unwarranted stress on the veteran. This will lead to reduced engagement in clinically required services and reduction in veteran wellbeing.

As it stands, DVA entrusts the medical profession, dental and optical, to ensure integrity and delivery of only clinically required services. Just like these health professionals, what is the reason that DVA should not entrust other health professions?

Our professional regulatory bodies require us to act with integrity and only provide clinically appropriate services. Should we not abide by this, we risk losing our registration, career and livelihood.

Establishing an independent quality assessment team and system would be a method to safeguard against possibility of overservicing.