Review of the Department of Veterans' Affairs Dental and Allied Health Arrangements

Action item from Ex-service Organisation Round Table meeting of 11 August 2017

The purpose of this paper is to provide information regarding the 'treatment cycle' concept for allied health referrals, and data on Department of Veterans' Affairs (DVA) dental and allied health services utilisation as requested by members of the Ex-service Organisation Round Table (ESORT) at the meeting on 11 August 2017.

1. Issues identified by the Review

The following issues were identified as barriers to DVA clients receiving optimal health outcomes from allied health care services.

- Care is not always well coordinated as the GP has limited visibility of the patient's progress and quality of care.
- Long term ongoing services do not support progress towards self-management and there is limited evidence to determine if treatment outcomes are being achieved.
- There is a lack of communication between allied health providers.
- Allied health providers are finding it increasingly difficult to treat DVA clients, as some consider that DVA fees do not reflect the market rate.

There is no mechanism to prompt allied health providers to report back to the referring general practitioner (GP). While it is reasonable to expect communication between the allied health provider and the GP, advice provided through the review suggests this is not occurring routinely. GPs suggest that under the current referral arrangements they are unaware of the intensity, duration and progress of treatment provided to their patients.

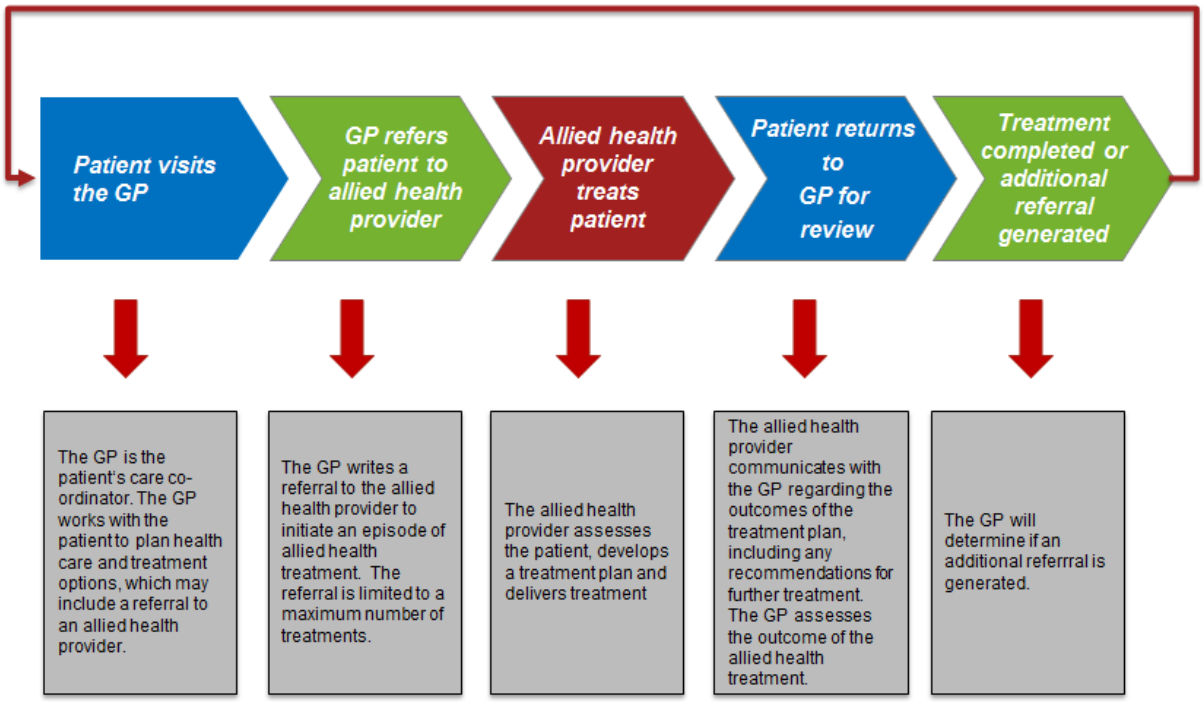
2. Proposed 'treatment cycle' for service referral

The 'treatment cycle' concept was developed in response to the issues identified through the Review. Specifically, to support health care outcomes for the veteran community by:

- increasing GP visibility of patient's health care and treatment results;
- increasing communication and coordination between general practitioners and allied health providers and between allied health providers; and
- reducing long term ongoing use of allied health services with no apparent treatment pathway, goal setting or progress towards self-management.

Currently, a referral from a general practitioner (GP) is current for 12 months, unless the GP indicates that the client has a chronic condition in which case the treatment can continue beyond 12 months or indefinitely. This option seeks to introduce a 'treatment cycle' of 12 services that can be provided against a single referral, and would require a subsequent referral to access a further cycle of treatment.

The 'treatment cycle' process is illustrated below.



As the primary health care provider, GPs have a duty of care to their patients. GPs must understand that each patient is unique, and work in partnership with them, adapting what they do to address the needs and expectations of each patient. In the DVA context, GPs therefore need to be aware of the intensity, duration and progress of treatment provided to patients by all health providers.

The treatment cycle model directs the veteran back to their GP at regular intervals. This enables the GP to assess their current treatment pathway, allowing for a new determination for continuation with the current treatment modality, another modality, or cease treatment altogether due to the outcome being achieved. The proposed service model would require the cessation of indefinite referrals. While it is acknowledged that patients with chronic conditions may intermittently require intensive allied health treatment, this should not occur without the oversight of the GP.

It is important to acknowledge the role of active treatment versus passive treatment. DVA encourages 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. 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 will commit to agreed lifestyle changes such as exercise regimes or healthy eating regimes as a part of the treatment plan.

The average number of GP consultations by the total DVA treatment population, i.e. gold and white card holders is 12, which is about 1 GP visit a month. This level of GP consultations has been relatively stable since 2010-11.

In considering the 'treatment cycle' concept, it is important to understand that it is not imposing any 'cap' or limit on the number of clinically necessary services. The treatment cycle is building a mechanism to support health outcomes through a regular/formal review of the allied health treatment being delivered. Any decision to continue, alter or cease the treatment is a decision by the patient's GP giving consideration to advice from those also involved in the patient's care.

As a point of comparison between the proposed DVA treatment cycle and the Medicare arrangements for persons accessing allied health for chronic diseases, Medicare patients have a limit of five services per calendar year. These five services may be made up of:

- one type of service, for example five physiotherapy services; or
- a combination of different types of services, for example one dietetic and four podiatry services.

A separate referral form is needed for each service type. The referral is valid for the number of services outlined in the referral. Medicare benefits are not payable for services provided in excess of the number specified in the referral.

In addition, Medicare also requires that a GP Management plan is prepared, which includes the following information:

- patient's conditions, health needs and relevant conditions;
- management goals with which the patient agrees;
- treatment and services required, including actions to be taken by the patient; and
- arrangements for providing treatment and services – when, by who and contact details.

3. Utilisation of DVA allied health services

The following tables show changes in expenditure, utilisation and patient numbers over all categories of services from 2010-11 to 2015-16. Both musculoskeletal and mental health services show substantial increases. Increased use of mental health can be attributed to expansion of non-liability health care arrangements and the promotion of access to mental health services.

The following table *All services (excluding optical)* represents expenditure across all dental and allied health services for the period 2010-11 to 2015-16, including:

- general and specialist dental, and dental prosthetists;
- chiropractic;
- diabetes educators;
- dietetics;
- exercise physiology;
- occupation therapy, including mental health;
- orthoptics;
- osteopathy;
- physiotherapy;
- psychology and clinical psychology;
- podiatry;
- social work, including mental health; and
- speech pathology.

All services (excluding optical)	**2010-11**	**2015-16**	**Change %**
Total cost	$273.0M	$297.3M	9%
Total service quantity	3.5M	3.7M	5%
Total veterans	177,445	139,848	-21%
Average services per veteran	19.7	26.3	34%
Average cost per veteran	$1,539	$2,126	38%

The *Musculoskeletal services* table includes all consultations and services provided under chiropractic, exercise physiology, occupational therapy (excluding mental health), osteopathy, physiotherapy and podiatry.

Musculoskeletal services	**2010-11**	**2015-16**	**Change %**
Total Cost	$161.7M	$190.9M	18%
Total service quantity	2.6M	2.8M	10%
Total veterans	149,534	118,584	-21%
Average services per veteran	17.5	24.2	38%
Average cost per veteran	$1,081	$1,609	49%

The *Dental services* table includes all consultations and services provided by general and specialist dentists, as well as dental prosthetists.

Dental services	**2010-11**	**2015-16**	**Change %**
Total Cost	$105.6M	$93.7M	-11%
Total service quantity	822,205	693,700	-16%
Total veterans	94,989	74,197	-22%
Average services per veteran	8.7	9.3	7%
Average cost per veteran	$1,112	$1,264	14%

The *Mental health services* table includes all consultations for all psychologists (clinical, general and neurological), as well as mental health services provided by occupational therapists and social workers.

Mental health services	**2010-11**	**2015-16**	**Change %**
Total Cost	$1.5M	$6.8M	329%
Total service quantity	15,267	55,432	263%
Total veterans	2,549	6,020	136%
Average services per veteran	6.0	9.2	54%
Average cost per veteran	$625	$1,135	82%

The *Other clinical services* table includes consultations for diabetes educators, dietitians, orthoptists, speech pathology and social work (excluding mental health).

Other clinical services	**2010-11**	**2015-16**	**Change %**
Total Cost	$4.0M	$5.9M	45%
Total service quantity	51,000	66,653	31%
Total veterans	9,804	10,106	3%
Average services per veteran	5.2	6.6	27%
Average cost per veteran	$416	$584	40%

4. Utilisation of musculoskeletal allied health services

The Review identified high average utilisation for musculoskeletal services. In particular exercise physiology and physiotherapy data showed a high volume and frequency for DVA clients over several years. The following table shows the musculoskeletal services by services, by utilisation number of unique clients, and cost for 2015-16.

Musculoskeletal utilisation for 2015-16

2015-16 services	**chiropractic**	**exercise physiology**	**occupational therapy**	**osteopathy**	**physiotherapy**	**podiatry**
average	14.8	38.6	5.6	14.2	23.4	7.6
median	11	28	4	9	12	7
clients	9,426	13,520	42,772	2,311	55,901	81,724
services	139,444	521,335	239,167	32,750	1,309,713	622,843
cost	$8,836,930	$33,283,711	$21,961,463	$2,072,994	$81,789,228	$42,993,051
cost/client	$937.51	$2,461.81	$513.45	$897.01	$1,463.11	$526.08

In the 2015-16 financial year 13,520 individuals received over 520,000 exercise physiology services, for an average of 38.6 services per person. For the same period, nearly 56,000 individuals received over 1.3 million physiotherapy services, at an average of 23.4 services per person.

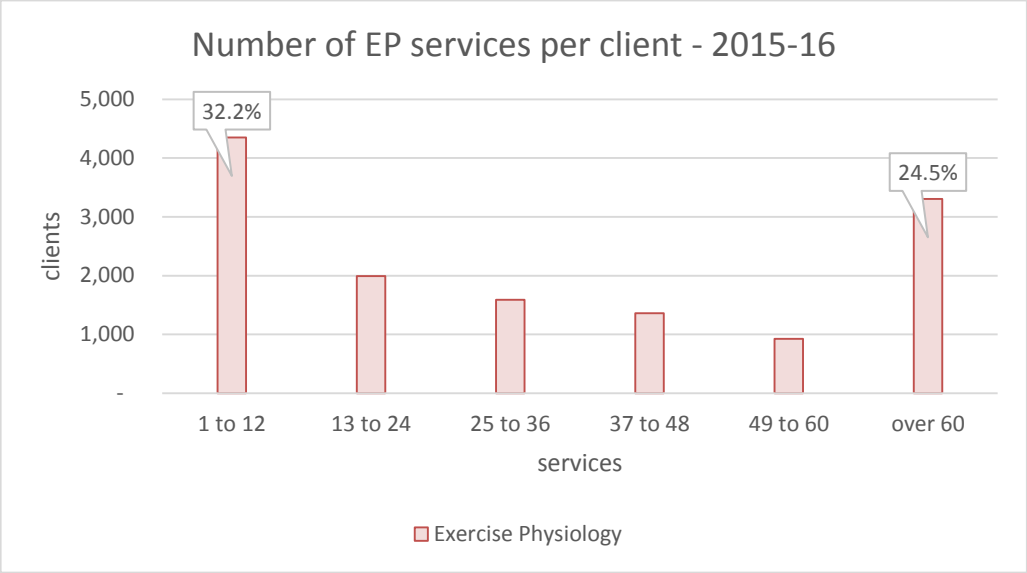
The median for physiotherapy services in 2015-16 was 12, meaning that half of all physiotherapy clients received 12 or fewer services in the 2015-16 financial year. In comparison, the median for exercise physiology services in 2015-16 was 27, meaning that half of all exercise physiology clients received 27 or fewer services in the 2015-16 financial year.

The ongoing high level and regular frequency of exercise physiology and physiotherapy services by DVA clients does not accord with clinical advice on appropriate levels of service required to achieve treatment goals. Exceptional individual circumstances may provide an explanation for the levels of service in a small number of cases but would not account for the scale of the consumption represented in the data.

5. Utilisation of exercise physiology services

The following charts show the number of DVA clients accessing exercise physiology (EP) services.

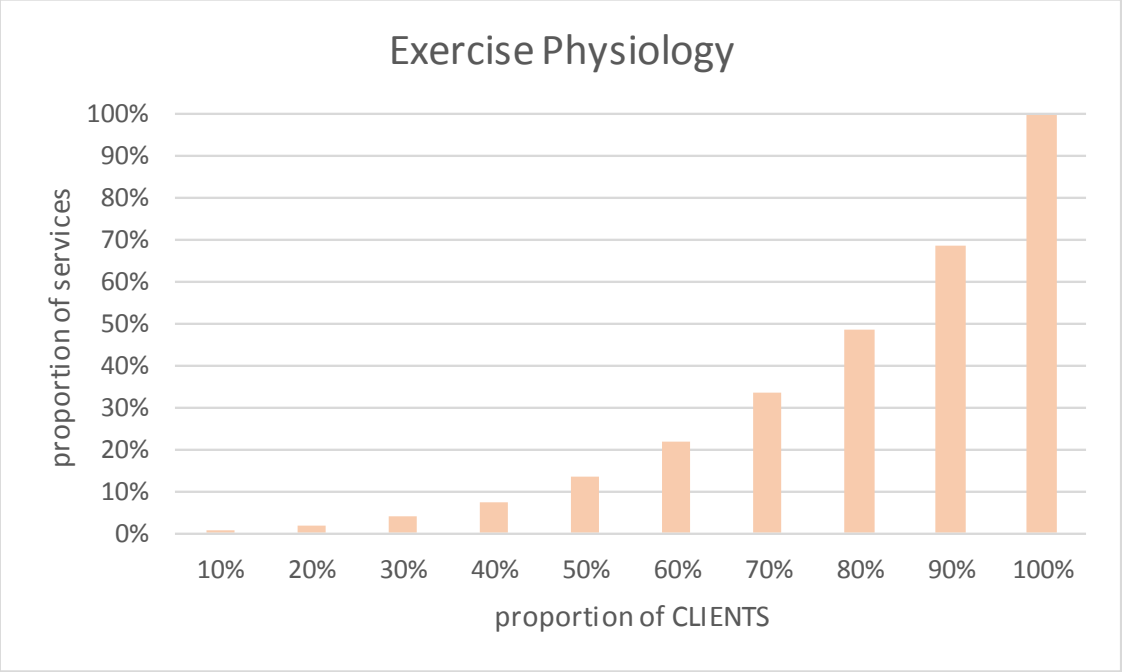
Chart 1 – Number of EP services per EP client in 2015-16



- Almost one third or 32.2% of exercise physiology clients received 12 services or fewer.
- Nearly one quarter or 24.5% of exercise physiology clients received more than 60 services.

The following chart shows the proportion of DVA clients and the proportion of exercise physiology services they consume.

Chart 2 – proportions of exercise physiology clients and services



Each bar represents 10% of the client population accessing exercise physiology, so the difference between the 90% bar and the 100% bar indicates that the top 10% of clients received over 30% of all EP services in 2015-16.

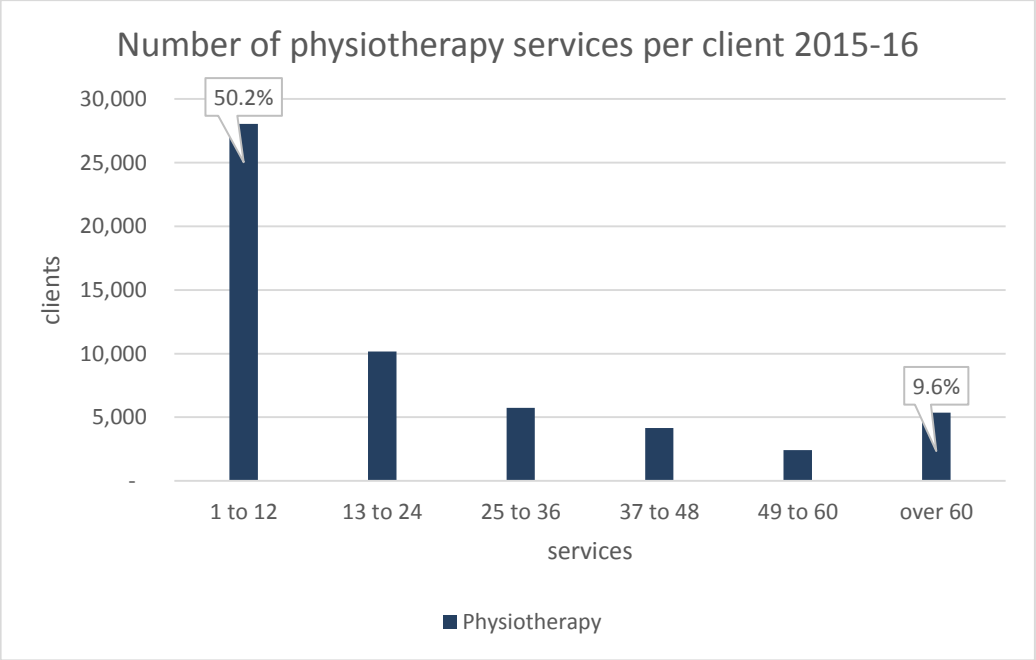
The top 20% of exercise physiology clients received 50% of all exercise physiology services in 2015-16, averaging just over 100 services per year.

The top 1% of exercise physiology clients (135 clients) received over 5% of all exercise physiology services (over 28,000 services) in 2015-16, averaging over 200 services in the year.

6. Utilisation of physiotherapy services

The following chart shows the number of DVA clients accessing physiotherapy services.

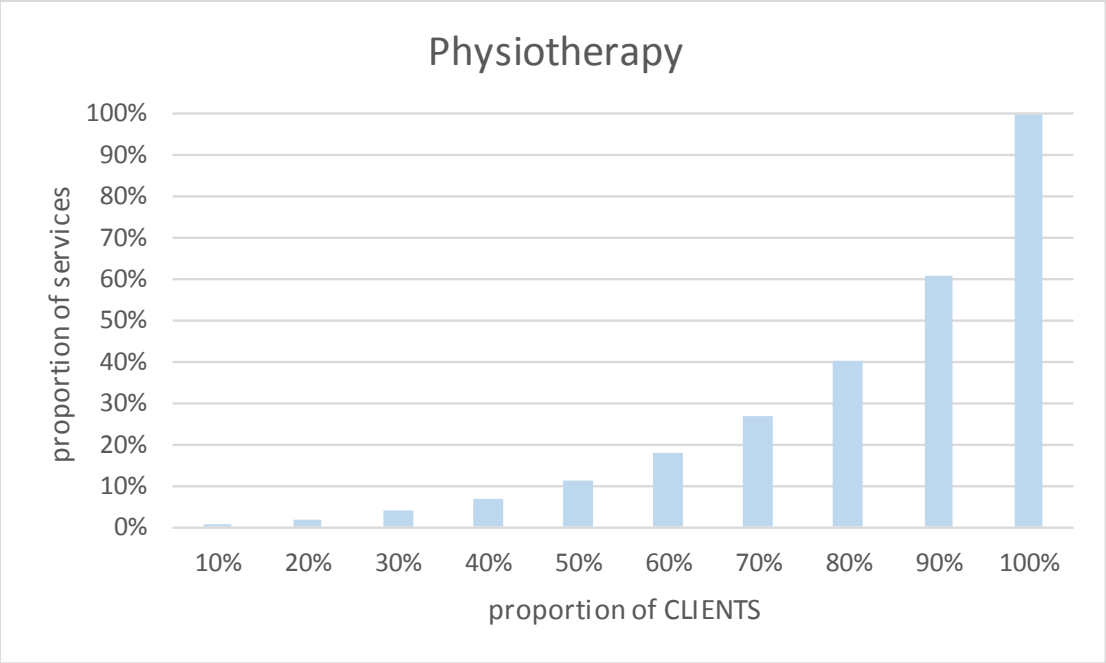
Chart 3 – Number of physiotherapy services per physiotherapy client in 2015-16



- Over half (50.2%) of physiotherapy clients received 12 services or fewer in 2015-16.
- Nearly one in ten physiotherapy clients (9.6%) received more than 60 services.

The following chart shows the proportion of DVA clients and the proportion of physiotherapy services they consume.

Chart 4 – proportions of physiotherapy clients and services



Each bar represents 10% of the client population accessing physiotherapy, so the difference between the 90% bar and the 100% bar indicates that the top 10% of clients received 40% of all physiotherapy services in 2015-16.

The top 20% of physiotherapy clients received nearly 60% of all physiotherapy services in 2015-16.

The top 1% of physiotherapy clients (560 clients) received over 7% of all physiotherapy services (approx. 93,000 services) in 2015-16 (averaging more than 160 services in the year).