REVIEW OF DVA DENTAL & ALLIED HEALTH ARRANGEMENTS

Final Report

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Department of Veterans' Affairs

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The Department of Veterans' Affairs would like to acknowledge the input and advice from a range of people in conducting the review of dental and allied health arrangements (the Review). In particular, the Department would like to thank:

- The representatives of the ex-service community who provided their views and contributions, including participation in the working groups.
- The professional associations which made written submissions to the Review, including recommendations and suggestions.
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GLOSSARY

Allied health services (in-scope for the Review): chiropractic services, diabetes education, dietetics, exercise physiology, occupational therapy, occupational therapy (mental health), optometry, orthoptics, osteopathy, physiotherapy, podiatry, psychology (including clinical and neuro psychology), social work, social work (mental health), and speech pathology.

Client (also "DVA client"): recipient of services funded by DVA; veterans and their dependants who are clients of DVA.

Dental services (in-scope for the Review): this includes services provided by dentists, dental specialists, and dental prosthetists.

DVA: the Department of Veterans' Affairs.

Ex-Service Organisation (also "ESO" or "ex-service community"): member-based non-government organisations supporting veterans and/or their families.

Ex-Service Organisation Round Table (also "ESORT"): the main forum for dialogue between the Military Rehabilitation Compensation Commission, Repatriation Commission, Department of Veterans' Affairs and the leadership of the ESO and Defence communities.

Gold Card holder: DVA client who is eligible to receive clinically necessary treatment for all medical conditions.

GP: general practitioner.

MBS: Medicare Benefits Schedule.

Patient: recipient of services from a provider funded by DVA.

Provider: practitioner who is funded by DVA for services delivered to DVA clients.

Review: the Dental and Allied Health Review.

Schedule (also "fee schedule"): the fee schedule allied health providers' use when claiming for a service to DVA client.

Treatment cycle: a course of clinically necessary allied health treatment of up to 12 sessions as referred by a GP.

Treatment Population: the cohort of DVA clients who hold either a DVA Gold card or a DVA White card, through which they are covered for dental and allied health services.

White Card holder: DVA client who is eligible to receive clinically necessary treatment for the treatment of specific medical conditions accepted under DVA arrangements.

Working group: working groups comprised of nominations from provider associations and ex-service organisations.

Review of DVA Dental & Allied Health Arrangements

EXECUTIVE SUMMARY

1. As part of the 2015-16 Budget measure *Dental and allied health provider fees - continuation of the indexation pause*, the Australian Government committed the Department of Veterans' Affairs (DVA) to review its dental and allied health funding arrangements (the Review).

2. The Review looked for opportunities, where appropriate, to re-balance DVA dental and allied health funding arrangements to ensure that services continue to best meet current and future needs of the veteran community. The Review was undertaken in consultation with representatives of the veteran community, dental and allied health associations and DVA clinical advisers. DVA also sought the views of the medical profession, through the Australian Medical Association and the Royal Australian College of GPs.

3. In 2016-17, DVA expenditure on dental and allied health services was approximately $319 million for 4.0 million services, delivered to over 140,000 DVA card holders, or 72 per cent of DVA's treatment population (defined as all holders of DVA Gold or White cards). This equates to an average of 29 services and over $2,200 per client per year.

4. In conducting the Review, DVA:

   - Invited written submissions from provider associations.
   - Consulted with members from ex-service organisations and clinical representatives from provider associations, through participation in working groups.
   - Consulted with DVA clinical advisers.
   - Reviewed service usage and client data.
   - Developed options for improving DVA's dental and allied health funding arrangements.

5. The main themes of submissions made by provider associations to the Review were:

   - Fees – concern was expressed by providers about the adequacy and competitiveness of fees, including the impact of the pause on indexation.
   - Schedules – proposals were made to support contemporary clinical practice, including making schedules more consistent and simpler.
   - Communication – suggestions were made on the need to better share information between allied health providers and general practitioners (GPs).

6. DVA formed five working groups to conduct the Review in the following areas: dental, mental health, musculoskeletal, optical and other clinical.

7. Working group membership included an ex-service organisation member, allied health providers, GP representatives, DVA clinical advisers and departmental officers. The role

of the working groups was to provide expert advice to DVA to ensure that DVA funding arrangements reflected contemporary clinical best practice. The working groups focused on analysis of current arrangements including service data for each profession; review of DVA schedules; and providing evidence-based options for the modification of existing items or the addition of new items. A number of common themes emerged:

- The need to promote multidisciplinary, collaborative care between allied health providers and GPs.
- Higher than expected use of some services – particularly some modalities in the musculoskeletal category.
- A need to recognise (and appropriately remunerate) the difference between treatment of clients experiencing acute episodes and complex clients with multiple comorbidities.
- How to deliver services out-of-rooms, when appropriate.

8. The Review found the main opportunities for improvement included:

- Improved quality of care through stronger communication channels between GPs and allied health providers.
- Improved efficiency of service delivery through simpler, more streamlined and coherent structure to the fee schedules.
- Introducing new and updated schedule items, including better alignment of the range of items available to the veteran community with contemporary clinical practice and services available to the general population.

9. DVA considered the content of submissions, deliberations in working groups and the results of data analysis to inform the recommendations of the Review.

10. Recommendations of the Review are:

- *Recommendation one*: implement a new Treatment Cycle model of service delivery to improve quality of care under allied health arrangements. Under this model, GPs would refer clients to allied health services (except for dental and optical) for up to and including 12 sessions of delivery or for a year, whichever is sooner.
- *Recommendation two*: undertake updates to the dental and allied health fee schedule to better reflect contemporary clinical practice and future needs and take advantage of strategic opportunities such as new technologies and innovative funding models.
- *Recommendation three*: undertake trials of new funding models to determine if more effective funding models could be implemented to meet future needs.

Review of DVA Dental & Allied Health Arrangements

1. INTRODUCTION TO THE REVIEW

11. This section of the report summarises the terms of reference and methodology of the Review.

12. Through its dental and allied health funding arrangements, the Department of Veterans' Affairs (DVA) seeks to ensure quality, effective, and clinically appropriate services to meet current and future needs of the veteran community.

13. The structure of this report consists of the following parts:

- Section 1: Introduction to the Review.
- Section 2: Background.
- Section 3: Review analysis.
- Section 4: Consideration by working groups.
- Section 5: Proposed Reform Package.

14. DVA undertook a review of its dental and allied health funding arrangements to ensure that they continue to meet the current and future needs of the veteran community. The Review was a component of a 2015-16 Budget measure *Dental and allied health provider fees - continuation of the indexation pause*.

15. DVA sought to maintain consistency with broader government policy and reforms in the Review's considerations. The Review occurred at the same time as the review of the Medicare Benefits Schedule (MBS) undertaken by the Department of Health.

16. The Review:

- Considered DVA fees, business rules, service utilisation and trends including prior approval arrangements for dental and allied health services.
- Considered contemporary and evidence based trends in the delivery of dental and allied health services in Australia.
- Considered opportunities to streamline interaction with DVA and identify options to reduce red-tape for health care providers.
- Sought to remain cost-neutral to government – i.e. any additions to expenditure would need to be offset by reductions in other expenditure.
- Complemented, and not duplicated, the review of the MBS.
- Was undertaken in consultation with representatives of the ex-service community, GPs and dental and allied health care providers.

17. In conducting the Review, DVA engaged with health providers and their representatives from associations to ensure a broad representation. The following allied health services were in-scope for the Review:

- chiropractic
- clinical psychology
- dental – including dental specialty
- dental prosthetics
- diabetes education
- dietetics
- exercise physiology
- neuropsychology
- occupational therapy
- occupational therapy (mental health)
- optometry
- orthoptics
- osteopathy
- physiotherapy
- podiatry
- psychology
- social work
- social work (mental health)
- speech pathology

18. In order to consult with clinical experts from these professions, DVA formed five working groups in the following areas: dental, mental health, musculoskeletal, optical and other clinical. Information on membership of the working groups is at Attachment A. The optical working group discussion was about current arrangements for the DVA visual aids schedule.

19. The following items were out-of-scope for the Review:

- Arrangements within the scope of the MBS Review (to avoid duplication of activity). This included optical consultations available on the MBS.
- Proposals that were not cost neutral to Government (any changes to fee schedules would need to be offset by reductions in other areas).

20. Broadly, the Review was undertaken in three phases:

- Phase one: Data analytics (service utilisation), conducted from 2015 to 2017.
- Phase two: Stakeholder engagement and communication (by establishing working groups with professional associations and the ex-service community including through the Ex-Service Organisation Round Table (ESORT) and focus group) conducted from 2016 to 2017.
- Phase three: Analysis and reporting conducted from 2017 to 2018.

2. BACKGROUND

21. This section of the report sets out the program context and history of DVA's dental and allied health arrangements, details about indexation, and prior approval arrangements.

2.1 Program Context & History

22. The Australian Government provides almost $5 billion per year in funding for health treatment, services and support to veterans and their families. DVA uses a health card system as the basis for enabling access to health and other care services for veterans, war widows and eligible dependants. Gold card holders are eligible to receive clinically

appropriate treatment for all of their medical conditions. White card holders are eligible to receive clinically appropriate treatment for specific medical conditions accepted under DVA arrangements.

23. Under the *Veterans' Entitlements Act 1986* (VEA), the *Safety, Rehabilitation and Compensation (Defence-Related Claims) Act 1988* (DRCA) and the *Military Rehabilitation and Compensation Act 2004 (*MRCA), arrangements for the provision of health care services is set out in the Treatment Principles under Section 90 of the VEA and Section 286 of MRCA. Health care services under the DRCA are provided through the VEA Treatment Principles.

24. Under the Treatment Principles access is provided to a broader range of treatments and services than services available to the general population through Medicare. These services include private or public hospital treatment, GP services and specialist services, allied health services, dental services, optical services and ambulance. DVA health card holders are also covered for a wide range of rehabilitation devices and appliances, pharmaceuticals, travel and accommodation for treatment.

25. The DVA scheduled fee for medical and other health services available on the MBS is significantly higher than the MBS. For example, out of hospital procedures and specialist consultations for DVA clients are 140 per cent and 135 per cent of the MBS fee respectively. For GP consultations the DVA scheduled fee is 115 per cent of the MBS fee. Additionally, the DVA fee represents the full payment for service with no scope for the provider to charge a co-payment to DVA patients, except for pharmaceuticals and some dental items.

26. From 2007, statutory registration was progressively introduced to most categories of medical, dental and allied health providers in order to simplify the registration process and avoid the need for providers to enter into individual contracts with DVA. Statutory registration allows for any provider who is registered with the Department of Human Services (formerly Medicare Australia) to treat DVA patients under DVA arrangements.

27. The last major review of DVA's fees was carried out in 2006. This package, known as '*Maintaining the Integrity of the Gold Card'* took effect from 1 November 2006 and established a new basis for DVA fees.

28. From 1 November 2010, the DVA allied health fee structures for mental health providers were aligned to the MBS mental health items under the MBS *Better Access* initiative for clinical psychologists, psychologists, social workers (mental health) and occupational therapists (mental health).

29. DVA has specific arrangements for provision of services by neuropsychologists.

30. Under current service arrangements, in order to access DVA funded allied health services, DVA clients need a GP referral, except for dental and optical treatment. A referral is valid for twelve months unless it is an ongoing referral. For each new condition requiring treatment, a referral must be obtained.

2.2 Indexation of DVA Fees

31. Since 2006-07, DVA specific medical, dental and allied health fees have generally been indexed in the same way as MBS indexation, including aligning of the timing, quantum and indexation pauses under Government Budget measures.

32. The Government last indexed fees for dental and allied health providers under DVA arrangements in November 2013. As part of the 2015-16 Budget measure *dental and allied health provider fees – continuation of the indexation pause,* DVA dental and allied health fee indexation is recommencing from 1 July 2018, one year prior to indexation of general MBS allied health fees on 1 July 2019.

2.3 Prior Approval Arrangements

33. Providers may submit a request to obtain approval to provide treatment for DVA clients when:

- Items are not listed on the MBS or DVA's dental and allied health schedules.
- Where items are listed but there are special circumstances / complexities that justify a higher fee
- Where the fee requested is above the DVA scheduled fee.

34. Such requests are determined on the basis of clinical need and the patient's ability to reasonably access another provider is also taken into account.

3. REVIEW ANALYSIS

35. The Review considered extensive data on patterns of utilisation of the dental and allied health services by DVA cardholders. DVA undertook in-depth data analysis, providing this analysis to the working groups for consideration. This section of the Review report provides a high level summary of this data and analysis, with a section on overall trends followed by sections showing a summary of analysis of dental and allied health services between 2011-12 and 2016-17.

3.1 Overall trends

36. Between June 2012 and June 2017, there was a net decline of 17 per cent in the overall numbers of the DVA treatment population and a 27 per cent decline in the numbers of DVA gold card holders (treatment all conditions). Approximately 78 per cent of the current treatment population is over the age of 60, with an increasing number of clients with a white card (treatment specific conditions). This reflects a shift from the World War II population to the more recent generations of conflict/ service in DVA's client profile.

TABLE 1: CHANGE IN DVA TREATMENT POPULATION OVER TIME

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Gold Cards	185,031	174,168	163,578	153,033	143,635	135,263
Change %		-5.9%	-6.1%	-6.4%	-6.1%	-5.8%
White Cards	48,769	49,013	53,984	55,148	56,610	58,705
Change %		-0.5%	+10.1%	+2.2%	+2.7%	+3.7%
Total	233,800	223,181	217,562	208,181	200,245	193,968
Change %		-4.5%	-2.5%	-4.3%	-3.8%	-3.1%

Note, change % is based on the actual figures not rounded numbers for this and all tables in this report

37. Notwithstanding the overall decline in client numbers, expenditure on dental and allied health services has risen by 22 per cent. Indexation has not been a major cost driver in this period, as indexation was paused from November 2013. Table 2 shows how expenditure has risen overall across dental and allied health services from 2011-12 to 2016-17, in the context of declining patient numbers.

TABLE 2: CHANGE IN DVA DENTAL & ALLIED HEALTH ARRANGEMENTS OVER TIME

All Services	2011-12	2016-17	Change %
Total expenditure (millions)	$261.7	$319.4	+22%
Total service quantity (millions)	3.4	4.0	+18%
Total patients	173,534	140,367	-19%
Average services per patient	19.4	28.5	+47%
Average cost per patient	$1,505	$2,285	+52%

38. Contained within these overall trends, both musculoskeletal and mental health services show substantial increases in the number of services over 2011-12 to 2016-17. Increased use of mental health services can be attributed to the expansion of non-liability health care arrangements and the promotion of access to mental health services. These trends will be discussed in more detail below for dental, mental health, musculoskeletal, optical and other clinical services. These categories align with the working group considerations and analysis.

3.2 Dental services

39. *Dental services* has the second largest expenditure under DVA's dental and allied health arrangements. This includes all consultations and services provided by general and specialist dentists, as well as dental prosthetists. Table 3 shows a 5 per cent growth in total cost between 2011-12 and 2016-17, a steady level of service quantity, and a 25 per cent increase in cost per patient over the same period.

TABLE 3: DENTAL SERVICES

Dental Services	2011-12	2016-17	Change %
Total expenditure (millions)	$88.1	$92.1	5%
Total service quantity	687,558	689,828	0.3%
Total patients	85,191	70,998	-17%
Average services per patient	8.1	9.7	+20%
Average cost per patient	$1,034	$1,297	+25%

40. The dental fees schedule is the most complex of all dental and allied health schedules, due largely to the potential for a number of separate individually funded services that may be provided in a single appointment.

3.3 Mental Health services

41. *Mental health* services includes all consultations for psychologists (clinical, general and neuro), as well as services provided by mental health occupational therapists and social workers. There has been significant growth both in total patients and average cost per patient, although from a relatively low base. It should be noted that the figures below do not include services provided by the Veterans and Veterans Families Counselling Service (VVCS), which operates independently from DVA card arrangements. The Review did consider the relationship between VVCS and DVA arrangements, therefore VVCS representatives were included as part of the mental health working group.

TABLE 4: MENTAL HEALTH SERVICES

Mental Health Services	2011-12	2016-2017	Change %
Total expenditure (millions)	$1.9	$8.7	+358%
Total service quantity	16,365	71,109	+335%
Total patients	737	1,357	+84%
Average services per patient	22.2	52.4	+136%
Average cost per patient	$2,558	$6,380	+149%

42. The growth in the provision of mental health services shows the focus on improving access to mental health, including through non-liability healthcare arrangements in which a veteran may access mental health care through a white card. Most recently, these arrangements were expanded so that any person with a day's permanent service in the Australian Defence Force may access these arrangements for all mental health conditions.

3.4 Musculoskeletal services

43. *Musculoskeletal* includes services for chiropractors, exercise physiologists, occupational therapists (general), osteopaths, physiotherapists and podiatrists. As shown in Table 5, there has been significant growth in the overall provision of services in this sector over 2011-12 to 2016-17, with a growth of 59 per cent in cost per patient.

TABLE 5: MUSCULOSKELETAL SERVICES TOTAL

Musculoskeletal Services	2011-12	2016-17	Change %
Total expenditure (millions)	$152.8	$197.1	+29%
Total service quantity (millions)	2.4	3.0	+25%
Total patients	138,532	112,122	-19%
Average services per patient	17.5	26.4	+51%
Average cost per patient	$1,103	$1,758	+59%

44. Given that musculoskeletal services covers such a broad range of professions, Table 6 shows the relative number of clients, services and costs across the different musculoskeletal disciplines in 2016-17, with physiotherapy, exercise physiology and podiatry being the largest expenditure categories.

TABLE 6: SUMMARY OF MUSCULOSKELETAL SERVICES PER MUSCULOSKELETAL PROVIDER GROUP

	Osteopathy	Chiropractic	Occupational Therapy	Podiatry	Exercise Physiology	Physiotherapy
Total expenditure:	*(millions)*	*(millions)*	*(millions)*	*(millions)*	*(millions)*	*(millions)*
2011-12	$1.3	$7.1	$17.3	$44.4	$17.5	$65.3
2016-17	$2.1	$8.7	$21.7	$41.4	$41.9	$81.3
Change %	+62%	+23%	+25%	-7%	+139%	+25%
Total services:						
2011-12	21,756	117,245	207,916	695,271	294,830	1,092,109
2016-17	33,108	136,580	229,484	597,489	653,152	1,304,636
Change %	+52%	+16%	+10%	-14%	+122%	+19%
Total patients:						
2011-12	1,864	9,383	43,364	103,637	7,603	55,748
2016-17	2,328	9,120	39,598	75,152	16,005	54,214
Change %	+25%	-3%	-9%	-27%	+111%	-3%
Cost per patient:						
2011-12	$697	$757	$399	$428	$2,302	$1,171
2016-17	$900	$949	$547	$551	$2,619	$1,500
Change %	+29%	+25%	+37%	+29%	+14%	+28%
Average service per patient:						
2011-12	11.7	12.5	4.8	6.7	38.8	19.6
2016-17	14.0	15.0	6.0	8.0	41.0	24.0
Change %	+20%	+20%	+25%	+19%	+6%	+23%

45. Musculoskeletal expenditure represented 62 per cent of the total DVA dental and allied health expenditure in 2016-17 (excluding optical consultation services) and an increasing level of services for some disciplines.

46. Analysis of the data shows many clients are using a high number of services per year. More than a quarter of all clients who received a musculoskeletal service between 1 July 2016 and 30 June 2017 received more than 12 services (in at least one treatment type). For example, in 2016-17, the average number of services per patient for exercise physiology was 41 services and for physiotherapy it was 24 services.

47. Additionally, a number of patients have been receiving a high number of services consistently over multiple years. For example, nearly 5 per cent of all exercise physiology patients and nearly 13 per cent of all physiotherapy patients received more than 12 services in all three years across 2014-15 to 2016-17.

3.5 Optical Visual Aids

48. *Optical* includes items available on the visual aids schedule. Table 7 shows a decrease of 5 per cent in total expenditure. In addition, while there have been decreases to both total services and total patients of 16 per cent, from 2011-12 to 2016-17, there has been an increase in the average amount paid per service.

TABLE 7: OPTICAL VISUAL AIDS

Optical	2011-12	2016-17	Change %
Total expenditure (millions)	$15.2	$14.5	-5%
Total service quantity	246,583	208,202	-16%
Total patients	59,627	50,267	-16%
Average services per patient	4.1	4.1	0%
Average amount paid per service	$61.5	$69.7	+13%
Average cost per patient	$254	$289	+14%

3.6 Other clinical services

49. *Other clinical* services includes consultations for diabetes educators, dietitians, speech pathologists and social workers (non-mental health). Table 8 shows an increase of 78 per cent in total service quantity, although a small number of total patients and cost per patient overall.

TABLE 8: OTHER CLINICAL SERVICES

Other Clinical Services	2011-12	2016-17	Change %
Total expenditure (millions)	$3.7	$7.1	+92%
Total service quantity	44,965	80,024	+78%
Total patients	10,564	11,314	+7%
Average services per patient	4.3	7.1	+65%
Average cost per patient	$354	$624	+76%

50. Given other clinical services contains a diverse range of professions, Table 9 shows the relative number of clients, services and costs across the different other clinical provider groups in 2016-17, with social work (general), speech pathology and dietetic numbers showing the greatest increase in expenditure and number of patients, although from a relatively low base. Overall expenditure in this category is low comparative to other allied health provider groups.

TABLE 9: SUMMARY OF OTHER CLINICAL SERVICES PER PROVIDER GROUP

	Diabetes Education	Dietetics	Social Work	Speech Pathology
Total expenditure (millions):				
2011-12	$0.1	$2.6	$0.4	$0.9
2016-17	$0.2	$5.1	$1.2	$1.6
Change %	+50%	+97%	+222%	+75%
Total services:				
2011-12	1,823	34,397	3,906	7,589
2016-17	2,546	63,996	11,448	11,819
Change %	+40%	+86%	+193%	+56%
Total patients:				
2011-12	813	6,622	716	1,239
2016-17	923	8,728	1,191	1,257
Change %	+14%	+32%	+66%	+1%
Cost per patient:				
2011-12	$166	$394	$510	$739
2016-17	$219	$589	$989	$1,278
Change %	+32%	+49%	+94%	+73%
Average service per patient:				
2011-12	2.2	5.2	5.5	6.1
2016-17	2.8	7.3	9.6	9.4
Change %	+23%	+41%	+76%	+54%

4. CONSIDERATION BY WORKING GROUPS

4.1 Overview

51. This section of the Review report provides summary details of the themes that emerged from the working groups.

52. Associations representing GP, dental and allied health providers were invited to participate in a consultation process to help identify issues and priorities for consideration. The professions were organised into five working groups with submissions invited from each provider association. The working groups also included representatives from ex-service organisations as well as DVA clinical advisers and departmental officers.

53. Further information on membership of the working groups and list of written submissions can be found at Attachment A.

54. The working groups agreed on a set of core principles that underpinned discussions. Care to DVA clients should:

- Place veterans and clients first.
- Be based on the best evidence.
- Be clinically appropriate.
- Be well coordinated across different providers.
- Deliver positive outcomes.
- Enable self-management.

55. The following themes emerged from the working groups:
- While the number of clients is decreasing the number of individual services is generally increasing.
- The GP does not always have visibility of the veteran's progress and quality of care.
- There are issues with communication between allied health providers and GPs, particularly when treating complex patients.
- Care is not always well coordinated.
- There is limited evidence to determine if treatment outcomes are being achieved.
- Periodic review is not generally undertaken within the 12 month referral period.

56. The allied health associations made submissions to the Review which covered a range of issues, including fee levels, partly in response to the indexation pause and partly to reflect the changing cost of some items and new treatments. DVA emphasised throughout the consultations that any increases in fees would need to be fully funded through efficiencies.

57. Taking account of these themes, DVA developed a new Treatment Cycle model. This model has been designed to address care coordination challenges and to better leverage the role of GPs in assessing the appropriateness of ongoing treatment across one or more modalities in conjunction with the treating allied health providers. Currently, GPs make a referral to allied health providers valid for up to 12 months (unless it is an

ongoing referral for a chronic condition). Details of the Treatment Cycle can be found in Section 5 of this report.

58. Further details of the issues and options discussed are outlined below.

4.2 Dental services

59. The dental fee schedule is predominately activity based, with fees paid for procedures undertaken rather than based upon time taken to provide treatment.

60. The main issue for dental services is updating the current DVA fee schedule to reflect the current Australian Dental Association schedule of services. This would help clarify service definitions and encompass new types of treatment. Proposed changes could also re-configure some fees to better reflect the costs of providing the service.

61. The working group also discussed how there are already a number of controls to manage cost, which include elements of patient contributions.

4.3 Mental health

62. Currently fee schedules are based on time based items for the different mental health providers. Different options were considered for funding services provided by psychologists, mental health social workers and mental health occupational therapists. These options were principally a fee model based upon the service provided (for example, trauma-focused therapy, cognitive behavioural therapy, counselling, case management were some of the preferred options). Currently the schedules are based upon time based fees for different professions.

63. After considering issues raised in the working group, DVA considered that the qualification-based model should be maintained for the time being, with some modifications. Further work is required across mental health professions to clarify issues in relation to the scope of practice required to support a service-based funding model.

4.4 Musculoskeletal services

64. Musculoskeletal services (chiropractic, exercise physiology, occupational therapy, osteopathy, physiotherapy and podiatry) represent approximately 62 per cent of total dental and allied health expenditure.

65. Service trends for musculoskeletal services demonstrate consistently high and increasing levels, notwithstanding the declining trend in the DVA treatment population. With the exception of occupational therapy and podiatry services, average service use is at least 12 per year.

66. In 2016-17, the average for exercise physiology was just over 40 visits, and for physiotherapy the average service use was just over 24 visits. In comparison, the average annual GP consultations has remained stable at around 12 visits per year since 2010-11 as shown in Table 10 below.

TABLE 10: SUMMARY OF GP CONSULTATIONS

GP consultations	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Total expenditure (millions)	$143.8	$141.9	$137.8	$131.9	$125.0	$118.1
Total service quantity (millions)	2.6	2.4	2.3	2.2	2.0	1.9
Total patients	209,381	198,438	189,529	179,933	170,457	162,065
Average services per patient	12.2	12.3	12.3	12.1	12.0	11.8
Average cost per patient	$687	$715	$727	$733	$733	$729

4.5 Optical

67. A range of options were discussed about the DVA visual aids schedule to allow the DVA card holder more flexible options, particularly single rates for frames, low vision aids, contact lenses and consumables.

68. Providers also provided feedback that the DVA schedule would benefit from further alignment with industry standards, enabling providers to better meet the needs of the veteran community while also reducing red-tape.

4.6 Other clinical services

69. No substantive issues were identified across the utilisation of services, for diabetes education, dietetics, speech pathology, and social work. The main area of interest was the opportunity for potential new service items.

5. PROPOSED REFORM PACKAGE

70. DVA considers there is both an opportunity and a need to re-balance funding arrangements for dental and allied health services, in order to both improve quality and efficiency. Rather than taking the approach of a general fee increase, DVA instead considered upgrades for particular items, for instance where there is a new treatment or in order to provide a new type of service for clients. This section of the report sets out a proposed reform package with four main elements.

5.1 Element 1: Technical adjustments to the schedules

71. DVA could move to implement a number of technical adjustments to the dental and allied health fee schedules in the short term. The aim of these changes would be to upgrade the schedules to a more contemporary industry standard. For instance, DVA could implement a number of technical changes to the dental and optical fees schedule to better align the schedules to the relevant industry standard.

72. DVA would need to consult with affected professional associations before implementation of these changes. These technical changes would need to be cost neutral over current budget estimates.

5.2 Element 2: A New Treatment Cycle

73. A number of concerns emerged from DVA's analysis and discussions in the working groups of the dental and allied health arrangements that indicated both quality and efficiency of the arrangements needed to be improved. Concerns included the GP needing to have more visibility of the client's progress and quality of care, the need to improve communication between allied health providers and GPs when treating complex patients, and improving care coordination.

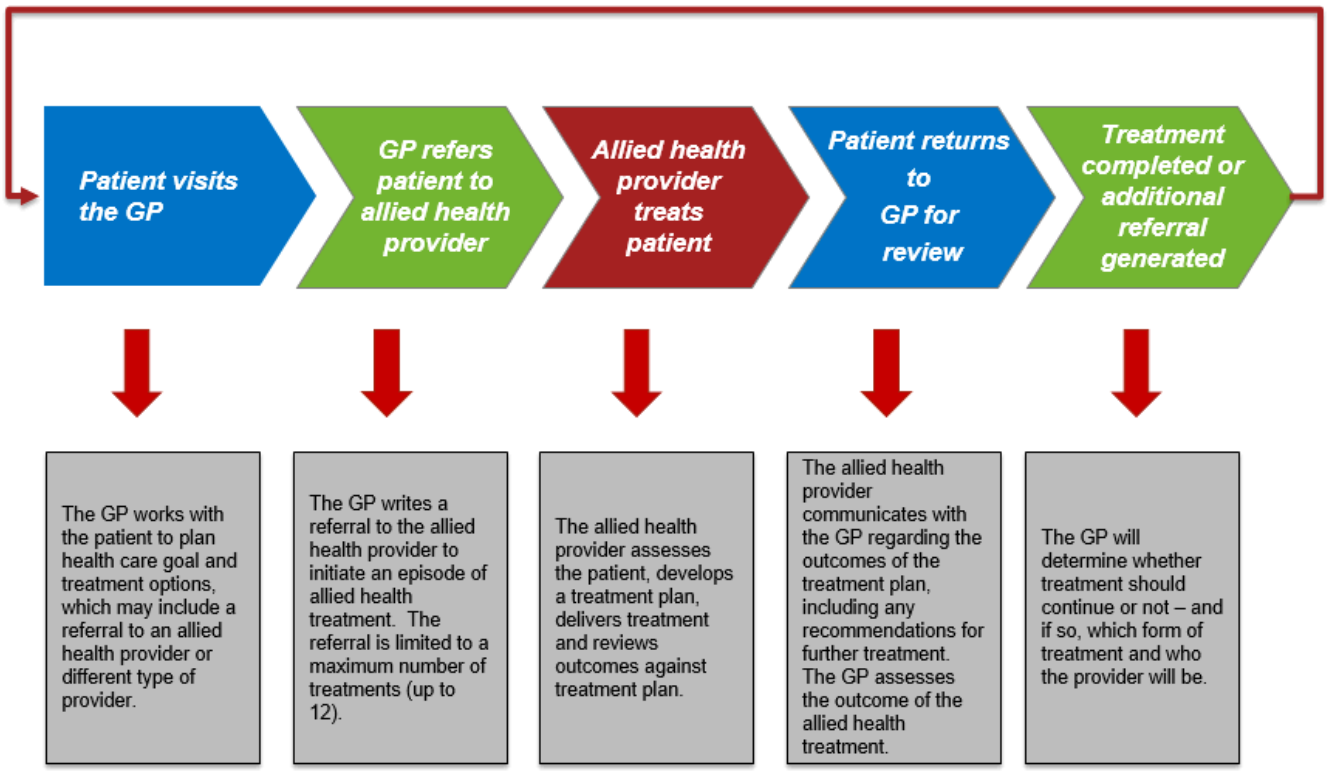
74. In order to help address these concerns, DVA has developed a Treatment Cycle model, in which the GP may make a referral for up to 12 sessions of allied health service delivery, if it is clinically required for the patient. The allied health provider would develop a treatment plan in consultation with the patient, and the patient would then undertake the treatment.

75. At the end of the Treatment Cycle, the allied health provider would provide a report back to the GP. If the GP assesses that allied health treatment is still clinically required, a further treatment cycle of up to 12 sessions could be undertaken. A client may have as many treatment cycles as clinically required. Under this Treatment Cycle approach, a GP referral would last for up to 12 sessions or a year, whichever is sooner.

76. This new referral method would apply to all DVA allied health services, excluding dental and optical services as current referral practices for DVA clients are consistent with general community referral provisions.

77. Elements of the Treatment Cycle model are set out in Diagram 1 below.

DIAGRAM 1: TREATMENT CYCLE



78. As the primary health care provider, GPs are expected to make clinical judgements about the intensity, duration and progress of treatment provided to patients by allied health providers.

79. Current DVA arrangements set no limit to the number of allied health services that can be supplied within a valid 12-month referral period. For services where there are no limits, many GPs may not be fully informed of the intensity, duration and progress of treatment provided by the allied health providers under DVA arrangements. By contrast Medicare allied health arrangements have caps for the general community, both in terms of who may access the arrangements and how many sessions may be provided.

80. The Treatment Cycle model would direct the veteran back to their GP once the treatment by the allied health provider is complete. This enables the GP to assess current treatment pathways, and consider whether or not continued treatment is required. If it is required then the GP would consider whether the current treatment modality is required, and who the provider should be. While it is acknowledged that patients with chronic conditions may intermittently require intensive allied health treatment, this should not occur without the knowledge of the GP.

81. DVA would encourage active treatment where the responsibility for achieving health treatment outcomes is shared between the provider and the patient with the ultimate goal of self-management, if possible. In this respect, the treatment plan is developed collaboratively with the client and is not limited to clinical services. There is also an expectation that the client would commit to agreed lifestyle changes such as exercise regimes or healthy eating regimes as a part of the treatment plan.

82. For many clients, this would not mean any additional visits to the GP. As shown in Table 10 above, the average number of GP consultations by the total DVA treatment population is 12, which is about one GP visit a month per year. This level of GP consultations has been relatively stable since 2011-12.

83. There are also opportunities for improved quality of care and efficiencies through strengthened GP involvement, for instance with medication reviews and early diagnosis of emerging problems.

84. To support the Treatment Cycle, there would need to be a range of supports such as:

- Development of clinical protocols and assessment templates to help support clinicians make decisions about clinical pathways. These would need to be developed in consultation with provider associations and clinical experts.
- Consideration of practice software upgrades to help support clinical practice.
- Education and promotion with allied health professions and GPs.

85. Consideration could also be given to funding for treatment cycle planning, with the making of a treatment plan, communication with other providers at the start and end of the treatment cycle. DVA would also develop some protocols and assessment forms that would assist and guide in the development of the treatment plans, and to support the treatment cycle model.

86. DVA estimates that the Treatment Cycle approach would not result in less allied health care being provided for many DVA clients accessing allied health services. For those clients requiring an additional GP referral, many clients regularly see their GP and are not expected to require additional appointments.

87. DVA discussed the Treatment Cycle model with a number of the working groups as well as a focus group from the Ex-Service Organisation Round Table (ESORT).

88. The working groups agreed an effective treatment plan should allow enough time for progress to be reviewed in order to make an appropriate clinical decision to either continue, modify, escalate or terminate the treatment. While accounting for differences in treatment provisions across the various allied health provider groups, it was considered by the working groups that most treatment could be completed within a series of 12 sessions.

89. Most ex-service representatives from ESORT were either supportive or neutral about the concept. However, some expressed concern. While the ESORT focus group agreed the Treatment Cycle might improve communication across allied health providers and GPs and overall coordination of care, concern was expressed over the perceived burden that might be placed on DVA clients or GPs. The implementation of the treatment cycle would need to address these concerns, in terms of communicating the importance of the GP in the ongoing treatment and care of DVA clients.

5.3 Element 3: Trials of funding models

90. Drawing from discussions from the working groups and in consultation with relevant allied health provider associations, DVA could develop and design up to four trials of new funding approaches for allied health services. These trials would test alternative funding approaches for selected professions to determine if outcomes could be improved for clients.

91. For instance, many of the allied health schedules are based upon time based resourcing, with amounts paid for the allied health provider's attendance to provide care. The trials could explore if other approaches might be beneficial, both for client outcomes and for efficiencies. One alternative might be moving towards a more activity based approach or a case payment for a package of services.

92. The trials would need to be evaluated with a report provided back to Government for consideration.

5.4 Element 4: Upgrades to meet future needs

93. DVA could consider updates to key parts of the dental and allied health schedules to help meet future health needs. A range of proposed upgrades have been identified after considering submissions from provider associations, deliberations of working groups, and advice from DVA clinical advisers.

94. Any proposed upgrades would also need to be informed by the other elements of this reform package.

95. Proposed changes could include addressing:

- Use of new technologies. For instance in relation to mental health services, there is promising evidence that on-line video counselling is as at least as effective as traditional face to face counselling, in terms of clinical outcomes, therapeutic alliance and satisfaction ratings.
- Growing evidence on the clinical benefit of certain therapeutic techniques to address health problems. For instance, this includes physiotherapy to assist with incontinence, neurological and vestibular (balance) issues.
- Consistency with industry standards in order to ensure that the DVA fee schedules are up to date and to help reduce red tape for providers.
- Opportunities to make improvements for complex care management, for those at risk of suicide, those who are homeless, and those discharging from hospital.
- These upgrades will be made subject to the success of the new treatment cycle in ensuring only clinically necessary service provision.

96. The proposed reform package could update the dental and allied health fee schedules to better reflect contemporary services and better support the workforce providing services to support the health and wellbeing of the veteran community. These upgrades come at a cost, and would need to occur subject to the success of the Treatment Cycle in providing efficiencies.

97. A range of potential upgrades are set out in Attachment B. There would be consultation with relevant professional associations about the design and scope of these potential upgrades.

5.5 Implementation of the Reform Package – next steps

98. Subject to Government approval, the reform package could be implemented in three major phases.

- In the first year, DVA could make technical or other adjustments to funding schedules that would have no additional cost on forward estimates.
- In the second year, DVA could commence the new Treatment Cycle model. This Treatment Cycle approach would be evaluated to determine whether it would deliver efficiencies, with a report back to Government for consideration.
- Subject to the results of the evaluation of the Treatment Cycle, realisation of anticipated efficiencies from the successful implementation of the Treatment Cycle and Government consideration, DVA could then update key parts of allied health fee schedules to align them to a more contemporary standard.

ATTACHMENT A

Working Groups and submissions made to the Review

Working Group	Provider association	Provider representation
Dental Representatives from provider associations and: - War Widows' Guild of Australia	Australian Dental Association* Australian Dental Prosthetists Association*	Dental Prosthetists General Dentists Specialist Dentists
Mental health Representatives from provider associations and: - Australian Medical Association* - Returned Services League of Australia - Royal Australian College of General Practitioners	Australian Association of Social Workers* Australian Psychological Society* Occupational Therapy Australia*	Clinical Psychologists Neuropsychologists Occupational Therapists (mental health) Psychologists Social Workers (mental health)
Musculoskeletal Representatives from provider associations and: - Australian Medical Association* - War Widows' Guild of Australia	Australasian Podiatry Council* Australian Physiotherapy Association* Chiropractors' Association of Australia* Exercise and Sports Science Australia* Occupational Therapy Australia* Osteopathy Australia*	Chiropractors Exercise Physiologists Occupational therapists Osteopaths Physiotherapists Podiatrists
Optical Representatives from provider associations and: - Vietnam Veterans' Association of Australia	Australian Dispensing Opticians Association* Australian Orthotic Prosthetic Association* Optometry Australia* Orthoptics Australia	Optometrists Optical dispensers Orthoptists
Other clinical Representatives from provider associations and: - Returned and Services League of Australia	Australian Association of Social Workers* Australian Diabetes Educators Association* Dietitians Association of Australia* Speech Pathology Australia*	Diabetes Educators Dietitians Social Workers (general) Speech Pathologists

* Indicates the association made a submission to the Review.

ATTACHMENT B

Potential dental and allied health schedule upgrades

This Attachment provides details on:

1. Potential changes to support the implementation of the proposed treatment cycle.
2. Potential upgrades to the dental and allied health fee schedules.

Proposed upgrades are subject to change depending on the outcome of the evaluation of the Treatment Cycle and report back to Government, as well as consultation with professional associations.

Table 1: Potential changes to support the treatment cycle

Professional Category	Issue	Schedule change	Description
Mental health	Premium on first consultation in the treatment cycle	New item	A premium could be assessed for 50+ minute consultations for: • Psychology, general clinical & neuro • Social work (mental health) • Occupational therapy (mental health) This premium would support the implementation of treatment planning for up to 12 sessions & communication with the GP.
Mental health	Case conferencing for complex cases	New item	This could provide the capacity for allied providers to case conference with the GP and support the treatment planning for complex care patients.
Musculo-skeletal	Premium on first consultation in the treatment cycle	New item	A premium could be assessed for an initial consultations for: • Exercise physiology • Physiotherapy • Osteopathy • Chiropractic • Podiatry • Occupational therapy

Professional Category	Issue	Schedule change	Description
			This premium would support the implementation of treatment planning for up to 12 sessions & communication with the GP.
Musculo-skeletal	Case conferencing for complex cases	New item	This could provide the capacity for allied health providers to case conference with the GP and support the treatment planning for complex care patients.
Other clinical	Premium on first consultation in the treatment cycle	Premium paid on initial consult	A premium could be assessed depending upon the current fee structure in place & whether items are already available for initial client assessments to start the treatment cycle.
Other clinical	Case conferencing for complex cases	New item	This could provide the capacity for allied health providers to case conference with the GP and support the treatment planning for complex care patients.

A range of other activities could also help support the implementation of the treatment cycle, including:

- Development of clinical protocols & assessment templates, with input from clinical advice & liaison with industry associations.
- Potential for software upgrades.
- Liaison with professional associations and education of providers.

Table 2: Potential upgrades to the dental and allied health fee schedules.

Provider Category	Issue	Schedule	Description
Dental	Partial dentures	Schedule update	A new fee structure could be developed for partial dentures to align with the Australian Dental Association schedule.
Dental	Schedule	Schedule update	Alignment could occur where appropriate with the Dental Association's "The Australian Schedule and Dental Glossary Twelfth Edition".
Dental	Re-configure fees	Schedule update	The costs of production of some items have changed over the years. Revised fees could be explored based upon expert advice.
Mental health	Case review for social workers	New item	A new mental health social work case review item could be introduced. Psychologists and clinical psychologists have this item and the item is within social workers scope of professional practice.
Mental health	Complex care	Amended item	The current trauma therapy item could be expanded to include complex care management, including for those at risk of suicide, those who are homeless, and those vulnerable after hospitalisation.
Mental health	Neuro-psych provision	New item	An item for the provision of additional services by clinical neuropsychologists could be introduced. The main work undertaken by neuropsychologists is assessments which is currently funded. However, clinical neuropsychologists also undertake psychoeducation and remedial work for cognitive impairments such as memory impairments or executive function deficits.
Mental health	Telehealth consultations	New item	Telehealth consultations could complement face to face consultations in circumstances where access to allied health providers is

Provider Category	Issue	Schedule change	Description
			difficult because of distance from the provider or the DVA client has other issues which pose a barrier to face to face consultation.
Musculo-skeletal	Neurological, continence and vestibular (balance) treatments for physio-therapy	New items	This could provide clients with access to specialised treatments for the disorders relating to neurological, continence and vestibular disorders.
Musculo-skeletal	Rationalise schedule for occupational therapists	Schedule update	The “treatment” and “aids assessment” codes could be rationalised into one category. This would simplify the schedule and have the effect of increasing investment in occupational therapy.
Musculo-skeletal	Add new items for podiatrists	New items	A range of new items could be implemented to allow for clients to access new types of treatment, such as video gait analysis, digital scanning of feet, and an item for biomechanical assessment, an item for neurological testing lower limb/foot, and an item for a diabetes foot check.
Optical	Frames	Schedule and fee update	Current frame types could be consolidated into one category. This would improve the choice for clients particularly for plastic frames.
Optical	Low vision aids	Schedule update	Updates could include task lighting (non-magnifying) in the schedule of low vision products would take in desk, floor or wall mounted lighting, as well as head lamps and torches.

Provider Category	Issue	Schedule change	Description
Optical	Contact lenses and consumables	Schedule update	Updates could include supply of certain lens features and combinations that are now commonly supplied to the general community. An upgrade would increase level of functionality for clients.
Other clinical	Group treatment - dieticians	New item	This new item could recognise the potential benefit to patients in interacting with and learning from peers with similar conditions.
Other clinical	Telehealth consultations	New item	Telehealth consultations could complement face to face consultations in circumstances where access to allied health providers is difficult because of distance from the provider or the DVA client has other issues which pose a barrier to face to face consultation. It could apply to dietetics & speech pathology.
Other clinical	Case review for social workers	New item	A new social work case review item could be introduced, similar for mental health social workers.