Australian Physiotherapy Association
Submission

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Department of Veterans' Affairs Dental and Allied Health Review

Presented to the Department of Veterans' Affairs (DVA)

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Executive Summary

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the Department of Veterans' Affairs (DVA) Dental and Allied Health Review.

We recognise that the major challenge facing modern health systems internationally is how to ensure that quality services are available to all citizens at an affordable price. We also recognise that fiscal sustainability is a concern for schemes that subsidise health care across Australia.

The aim of physiotherapy is to achieve better care at an equivalent or lower cost to the nation, with better patient experience. To achieve this triple aim, we recognise that health care providers (physiotherapists), patients and payers (the DVA) need to collaborate to build the right environment for improved patient care, decreased healthcare spending and satisfied veterans.

Our submission is set in the context of longstanding problems with the subsidisation of physiotherapy services by the DVA. These barriers were, for example, the subject of our submission to the DVA in October 2009. Many remain unaddressed.

The federal government's measure in the 2014-15 Budget to pause indexation for allied health items from 1 July 2014 to 1 July 2018 concerns physiotherapists. Physiotherapists are concerned that measures to constrain rebates reflect an inability to adopt more radical improvements including changes to the path of authorisation for services and changes in the allocation of resources.

Physiotherapists have been changing their interactions with the veteran community. In the face of low rebates, physiotherapists have been reconsidering the way they care for veterans.

We recommend that the traditional paradigms of general-practitioner-coordinated care need to be reviewed. Particularly for residents of aged care facilities and for home-bound veterans, reductions in continuity by GPs are leading to discontinuities in the validity of referrals for the maintenance of an active period of care. These discontinuities are problematic for veterans and the physiotherapists who care for them.

Physiotherapists report that often veterans are attending their GP for no other reason than to obtain a referral for appliances. New models that explore ways to leverage the expertise of non-medical professions in leading and maintaining collaborative and integrated care to people with complex and ongoing health needs are being explored in a number of other environments including disability and mental health. The DVA needs to explore these models.

We are aware that the community subsidises the care of veterans through the re-distributive role of Australia's taxation arrangements.

We have consistently advised the DVA that our national costs benchmarking studies indicate that the full average cost of providing high quality physiotherapy to veterans is higher than the subsidies paid under the DVA's Physiotherapists Schedule of Fees.

We have also consistently advised the DVA that the subsidies paid by the DVA are below the average fees charged. The discrepancy between the cost of physiotherapy care and the subsidies paid by the DVA result in the tax-funded subsidies paid by the DVA for physiotherapy being supplemented in other ways by other levels of government, the community and the physiotherapy profession.

Physiotherapists have responsibly charged co-payments in conjunction with a number of other insurance schemes, including other compensable schemes. We recommend consideration of a policy shift, allowing physiotherapists to charge veterans co-payments.

In the context of unsustainable rebate levels, we are increasingly making the decision to cease treating veterans altogether, and to treat other patient groups, rather than veterans.

We have devised a set of service descriptors for physiotherapy services – the National Physiotherapy Services Descriptors (NPSDs). These descriptors, being revised in 2016, reflect the profession's shared view on service types in physiotherapy. We recommend their adoption.

We are concerned by reports of problems with online claiming for allied health services. We recommend that these be investigated and that recovery of funds from physiotherapists that arise from limitations of the online claiming arrangements be suspended until the system overcomes the limitations.

We are concerned that the review and ongoing expressions of concern by government about the costs of health care will signal an increase in auditing by the DVA. We recommend careful consultation with the profession about any auditing models.

The DVA needs to be nimble, keeping pace with emerging models of practice and technological innovations. These models include the use of aides and the use of home-based technologies.

The APA is committed to helping to improve the DVA patient's journey, to offer lower cost, better care and better patient experiences. This submission reflects its willingness to collaborate with the DVA to embed safe, cost-effective, high quality practice and support innovation.

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1 Introduction

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the Department of Veterans' Affairs (DVA) Dental and Allied Health Review.

We recognise that the major challenge facing modern health systems internationally is how to ensure that quality services are available to all citizens at an affordable price.[1] We also recognise that fiscal sustainability is a concern for schemes that subsidise health care across Australia.

We believe that all Australians should have access to safe, high quality physiotherapy in order to optimise the health and wellbeing of individuals, families, communities, and the nation as a whole. We recognise that the programs of the DVA are integral to achieving access to physiotherapy.

We understand that the DVA aims to provide a wide range of mental and allied health care services, including counselling and referral services for veterans, war widow/ers, serving members, former defence force members and their families. For ease in this submission, we refer to these groups as 'veterans'.

Recent Federal Budget papers indicate that the DVA anticipates that expenditure for allied health care and transport to increase as an ageing veteran population access a greater variety of health care services. These Budget papers also acknowledge that expenditure and utilisation of services are demand (rather than supply) driven, depending on the health care needs of entitled beneficiaries.

The aim of physiotherapy is to achieve better care at an equivalent or lower cost to the nation, with better patient experience. To achieve this triple aim[2], we recognise that health care providers (physiotherapists), patients and payers (the DVA) need to collaborate to build the right environment for improved patient care, decreased healthcare spending and satisfied veterans.

However, our submission to the DVA is set in the context of longstanding problems with the subsidisation of physiotherapy services. Although physiotherapy is a critical component of the range of services that the DVA aims to provide, there appear to be enduring barriers to the provision of high quality physiotherapy care for veterans. These barriers were, for example, the subject of our submission to the DVA in October 2009.

The federal government made a commitment that, after 1 July 2014, subsidies/rebates for medical, dental and allied health services paid by the DVA would be indexed on an annual basis, consistent with indexation of the Medicare Benefits Schedule (MBS). At the same time, a measure in the 2014-15 Budget paused indexation for allied health items from 1 July 2014 to 1 July 2018.

Physiotherapists are concerned that this measure represents an approach by which short term, apparent savings are being made, resulting in less obvious and larger costs in the hospital and residential care sector.

Physiotherapists are also concerned that measures to constrain rebates reflect an inability to adopt more radical improvements including changes to the path of authorisation for services and changes in the allocation of resources.

Physiotherapists have been changing their interactions with the veteran community. In the face of low rebates, physiotherapists have been reconsidering the way they care for veterans.

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2 The model of authorising care for veterans needs to reflect the central role of physiotherapy

Traditional paradigms of general-practitioner-coordinated care need to be reviewed.

The APA supports the whole-of-person care provided by general practitioners (GPs).

However, the number of GPs undertaking home visits to their own patients and providing ongoing care to patients entering residential aged care facilities (RACFs) is declining.[3] The Australian Medical Association's 2012 aged care survey found that more than 15 per cent of doctors who provide medical care to RACFs intended to reduce their visits over the next two years. The survey also showed that the majority of doctors who paid visits to RACFs were male and over 40. The sense of obligation that underpins this service provision is unlikely to be sustained as these GPs leave the workforce.

Reductions in continuity by GPs lead to discontinuities in the validity of referrals for the maintenance of an active period of care and can either lead to the physiotherapist:

- being unable to claim, or
- claiming without referral and risking audit, or
- ceasing therapy, the outcome of which can be a direct risk to the veteran's health.

Below is a personal account of one member's experience with the DVA's prior approval arrangements:

> *"Chasing up referrals for some veterans who need ongoing management often requires multiple phone calls as well as the update and report to the GP before it is provided. GPs are busy too and this adds to the expense of treating veterans, which is not an issue for other clients.*
>
> *It would be appropriate to just communicate 6 monthly or annually with the GP regarding the veteran's treatment and as long as the treatment is still justified, then a new referral should not be required. We always communicate when there is a concern about the veteran's health. Physiotherapists are well-trained and can pick up many health issues of which the GP needs to be made aware.*
>
> *Many veterans are on long-term treatment as they go downhill when you trial them on a break from treatment. Keeping them out of hospital is very important and most have little reserve capacity."*

Another illustration of unnecessary constraints to authorisation occurs in the Rehabilitation Appliances Program (RAP). Physiotherapists report that often veterans are attending their GP for no other reason than to obtain a referral for appliances.

New models that explore ways to leverage the expertise of non-medical professions in leading and maintaining collaborative and integrated care to people with complex and ongoing health needs are being explored in a number of other environments. These are relevant to the veteran population which has high prevalence of chronic disease and multiple co-morbidities and thus needs multi-disciplinary care. These models are relevant, as is shown in the disability and mental health sectors, regardless of whether the population is older (as has traditionally been the case with veterans) or younger (as is the case with more recently eligible veterans).

Using care coordinators within practices, especially multi-disciplinary practices is likely to provide more timely and targeted access to care (including appliances) and to reduce secondary costs (e.g. unnecessary GP visits).

Simple accreditation processes could limit "valid referrers" if it were deemed necessary.

Recommendation 1:

We recommend that the Department of Veterans' Affairs establish models of authorising care for veterans that overcome discontinuities in the validity of referrals and/or visit to a GP solely for a referral and include roles of care coordination by physiotherapists.

Recommendation 2:

We recommend that the Department of Veterans' Affairs establish models of physiotherapy /care coordinator authorisation of access to the Rehabilitation Appliances Program in addition to general practitioner authorisation.

3 The cost-effectiveness of the DVA model depends on other parties supplementing subsidies for physiotherapy services

We are aware that the community subsidises the care of veterans through the re-distributive role of Australia's taxation arrangements.

We have consistently advised the DVA that our national costs benchmarking studies indicate that the full average cost of providing high quality physiotherapy to veterans is higher than the subsidies paid under the DVA's Physiotherapists Schedule of Fees.

We have also consistently advised the DVA that the subsidies paid by the DVA are below the average fees charged. Biennially, we commission an independent nationwide study of fees charged by physiotherapists. This price benchmarking survey was last commissioned in 2014 and showed that the national average fee for an initial consultation in 2014 was $85.95. The subsidy paid by the DVA represented 74% of this average fee.

The discrepancy between the cost of physiotherapy care and the subsidies paid by the DVA result in the tax-funded subsidies paid by the DVA for physiotherapy being supplemented in other ways by other levels of government, the community and the physiotherapy profession.

This cross-subsidy is central to the apparent cost-effectiveness of DVA-subsidised services.

Below, are illustrations of the ways in which this cross-subsidy occur.

3.1 Ways physiotherapists subsidise the care of veterans

Inequities in rebate levels between allied health providers strongly suggest that physiotherapists are subsidising the care of veterans.

For example:

- an initial consultation with an occupational therapist (in rooms) attracts a rebate that is 137% of the rebate for an initial consultation with a physiotherapist
- a clinical assessment by a speech pathologist (in rooms) attracts a rebate that is 166% of the rebate for an initial consultation with a physiotherapist.

In the absence of meaningful differences between the cost structures of these allied health professions, it appears that physiotherapists (by comparison with these two other professions) are subsidising veteran care.

Some physiotherapists subsidise the care of veterans by holding back on expenditure on some practice costs. Typically, these costs are 'hidden' and include capital, furniture and fittings (e.g. delayed replacement of floor coverings or equipment), staff costs (e.g. paying low wages), or time (e.g. undertaking few quality improvement activities). None of these approaches is sustainable. Practices closing because they cannot meet long-term costs may decrease access for veterans. Failing to fund 'hidden' costs will eventually undermine the safety and quality of care.

Some physiotherapists who have a passion for the veteran population appear to have lowered their income expectation. Relying on physiotherapists to do this results in horizontal inequities within the profession. It is unjust and is unsustainable. Other physiotherapists appear to have marginally increased the hours they work to ensure their income is sufficient. Other physiotherapists are considering remaining in the workforce for slightly longer.

We will shortly be surveying the profession to determine the extent of these problems.

3.2 Ways other members of the community subsidise the care of veterans

One of the mechanisms by which high quality care for veterans is sustained is by cross-subsidisation by other members of the community.

Some physiotherapists now consistently offset low subsidies for veterans care by charging co-payments on services for other patients and using a part of these co-payments to offset costs involved in providing care to veterans and eligible family members.

This choice lacks the transparency for veterans or other community members that our profession aspires to, but is a pragmatic solution for ensuring access to physiotherapy for some veterans.

3.3 Ways other levels of government subsidise the care of veterans

Some clinics have some overhead costs covered by other levels of government. An illustration of this is the provision of care through community health clinics where capital costs are offset by state/territory governments and local-government supported infrastructure. This is a no-nonsense model for physiotherapists.

3.4 Physiotherapists are ceasing to treat veterans

The business of delivering physiotherapy services is increasingly competitive. Treating DVA-rebated patients is often done at a loss. Physiotherapists feel that the DVA's fees do not accurately reflect the complexity of the patient cohort or the time taken to provide a quality service.

We are increasingly making the decision to cease treating veterans altogether, and to treat other patient groups, rather than veterans.

This reflects the most common reasons GPs gave when asked why they had decreased their visits to residential aged care facilities between 2008 and 2012 – that subsidies for patients were inadequate and did not compensate for lost time in the clinic, that unpaid non-face-to-face time was increasing, and that the practice was too busy.[4]

In 2016, we will repeat our nationwide costs benchmarking study, and anticipate that the gap between the DVA subsidies and costs of providing high quality care will have grown further.

In 2016, we will also repeat our 'secret shopper' study of physiotherapy prices. We anticipate that the gap between the subsidy paid by the DVA and the average fee of physiotherapists will have increased again.

The consistent feedback from working physiotherapists is that there will be further movement away from treating veterans. To advise the DVA on the likely impact of its current policy settings, the profession needs to have access to data on DVA-eligible patients and their service utilisation.

3.5 Physiotherapists need to be able to charge co-payments

Physiotherapists have responsibly charged co-payments in conjunction with a number of other insurance schemes, including other compensable schemes.

The ability to charge co-payments to veterans who can afford them sends a number of valuable signals. It indicates that the service itself is important and valuable. It indicates that the physiotherapist values the quality of the service.

Recommendation 3:

We recommend that the Department of Veterans' Affairs provide the Australian Physiotherapy Association with time series data on the number of DVA-eligible members of the Australian community; time series data on the number of unique MBS/DVA-eligible physiotherapists providing rebated services to veterans and time series data on the volume of physiotherapy services provided to veterans, including data distributed by total rebates claimed for care provided by eligible physiotherapists.

Recommendation 4:

We recommend that the Department of Veterans' Affairs provide the Australian Physiotherapy Association with time series data on the distribution of veterans across Australia (and overseas) including data on their distribution in urban, regional/rural and remote areas.

Recommendation 5:

We recommend that the Department of Veterans' Affairs provide physiotherapists with the ability to raise co-payments when veteran care is rebated by the DVA.

4 Veterans need the DVA to adopt the National Physiotherapy Service Descriptors

4.1 The National Physiotherapy Service Descriptors are the profession's view of service types

We have devised a set of service descriptors for physiotherapy services – the National Physiotherapy Services Descriptors (NPSDs).

These descriptors, being revised in 2016, reflect the profession's shared view on service types in physiotherapy that provide safe, high quality, and sustainable care.

4.2 The DVA needs to increase the subsidy for an initial consultation

In the NPSDs, the indicative relative value of an initial consultation is 1.5 times a subsequent consultation. The relatively higher cost of providing an initial consultation reflects that initial

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assessments are more time-intensive and involve taking a patient's history, as well as a physical assessment, diagnostic formulation, goal setting, developing a management plan, providing treatment and taking clinical notes.

In contrast, in the DVA schedule:

- The initial consultation in rooms (PH 10) attracts the same subsidy as a 'standard' consultation
- The initial consultation at home (PH11) is 7.5% higher than a 'standard' consultation
- The initial consultation at a hospital (PH12) is 7.5% higher than a 'standard' consultation.

We are aware of a number of responses to the current relativities in the DVA fee schedule.

Some practices assign veteran clients to less experienced physiotherapists. The cost structure for these clinicians is often lower. In line with broader models of expert care[5], however, we anticipate that care by less experienced clinicians will be comparatively inefficient, will require more supervision and will be more reactive to change (rather than anticipating it, and adjusting care in that context). Thus, it is unlikely that the costs to the system as a whole will be less.

The DVA's subsidy for an initial consultation is approximately 80% of the average fee for an initial consultation charged by physiotherapists in 2014. This provides an incentive for physiotherapists to divide the assessment into two consultations. The result is an increase in cost to the DVA, and an increase in time and travel costs to the veteran (or eligible family member).

There are better ways to offer a *lower cost* consultation to the veteran community. One option would be to offer a higher fee for service for the initial consultation, to offset two separate consultations. Patients would receive *better care*. While the physiotherapist obtains a detailed history, makes a thorough assessment of the patient's clinical needs and writes a comprehensive clinical plan for treatment, this is done in one occasion.

We believe that a thorough initial consultation will provide for a *better patient experience.*

To achieve this approach, however, the DVA schedule of fees needs to facilitate the model.

Recommendation 6:

We recommend that the Department of Veterans' Affairs establish a relativity between rebates for a standard consultation and an initial consultation of at least 1:1.5.

4.3 The DVA needs to recognise the complexity of initial presentations by veterans

In the NPSDs, complex presentations have a relative value three times that of a subsequent consultation.

In physiotherapy clinics, veterans supported by the DVA usually present with multiple co-morbidities. Historically, veterans are both older and frailer. As a result, a physiotherapy assessment consultation with a veteran typically requires more time, compared with other patient demographic groups.

Using our pricing data from 2014 and the prices of an average assessment consultation ($85.95, for a service with a relative value of 1.5), the more complex of initial presentations by veterans should attract a subsidy of $171.90.

A physiotherapist member provides the following assessment of the impact of the recent rate freeze and historically low treatment fees:

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"Veterans who live in the community are very old now and mostly quite frail. Their treatment often requires a longer consultation to properly treat the frailty but I can only bill for the standard consultation of $63.30.

Freezing the schedule fee means that the time spent with the veteran is more under pressure, as other clients are subsidising the veteran's treatment. As we are unable to charge a co-payment (unlike Medicare funded services), the practice takes the loss."

Recommendation 7:

We recommend that the Department of Veterans' Affairs allow a relatively higher rebate for consultations which are complex (e.g. involve multiple co-morbidities), by establishing a relativity between rebates for an initial consultation and that of an extended consultation of at least 1:3.

Recommendation 8:

We recommend that the Department of Veterans' Affairs fund a comparative study of presentations by veterans to physiotherapists to confirm the appropriateness of the Department's position that presentations by veterans are sufficiently homogenous to justify a single initial consultation item in the schedule of physiotherapy services.

4.4 The DVA needs to fund physiotherapy involvement in case conferences

In the NPSDs, case conferences are a discrete service.

We recognise the critical role of communication with other providers of care when the veteran requires multi-disciplinary support. Frequently, physiotherapists have sequential discussions with GPs and domiciliary or community nursing services. In effect, this is a 'serial case conference'.

Non-face-to-face time has been estimated to be equivalent to face-to-face time in the most complex of community-dwelling clients.

Recommendation 9:

It is recommended that the Department of Veterans' Affairs, include a case conference item in its schedule of services for physiotherapists.

Recommendation 10:

It is recommended that the Department of Veterans' Affairs, allow for a case conference to be rebated when it involves a series of bilateral discussions, rather than a single discussion amongst the treating practitioners (and patient, where included).

4.5 The DVA needs to cover direct costs associated with the care of veterans

In the NPSDs, a number of activities and costs commonly associated with physiotherapy care are discrete, reflecting the practice of physiotherapists to bill for these when they are incurred. These costs include such items as appliances (which the DVA recognises as a separate cost), reports (which the DVA recognises as a separate cost).

4.5.1 Veterans need the DVA to fund the first 10 kilometres of travel by physiotherapists

Home-based care for veterans can be more effective, especially in improving function preventing falls. The DVA should facilitate better service provision for veterans with poor mobility by reimbursing reasonable travel costs for physiotherapists to enable them to get to/from the veteran's home.

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Domiciliary physiotherapy offers a benefit for the community generally since the veteran does not need a family member to accompany them and take time off work to provide this care. Family members/carers/friends of veterans who are not very ambulant may assist the veterans to attend physiotherapy. This includes veterans who live close to services and those living some distance from a physiotherapy clinic. Some veterans take public transport.

However, physiotherapists report many occasions where informal support or public transport is not available, and others where the veteran is essentially home-bound.

In the NPSDs, travel costs are dealt with discretely, and billed separately.

Despite this, under DVA rules, a kilometre allowance is only payable after the initial 10 kilometres of each journey.

This approach is inequitable.

In some locations, and particularly at certain times of day, physiotherapists report that it can take 20 minutes to travel a distance of ten kilometres. Under the DVA's current fee schedule, physiotherapists who provide home visits to DVA-entitled clients within ten kilometres absorb vehicle running costs, the time costs of travel (such as the loss of income while travelling) and the marginal practice overhead costs.

A physiotherapist in Queensland reports being contacted by several patients from various residential locations around Brisbane to say that there were no physiotherapists in their area that provided home visits. The physiotherapist reports:

> *"The lack of travel cover, in addition to the lower treatment fees, means that it is a challenge to provide services such as a home visit to these clients, especially with the challenges of running a business today."*

In rural locations, physiotherapists report that they would incur significant travel expenses to visit some patients at a distance. Veterans in rural settings need equitable access to physiotherapy.

A physiotherapist member explains the difficulties in providing care in the home setting:

> *"Our practice is very low cost and is totally domiciliary. We charge $80 per treatment and $150 for an extended treatment. The $63.30 paid by the DVA represents only 79% of our standard fee. We cannot provide extended treatments to veterans in the home setting despite them being clinically indicated."*

Many veterans have rehabilitation post hospital discharge provided at home. The cost of a home consultation may prove considerably less than a DVA funded taxi to and from the local rehabilitation hospitals who offer day programs.

Physiotherapists consistently indicate that they are making the decision to reduce or cease home visits, transferring costs to veterans (time costs associated with visiting the physiotherapy clinic, or to the DVA (when the DVA funds travel to the clinic or subsequent health care costs after the veteran ceases physiotherapy care).

Under current DVA rules, a physiotherapist is exempt from claiming a kilometre allowance if there is a health practitioner located closer to the veteran's place of residence. This rule can create a perverse incentive for DVA patients to discontinue an existing therapeutic relationship with their current physiotherapist, in favour of a health practitioner located closer to the veteran's place of residence. The rule also fails to address the need for multiple providers if more specialised care is required, especially if these providers are collocated.

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Recommendation 11:

We recommend that the Department of Veterans' Affairs subsidise travel costs for the whole of a journey to a patient, rather than after the first ten kilometres.

Recommendation 12:

We recommend that the Department of Veterans' Affairs continue to subsidise travel costs for physiotherapists where the patient is an existing client, rather than preclude the claiming of a travel allowance if there is a physiotherapist closer to the veteran's place of residence.

4.5.2 The DVA could incorporate the cost of travel into subsidies for home visits by physiotherapists

As an alternative to adopting the NPSDs, the DVA could follow the model of the Medicare Benefits Schedule and incorporate travel costs into the overall subsidy for the service. This would mean that physiotherapy delivered in the home setting (item codes PH11, PH21, PH31) would attract a higher subsidy than clinic-based services.

4.5.3 Veterans need the DVA to fund pool entry fees and facility fees, where applicable

There is also evidence to support specifically water-based exercise therapy, which has been shown to be effective in treatment of rheumatic conditions and chronic low back pain, as it improves function, self-efficacy, joint mobility, strength and balance[6].

Physiotherapy has an extensive history of providing services through group modalities (e.g. hydrotherapy). It is increasingly recognised that groups can provide the additional benefit of peer support to people with health issues[7]. Additionally, some models of groups can be cost-effective as a part of an overall approach to staying/becoming healthy.

Similarly, classes delivered by a physiotherapist can be cost-effective as a component of an approach to maintaining or achieving good health.

In the NPSDs, facility fees and direct costs are separated from other activity costs, and billed separately.

A physiotherapist provided the following feedback:

> *"It is impossible to provide aquatic physiotherapy for a veteran, as most hydrotherapy pools charge an entrance fee for the client and physiotherapist as well as often charging a facility fee for using the pool for your treatment purposes. This puts it out of reach as the veteran or DVA cannot be billed for these costs."*

The subsidy for Supervised Individual Aquatic Physiotherapy (PH60) is the same as a standard consultation. This fails to recognise that in addition to funding ongoing overheads at the clinic, a physiotherapist often bears the additional costs of pool entry for two, and a facility fee.

Hydrotherapy patients commonly comprise an older demographic and require more time (e.g. in being supported to enter and exit the pool) and use of specialised equipment during an episode of care. These vulnerable patients are disadvantaged if physiotherapy practices cease offering hydrotherapy.

Physiotherapists advise that the DVA previously had arrangements through which they could purchase a 'pool pass' for DVA-entitled clients to continue their physiotherapist-prescribed pool exercises.

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Recommendation 13:

We recommend that the Department of Veterans' Affairs create separate items for aquatic physiotherapy to reflect two circumstances – where the physiotherapy occurs with no entry fee or facility fee (e.g. in some residential aged care facilities), and where the physiotherapy incurs direct costs such as pool entry fees and facility fees.

Recommendation 14:

We recommend that the Department of Veterans' Affairs, consider reinstituting a model of 'pool pass' that would subsidise the cost of access to a pool at the time a veteran was seeing their physiotherapist and for self-managed follow-up of prescribed exercises.

Recommendation 15:

We recommend that the Department of Veterans' Affairs, having addressed the additional costs of facility fees and pool entry fees, maintain the current relativity of individual and group aquatic physiotherapy.

4.5.4 Access to equipment for veterans in residential aged care facilities needs to be reviewed

We are concerned about apparent anomalies in the provision of appropriate equipment in residential aged care facilities (RACFs). We understand that DVA funding under its Rehabilitation Appliances Program (RAP) is less restricted for 'low care' resident-veterans; and that access to equipment under the RAP is precluded for 'high care' residents unless there are extenuating circumstances such as need for a customised piece of equipment such as specialised seating. Our understanding is that the DVA deems every veteran moving into a RACF as 'high care'.

In parallel, we are hearing reports that residential aged care providers are under-funded and/or preference other expenditure to that on aids and equipment. Where this is the case, the quality of life and wellbeing of veteran residents is compromised.

Recommendation 16:

We recommend that the Department of Veterans' Affairs, review the effectiveness of its current model of ensuring veterans have access to appropriate aids and equipment in residential aged care facilities.

4.6 Physiotherapists should be paid for developing care plans

Physiotherapists report ongoing examples of effective care where the physiotherapist leads care planning.

Most frequently, this occurs where a patient has a sound relationship with a general practitioner (GP) and the GP has confidence that the patient will seek help for any new health problem. In such contexts, GPs are sometimes confident that the patient's physiotherapists is well-positioned to lead care planning a patient's chronic conditions, where they can be effectively managed with a physiotherapist in the lead.

In such contexts, a patient might be able to claim a subsidy for the GP preparing a care plan, but not for their physiotherapist doing this.

An effective primary healthcare system should fund the most appropriate care provider to develop the Veteran Care Plan, assess the veteran's clinical needs and start treatment immediately.

Physiotherapists are likely to be the major contributor to a Veteran Care Plan for a number of chronic diseases. Of the conditions covered by the DVA, physiotherapists are particularly skilled in chronic disease prevention and management.

We recognise that the Commonwealth Government has embarked on a number of reviews of aspects of the health system, including a review of the MBS.

Arthritis Australia recently provided the House of Representatives Standing Committee on Health with another example. Arthritis Australia gave evidence that at least 10 per cent of joint replacements in Australia are avoidable[8]. In this example, Arthritis Australia estimated that a reduction in government expenditure of around $200 million per annum could be made by providing a multidisciplinary program for people with hip and knee osteoarthritis. Arthritis Australia also estimated this sort of program could be delivered for around $750 per person, compared to a joint replacement, which costs $25,000.

Physiotherapy leadership of some care planning provides an opportunity to achieve such improvements in the health system.

Recommendation 17:

We recommend that the Department of Veterans' Affairs introduce an additional item that provides a rebate for a physiotherapist's development of, or contribution to a care plan for an entitled person.

5 The DVA needs to address the failures in online claiming

In 2009, the DVA introduced online claiming for allied health services that attracted subsidies under the DVA's programs.

Purported benefits were to include:

- Less manual intervention – fewer errors and speedier resolutions.
- Online Veteran Verification confirms the veteran's details are known to the DVA prior to submission of a claim.
- Fewer data errors due to the capacity to check the validity of patient details with the DVA in real time.

The online claiming system within the DVA fails to notify physiotherapists in a timely manner that the patient is not covered for the condition treated. With respect to 'White Card holders', the physiotherapist needs to take the word of the veteran concerning 'accepted conditions on the card' unless there is alternative credible information.

Recommendation 18:

We recommend that the Department of Veterans Affairs provide the profession with data on the time lapse between service and report to the physiotherapist of an error, where a claim concerns 'accepted conditions', differentiated by 'card colour'; data on the number of consultations claimed during the period and the costs of the claims; and the number of physiotherapists and veterans affected by the costs of the subsidies to be refunded.

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Recommendation 19:

We recommend that the Department of Veterans Affairs cease reclaiming rebates until it can demonstrate real-time confirmation of 'accepted conditions' for physiotherapists using online claiming of entitlement and eligibility for veterans' care.

Physiotherapists have expressed concern about the speed of the DVA to upgrade its online claiming programs following changes in common software programs, as illustrated in the following comment:

> *"Electronic claiming needs to be up to date. Currently we are struggling to move to windows 10 as DVA electronic claiming is not compatible and they won't upgrade their system. We might have to go back to paper!!!"*

Recommendation 20:

We recommend that the Department of Veterans Affairs explore ways to reduce the time taken to upgrade online claiming programs following adoption of updated versions of common software programs.

5.1 The DVA needs sophisticated algorithms to assess the appropriateness of claiming subsidies

We are concerned that the review and ongoing expressions of concern by government about the costs of health care will signal an increase in auditing by the DVA.

5.1.1 Auditing of service use needs to account for innovative models of care

A significant proportion of veteran clients are in a high-need category. In addition to comprehensive assessments and treatment of acute conditions, many veterans need ongoing support to maintain their health status.

Research on the management of chronic conditions suggests that it is important to fund 'light-touch' models of practitioner engagement that ensure safe and continuous use of physiotherapy. This includes modalities such as assertive outreach using phone-based support services,[9] and 'booster sessions'.[10]

The frequency of treatment provided to veterans may reflect adoption of such innovations.

5.1.2 Auditing of service use needs to account for demand-driven service use

The federal Budget papers acknowledge that increases in the utilisation of services can be demand (rather than supply) driven, depending on the health care needs of entitled beneficiaries.

Our members sometimes express concern about the sense of 'entitlement' which can drive service use by some veterans – the sense that their personal preference, rather than health need and assessed likelihood to benefit from a health service, drives demand for physiotherapy services.

Despite carefully crafted responses to these demands, physiotherapists report concern that deterring veterans from seeking these services of no (physiotherapist-perceived) benefit, will damage the therapeutic relationship and deter veterans from seeking needed care.

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5.1.3 Auditing of service use needs to account for schedule-driven models of care

To provide high quality care in an environment where co-payments are precluded and subsidies are low, some physiotherapy clinics choose to treat veterans in a series of brief consultations, rather than a single longer consultation.

This continuous thread of service can be beneficial, where it is planned and undertaken consciously with veterans who would, otherwise, have difficulty maintaining their management plans (e.g. would cease necessary exercise regimes).

An audit of claiming needs to account for the beneficial frequency of service to a high-need veteran population.

Any clinical audit needs to account for new models of clinical contact. This is especially so for *groups* and *classes* that physiotherapy clinics operate on a more frequent basis, possibly once a week, which will drive up service levels. This is despite a class or group setting often representing the most clinically appropriate way of delivering physiotherapy for that specific patient demographic.

Recommendation 21:

We recommend that the Department of Veterans Affairs consult the profession carefully prior to developing any tools to be used to audit the appropriateness of claiming.

6 The DVA needs to be nimble, keeping pace with emerging models of practice and technological innovations

6.1 The DVA needs to reimburse physiotherapists for services provided in part by physiotherapy assistants

The physiotherapy profession continues to innovate in its use of its workforce.

The structured use of physiotherapy assistants is one of the areas of innovation. Well-supported, supervised physiotherapy assistants can provide reliably consistent care for patients.

The 'all-or-nothing' model within the DVA, where no part of a service may be provided by a properly qualified physiotherapy assistant is outdated.

Recommendation 22:

We recommend that the Department of Veterans' Affairs provide rebates for physiotherapy services provided <u>in part</u> by a properly qualified physiotherapy assistant.

6.2 The DVA needs to reimburse physiotherapists for services provided in part by students

Under current DVA rules, physiotherapy provided by a student under the supervision of a registered physiotherapist does not attract a rebate.

This sort of constraint contributes to the problem of shortages in placement opportunities for student physiotherapists, when practical experience is a vital part of the training of the next generation of physiotherapists.

When working in a placement, the supervising physiotherapist maintains the overall responsibility for the treatment of the patient, thus ensuring that the quality of service is maintained.

Recommendation 23:

We recommend that the Department of Veterans' Affairs provide rebates for physiotherapy services provided in part by an undergraduate student supervised by a registered physiotherapist.

6.3 Requirement for personal attendance needs to be reviewed

The APA recognises that telehealth is a suitable modality for clinical care.

The requirement for personal attendance can provide a barrier to ongoing care. This includes circumstances where the patient is in a rural or regional location and the expert treating practitioner in an urban location.

The APA recommends that the requirement for personal attendance of the practitioner be reviewed, with a view to broadening the attendance to include circumstances of synchronous audio-visual communication (telehealth) after a personal attendance for initial assessment and where the treating practitioner is satisfied that it is safe and clinically appropriate to provide a 'live' video consultation. This change reflects the rapidly changing digital landscape, especially for Australians (both patients and health professionals) in rural and regional locations.

In circumstances where a physiotherapist is satisfied that a synchronous audio-visual communication other than 'in-person' attendance is safe and clinically appropriate, this would improve access to care. This change reflects the rapidly changing digital landscape, especially for Australians, both consumers and health professionals, in rural and regional locations.

Recommendation 24:

We recommend that the Department of Veterans' Affairs broaden the definition of 'attendance' to include synchronous audio-visual communication other than 'in-person' attendance (e.g. telehealth).

6.4 Safe, reliable emerging technology needs to be adopted

The Discussion Paper for the Primary Health Care Advisory Group (PHCAG)[11] points to the importance of advancing health technologies, including software, smart phone applications, self-testing and point of care testing, as ways to improve quality and reduce unnecessary costs.

This paper signals that:

a) software compatibility across health care providers remains a challenge
b) education is required to ensure testing and monitoring devices are appropriately used, and deliver value for money, and
c) the storage and communication of health information with new devices is secure and compatible with national standards.

Physiotherapists also foresee distributed digital technologies (e.g. devices in their homes) allowing people to report on outcomes remotely. For example, there is already a device with advanced personal activity monitoring, cloud based analytics and reporting that provides information about trends in activity that might signal improvement or deterioration in wellbeing.

Several studies report a wide range of clinical benefits associated with home monitoring, including reduced mortality, hospital admissions and readmissions.

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The largest study, to date, was undertaken by the Veterans Health Administration in the US, which analysed data from a national home telehealth program, Care Coordination/Home Telehealth (CCHT). The program aids people to live independently in their own home by implementing home telehealth, health informatics and disease management technologies. In this study, patients were predominantly male (95%) aged 65 or older. Of the 17,025 patients that participated in the study, there was a 25% reduction in the number of bed days of care and a 19% reduction in numbers of hospital admissions. The study reported that the cost of monitoring a patient per annum was $1,600, far lower than the direct cost of primary care services ($13,121) or care provided in a nursing home ($77,745).

Remote monitoring was found to increase staff efficiency and decrease the number of nursing home visits and the amount of travel time[12].

The cost benefits associated with telehealth and remote monitoring have been found to be as follows:

a) reduction in the need for residential care,
b) decreasing the number of community care packages,
c) a reduction in ambulance travel costs,
d) reduced travel,
e) a reduction in visits to general practitioners,
f) early detection of symptom exacerbations, and
g) reduced hospitalisations and increased quality of life[13].

Recommendation 25:

We recommend that the Department of Veterans' Affairs establish mechanisms that facilitate prompt and rigorous adoption and evaluation of new digital technologies in its fee schedule.

7 Conclusion

The APA is committed to helping to improve the DVA patient's journey, to offer lower cost, better care and better patient experiences. This submission reflects its willingness to collaborate with the DVA to embed safe, cost-effective, high quality practice and support innovation.

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Australian Physiotherapy Association

The Australian Physiotherapy Association (APA) is the peak body representing the interests of Australian physiotherapists and their patients. The APA is a national organisation with state and territory branches and specialty subgroups. The APA corporate structure is one of a company limited by guarantee. The organisation has approximately 12,000 members, some 70 staff and over 300 members in volunteer positions on committees and working parties. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing. The APA has a Platform and Vision for Physiotherapy 2020 and its current submissions are publicly available via the APA website www.physiotherapy.asn.au.

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