

CONSULTATION RESPONSE



**Allied Health
Professions
Australia**

PRODUCTIVITY COMMISSION DRAFT REPORT COMPENSATION AND REHABILITATION FOR VETERANS

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Introduction

Thank you for the opportunity to respond to the Productivity Commission's Draft Report into Compensation and Rehabilitation for Veterans. Allied Health Professions Australia (AHPA) works on behalf of 20 individual allied health profession members and a further six affiliate members, together representing some 100,000 allied health professionals. Given the age profile and health needs of Australia's veterans, allied health professionals are important providers of care. The role of Department of Veterans Affairs (DVA) funding is particularly important in the context of allied health care due to the structural issues that currently limit access to services via Medicare.

In responding to this consultation, AHPA has chosen to comment only on those areas we feel we have sufficient knowledge and expertise. Those responses have been structured according to the individual recommendation, request for information or section. In broad terms, AHPA supports the overall recommendations of the draft report as a means to create a more sustainable system which provides appropriate access to services, which is easier to navigate for all concerned and we agree that reform is needed.

In addition to the specific feedback in this response, AHPA also encourages a review of our 2017 submission to the to the Senate Standing Committee on Community Affairs inquiry into the value and affordability of private health insurance and out-of-pocket medical costs (please see <https://ahpa.com.au/advocacy/value-affordability-private-health-insurance-submission/>) and our submissions to the Medicare Review (<https://ahpa.com.au/advocacy/mbs-review-framework-improving-access-allied-health-services/>).

The specific areas of the report in which we have an interest and have developed responses are:

- **Draft Recommendation 4.1 – Objectives and principles**
- **Draft Recommendation 6.3 – Transition arrangements**
- **Section 6.4 - Commissioning of services**
- **Information Request 6.2 – Consumer-directed care**
- **Recommendation 15.1 – White and Gold Card eligibility**
- **Recommendation 15.2 – Risk-based funding approaches**
- **Information Request 15.2 – Fee-setting arrangements**
- **Recommendation 15.3 – Review of mental health services**
- **Information request 15.3 – Subsidising private health insurance**
- **Achieving a cost effective system - Allied health arrangements**

Responses to individual recommendations and requests for information

Draft Recommendation 4.1 – Objectives and principles

AHPA fully supports the objectives and principles outlined in draft recommendation 4.1 as the basis for a more effective and equitable scheme to support Australia's veterans. We very much recognise the need to enshrine the right values and principles and support the need for a holistic wellness approach that has at its core a focus on wellness and a strengths-based approach. Given that the experience of many veterans, in the context of needing services, will be a situation of diminished ability and the significant challenges this presents, a more positive and empowering approach is essential. In this context we note that the types of interventions provided by allied health providers very much fit within this paradigm and we encourage greater emphasis on the value of allied health interventions.

We feel it is important to raise concerns about the draft report's references to financial affordability as a key principle and strongly recommend that the Commission apply caution when focusing on sustainability and financial affordability. While we very much support the need for reforms that ensure the scheme is using its funds effectively, our experience suggests that sustainability is often a de facto means of applying non-evidence-based rationing. This in turn can end up leaving consumers choosing one health service over another, even where this may be less appropriate, due to funding structures arising from rationing.

The current Medicare system is a perfect example of consumers being driven to seek what may be less appropriate care due to lack of funded access. In the context of health and disability-related services, this can often mean that access becomes limited to reactive needs where health outcomes may often be poorer as a result. We firmly argue for the need to keep a strong focus on preventative and early-intervention approaches that can make a significant difference to longer term outcomes for veterans.

Draft Recommendation 6.3 – Transition arrangements

AHPA strongly supports changes to the transition arrangements for veterans in need of rehabilitation services moving out of the Australian Defence Force. We support the recommendation that responsibility for managing this transition is managed by Joint Transition Command. We also support the recommendation that services remain in place until claims under the DVA scheme have been processed to ensure that veterans are able to access services during the interval between discharge and a successful DVA claim. Continuity of care not only increases the likelihood that veterans achieve appropriate rehabilitative outcomes, it also provides greater certainty for both veterans and the providers delivering care. This can ensure that both are able to focus on addressing the needs of the veteran rather than wrestling with uncertain funding arrangements.

AHPA also recognises and supports the need for rehabilitative care to be based on evidence-based approaches and that there is value in ensuring that outcomes are measured and reported. However,

we argue that caution is needed in applying this recommendation. We note, for example, that the recent Medicare Review has found that a large proportion of the care funded through the Medicare Benefits Schedule has only a minimal evidence base. This by no means suggests that the funded treatment is ineffective, rather it is the result of the significant costs and complexities involved in developing a vigorous evidence base. Instead we suggest that this recommendation limits funding for any interventions where evidence has shown that they are ineffective. A recent example is the use of knee arthroscopy for osteoarthritis.

We also note the significant challenge of reporting on outcomes given the current lack of agreed outcome measures, the lack of consistent systems to measure and report on these outcomes and the multitude of factors and time delays that can be involved in achieving outcomes. Many outcomes are heavily dependent on factors that are beyond the practitioner's control. We propose that an initial step towards the implementation of this recommendation is work with the relevant parts of the health and social support sectors in order to begin mapping consistent outcomes measures that could be applied across different types of rehabilitation service.

It will be important to consider whether these outcomes measures are able to align with the outcomes sought by veterans as part of a move to consumer-directed care. In conjunction with this work, it will be important for the DVA to begin mapping the capacity of different parts of the sector to measure and report these outcomes with the existing systems that are utilised or whether new systems will be required. If the latter, it will be essential to ensure that providers are supported to implement these systems and that such requirements do not inadvertently squeeze out smaller providers who may play an essential role in providing care, particularly in rural and remote areas with limited services.

Section 6.4 - Commissioning of services

The draft report suggests changes are required in the context of commissioning of rehabilitation services. More specifically, the report suggests options including:

The outsourcing of much of the rehabilitation management, coordination and provision to established service providers. This could be done on a state-by-state basis so that there may be only one (or two) providers per state or territory with the aim to have a small number (nationally) of high-quality and well-monitored providers, creating a competitive environment based on best practice approaches and outcomes.

AHPA has significant concerns about the potential impact of this approach on consumer choice and competition, on access to services in regions with lower demand and lower volumes of care, and on the overall quality of care provided to veterans. The allied health sector is an important provider of rehabilitation services to veterans, both physical and psychological. Currently a large majority of those allied health services are provided by private practitioners working in solo or small businesses. The move to have all services delivered by a small number of state-based or national organisations is likely to significantly impact the size of the marketplace, reducing choice for consumers, limiting access to quality services, and reducing individual incomes for providers who may be forced into employment or contractual arrangements with these providers.

The allied health sector's experience with the NDIS is showing that even without a focus on several large providers, smaller operators are effectively being squeezed out of the market by onerous compliance costs and regulations. AHPA is concerned that none of the current options sufficiently consider the structure of the allied health landscape or the impact of these different commissioning models on access to services or sustainability of those providers on whom veterans depend. As such, we strongly argue for the need to undertake additional work and consultation in this space ahead of a final report, focused on engagement with the allied health sector, aimed at ensuring the right balance is struck between efficient commissioning systems, quality, accessibility, and choice for consumers, and not endangering the viability of providers, particularly those in rural and remote regions.

Information Request 6.2 – Consumer-directed care

The Commission is seeking further views on the potential use of consumer-directed care for the rehabilitation services provided to veterans, or on alternatives for providing more tailored, person-centred rehabilitation services.

AHPA strongly supports a move to provide veterans with a more active role in directing their own care. A wide body of research has shown the positive impact that consumer-directed approaches can have on outcomes for consumers, allowing them to determine the outcomes that are important to them, providing greater choice and flexibility and providing greater dignity and empowerment to people who are in situations where they may feel that they have lost control and choice.

However, while AHPA strongly supports this approach, we advise caution and careful consideration in the design of a system based around consumer-directed care. The experience of those allied health providers delivering services across disability and aged care suggests that while some consumers are very health literate and well able to self-advocate, many more are not, and this can lead to significant differences in outcomes. We argue that being able to manage and direct one's own care requires substantial health literacy and for many consumers is likely to require significant support at the outset through a care coordinator or planner, as is provided under the National Disability Insurance Scheme (NDIS).

Importantly, our experience with the NDIS suggests that many planners and coordinators themselves lack knowledge and experience and this can impact negatively on the people they support. We argue that it will be vital to ensure that any providers involved in supporting care coordination and planning have the appropriate qualifications, training, and experience to understand the complex range of services and systems that make up our health and social support sectors. Only then can we ensure that veterans are provided expert, safe and appropriate support that allows them to build the knowledge and confidence to fully manage their own care.

Our recommendation is for a system that is based around consumer-directed care and funding of veterans based on their own needs with significant capacity to control how that funding is utilised. However, we recommend that as part of the transition to such services, all veterans are provided initial support to improve their understanding of their own needs and how the health and social support systems can support addressing those needs. This planning and coordination support should

aim to withdraw as the veteran, or their family support system is able to take on the role independently.

Recommendation 15.1 – White and Gold Card eligibility

AHPA generally agrees that the Gold card should not be extended to new categories and that the White card system is appropriate for those with service-related injury or disability. However, we wish to state our strong concerns about the stated premise that access to health care has now changed and that those not eligible for either card can rely on systems other than the Department of Veteran's Affairs for access to the care they may require. We strongly object to the notion that 'Australia's universal public health system means that veterans will have access to health care regardless of their financial circumstances' through Medicare and the fact that 'private health insurance is subsidised by the government'. Given our concerns, the Commission may wish to revisit the assumptions that underpin this recommendation for the final report.

There is extensive evidence from a wide range of expert commentators, showing that while Australians generally have access to a universal medical care scheme, the same does not apply to health care more broadly. Medicare provides only severely limited access to any allied health service and only for those with chronic and complex conditions. Annual limits on services severely restrict services even for those that are eligible and substantial 'gap' fees are the norm. In this context we note that recent reports from the Medicare Benefits Review as well as submissions by organisations including our own highlight the many access issues under the current structure. While some recommendations have been made for improvements, these are still subject to implementation and it will be important for the Commission to carefully monitor the outcomes of this work.

Leaving aside Medicare, private health insurance products are highly variable and generally provide only limited access to rebates for services provided by a small number of allied health professions. This access is not tied to the severity of the health condition and is not a genuine insurance product. Furthermore, these products are only available to those consumers with the capacity to pay for insurance. Current rates suggest that only around half of Australia's population has access to general treatment cover. We direct the Commission to our own submissions around private health insurance for further information about the issues that exist for consumers.

For those that can't access the health services they need via Medicare or private health insurance, their only option is to attempt to access publicly-funded State and Territory services, which generally have long waiting lists. All of these access issues are exacerbated further by rurality and remoteness. This flawed system has its greatest impact on the lower socio-economic groups whose access to 'universal health care' is effectively non-existent.

Recommendation 15.2 – Coordinated Veterans' Care program

AHPA strongly supports the need to provide additional coordination and support when veterans are at risk of hospitalisation. We note that the current Coordinated Veterans' Care (CVC) program, which funds general practices to provide more intensive support via block funding has shown some positive outcomes but is also showing higher costs and utilisation of medical services. We argue that

there is good reason to continue with the program though we recommend additional work is done to make sure the program is working effectively.

The draft report currently limits its recommendations to a risk-based fee schedule, which appears similar to what has been utilised for the government's Health Care Homes program. This is despite a note that the program could be improved by better targeting and measuring of outcomes. While we support an approach that ensures there is not an incentive to enrol veterans inappropriately, we are concerned that it does not seek to review how effective the program design is in meeting the needs of those patients.

Our concern about the current CVC program is that it focuses entirely on interventions by GPs and practice nurses despite a wealth of evidence showing that improving outcomes for people with chronic conditions requires a multidisciplinary approach. GPs play an essential role in risk-identification, diagnosis, medication prescription and referral. Similarly practice nurses can provide important coaching, education and other support. But this is only part of what is required to produce effective outcomes. For example, a person with diabetes and a high risk foot is at a high risk of amputation. Dealing with the diabetic foot effectively requires intensive care by a podiatrist or orthotist, not a GP or a practice nurse.

We argue that this is a fundamental flaw of the planning and development of the current health care homes program and that it is similarly a flaw in the design of the CVC program. If programs like these artificially isolate general practice from the rest of the primary care sector, we do not believe veterans will get the coordinated care they need; and the system will not utilise the most cost-effective and outcomes focused approaches. AHPA strongly urges a review of the program with the intention of expanding the involvement of the rest of the primary care sector, based around a strong evidence-based approach that delivers best practice care to enrolled veterans.

Information Request 15.2 – Fee-setting arrangements

The Commission is seeking participants' views on fee-setting arrangements for veterans' health care that would promote accessible services while maintaining a 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?

AHPA and its members have longstanding concerns about the rates paid by DVA for veterans and have spent significant time lobbying for increased fees in order to ensure greater access to services. Feedback from practitioners across a range of professions and across a range of locations and settings suggests that the low rates paid by DVA are a genuine barrier to access to high quality services, provided by experienced practitioners. Our view is that current rates are not sustainable and result in providers either refusing to provide services, using less experienced staff to deliver care, or to effectively subsidise services by charging lower than appropriate rates. None of these options are conducive to ensuring the best outcomes for veterans or supporting genuine choice. We

argue that an urgent review of fees is required to ensure the scheme remains sustainable for providers.

With regard to the request for information ‘*What would be the benefits and costs of separate fee-setting arrangements for Gold Card and White Card holders?*’ we consider that this would appear to be a reasonable approach whereby those with service-related injury and impairment have access to a higher level of benefits with the intention being to pay a higher rate for services and continuing to fully fund care.

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?

AHPA is cautiously supportive of an ability to charge co-payments for Gold Card holders, however we believe that White Card holders should have their care fully funded by means of a higher rate of fee. One of the biggest barriers to high quality care and consumer choice under the current DVA fee structure is the low levels paid for service. This has been noted in the report and is something providers frequently report to their peak associations. As such there is a strong argument to be made that allowing a co-payment to be charged would allow DVA to minimise fee increases for Gold Card holders while increasing the capacity of providers to charge a sustainable rate.

However, there is plenty of evidence that co-payments for those in vulnerable positions are a significant deterrent to accessing services and we are concerned about the consequences of such a change in terms of the accessibility of services for veterans and their dependants. While AHPA suggests that introducing co-payments for non-service related conditions would make provision of services to veterans or their dependents more viable for allied health practitioners, we recommend that changes are carefully evaluated to ensure that access does not become an issue for Gold Card holders. We reiterate our belief that White Card holders should have their care fully funded and that this care should be paid at a sustainable rate that is set much higher than the current rebates.

Recommendation 15.3 – Review of mental health services

AHPA supports the need to review mental health services and notes the range of recommendations and submissions made by other organisations and stakeholders. We also note that some work is already underway to review the quality of training. Given the range of other commentators on mental health, we have chosen to limit our comments in this space. However, while we very much support the recommendations made by other providers and strongly support an evidence-based approach, we note our strong contention that fundamental reforms are required in how we approach mental health services to reduce the artificial barrier between mental and physical health.

A growing body of evidence is showing the significant impact that physical factors can have on mental health with a range of research showing that diet and exercise interventions can be an important factor in supporting improved mental health. Similarly, a range of health and health-related issues, including communication issues or injuries resulting in loss of function can exacerbate mental health issues. Separating the approaches used to address mental health issues and those

related to physical health issues can be an impediment to coordinated and effective care for a veteran.

We also note that those experiencing significant mental health issues are likely to require additional support to address physical ill-health that can arise from the impact of their mental health condition, including psychotropic medications. Those experiencing mental illness have significantly higher rates of chronic illness and it is these chronic conditions such as cardiovascular disease and diabetes that often result in reduced life expectation and overall health outcomes. AHPA recommends that in considering an improved response to the mental health issues of veterans, the same wellness approach that is being considered in relation to rehabilitation should also be applied to mental health.

Information request 15.3 – Subsidising private health insurance

The Commission is seeking participants' views on the desirability of subsidising private health insurance for veterans and dependants in place of other forms of healthcare assistance.

AHPA strongly argues against any move to consider replacing the current DVA healthcare assistance mechanisms with private health insurance considering the many structural issues that are currently limiting the effectiveness of private health insurance more generally as well as the specific problems with general treatment cover that mean consumers with cover are not receiving fit-for-purpose or value-for-money services. We note that while our current government is attempting to improve insurance for consumers, many consumers are allowing their insurance to lapse at the same time as many expert commentators are challenging the question of whether government investment in private health insurance is effective. We have previously noted our specific concerns around access to allied health services through general treatment cover and further note that private health insurance is currently limited by structural limitations that limit rehabilitation services to in-patient services only. We strongly question whether the current structure of private health insurance products is likely to meet the needs of our veterans.

We also note again the dependence of private health insurance coverage on the ability of a veteran or dependent to pay the premiums and the gaps fees. This is particularly the case for general treatment services, which do not provide adequate access to allied health services and are dependent on the level of cover and arbitrary caps. Indeed the 'cover' for allied health services is not actually 'insurance' and has been previously described as a set of variable, poorly-targeted discount vouchers.

Achieving a cost-effective system – Allied health arrangements

AHPA wishes to raise a concern that the current draft report references the Australian Medical Association (p602) in suggesting that DVA's allied health arrangements do not sufficiently guard against high levels of service usage. We question the factual basis for this argument as well as the capacity and role of GPs in determining an appropriate amount of care by the treating allied health professional. While AHPA acknowledges that there may be occasions of overtreatment by any health professional group, we do not see that it is the role of one profession to police another.

More broadly, AHPA strongly supports structures that ensure better information-sharing between health professionals, particularly where a service referral has been made, and support the need to have reports sent back to the treating practitioner. We further argue that initiatives such as My Health Record can be an important means of improving understanding and awareness among the entire care team about the health care a veteran is receiving, and it may be appropriate to increase use of this system for veterans.

Similarly, we very strongly argue for improved usage of multidisciplinary care and greater referrals to allied health services. We note for example that GP referral rates for psychological services are far lower than rates of prescription for medications to people presenting with mental health issues. Our concern is that the primary care sector generally is not yet working as effectively as it could in supporting multidisciplinary care.

