3 Funding models must be appropriate to the problem DVA is aiming to solve

The May 2018 DVA Review of Dental and Allied Health Arrangements provides insight into the problem or policy challenges that DVA is seeking to address by exploring alternative allied health funding models. At the highest level, DVA is aiming to re-balance allied health funding arrangements to ensure that services meet the current and future needs of the veteran community. The 2018 Review found that the drivers for reform were:

- the need to promote multidisciplinary, collaborative care between AHPs and GPs
- higher than expected use of some services – particularly some modalities in the musculoskeletal category
- a need to distinguish between treatment for clients experiencing acute episodes and those clients with more complex conditions and multiple comorbidities.

The 2018 Review set out the evidence base for these reform objectives. It showed that over the five years to 2016-17 although there was a 19 per cent decline in the number of DVA clients (from around 173,000 to 140,000 DVA card holders), expenditure on dental and allied health services grew by 22 per cent (from $262m to $319m).

In the period to 2016-17 the strongest growth in allied health service expenditure and service delivery was in musculoskeletal and mental health services. Utilisation of services by allied health discipline was classified into the following categories of care.

Figure 1 | Classification of allied health service disciplines

Mental Health	Musculoskeletal	Other Clinical Services
Psychology (clinical, general and neuro)	Chiropractic	Dietetics
Occupational therapy (mental health)	Exercise physiologists	Diabetes education
Social work (mental health)	Occupational Therapy (general)	Speech pathology
	Osteopathy	Social work
	Physiotherapy	
	Podiatry	

In 2016-17 the bulk of expenditure on allied health services was directed to musculoskeletal services, accounting for $197m out of $319m total expenditure (or 62 per cent of all dental and allied health expenditure). In addition, musculoskeletal services made up 82 per cent of the growth in expenditure ($47.2m of the $57.7m in additional expenditure) over the five years to 2016-17.

Mental health services, by comparison, represented $8.7m out of the $319m total expenditure in 2016-17 (or just 2.7 per cent of total expenditure). This category of health services also accounted for 11.8 per cent

of the growth in expenditure ($6.8m of the $57.7m in additional expenditure) over the five years to 2016-17.

The 2018 Review was satisfied that the growth in mental health services could be attributed to the expansion of non-liability health care arrangements and the promotion of access to mental health services. There was, however, a less coherent clinical or policy rationale for the significant growth in the overall provision of musculoskeletal services over 2011-12 to 2016-17. Within the musculoskeletal category the sharpest expenditure growth was evident in exercise physiology and physiotherapy.

Figure 2 | Expenditure Growth over five years in Musculoskeletal Services

	Osteopathy	Chiropractic	Occupational Therapy	Podiatry	Exercise physiology	Physiotherapy
Total expenditure (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%
$ value of growth in expenditure	$0.8m	$1.6m	$4.4m	-3.0m	$24.4m	$16.0m
% of total five-year expenditure growth	0.5%	2.8%	7.6%		42.3%	27.8%

For exercise physiology, the dual drivers of the growth were a significant increase in the number of patients receiving services (more than doubling from 7,600 to over 16,000 patients) coupled with a six per cent increase in the average number of services per patient in a year. The growth in physiotherapy service expenditure was attributed to a 23 per cent growth in the average number of services per patient in a year and a 28 per cent growth in the cost of services per patient over the five years. Some of this increase in musculoskeletal services may be due to the ageing of the client population and some growth in nominal expenditure is attributable to indexation over this period.

More than a quarter of all clients who received a musculoskeletal service in 2016-17 received more than 12 services (in at least one treatment type). In comparison, in 2016-17, the average number of services per patient for exercise physiology was 41 services and for physiotherapy it was 24 services.

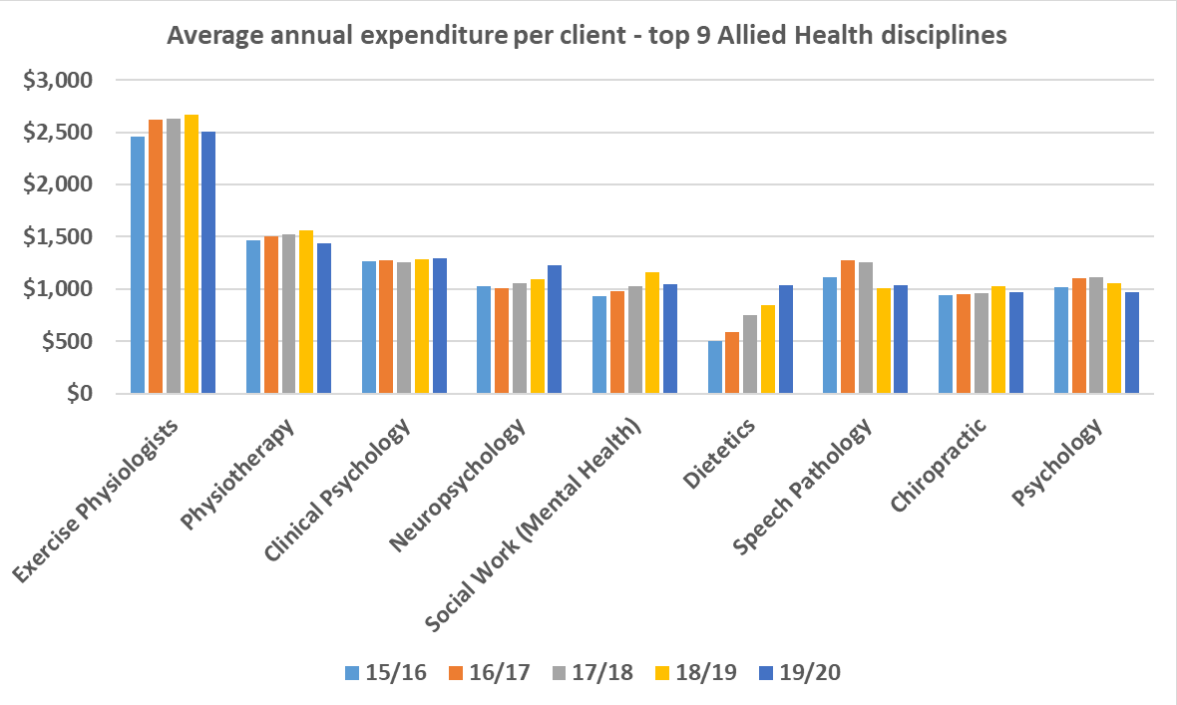
The 2018 Review drew several conclusions from the service utilisation analysis. These were:

- while the number of clients was decreasing, the number of individual services per client was generally increasing
- GPs do not always have visibility of the veteran's progress and quality of care. This meant that care was not always well coordinated and there was limited incentive for communication between AHPs and GPs, particularly when treating complex patients. Allied health was delivered by siloed disciplines and not under a coordinated care plan subject to professional review.

The 2018 Review, which included workshops with allied health and medical professionals outside of DVA, led to the introduction of the current Treatment Cycle model of funding for allied health services from 2019. The data used for the 2018 Review therefore represents activity under the previous funding model used by DVA for allied health services. Under the previous model a referral was needed; however, indefinite referrals were allowed[3].

The Treatment Cycle model has been in place since October 2019 and is currently the subject of a formative evaluation. Early indications are that though there is some evidence of more targeted referral by GPs for allied health service provision there is not a significant body of evidence on changes in the quality of care, active care coordination or improved access by 'at risk' client cohorts.

Figure 3 | Annual expenditure per client in main allied health disciplines



The early data from 2019-20 suggests that there has been no significant change in the number of services provided per client compared with the previous five years and consequential average expenditure by client in the major allied health disciplines. This early-stage data is inconclusive because the 2019-20 year includes pre and post treatment cycle data. It also includes the impact of the COVID-19 pandemic with access to health care affected by national lockdown. Noting these limitations, the data suggests that the relativities in the GP referral to and use of discrete allied health disciplines is largely unaffected.

Though the treatment cycle model was one step towards placing the GP at the centre of coordinating and managing referrals for allied health treatment of DVA clients, additional steps could be taken to bolster this objective. Alternative funding models for allied health services could be adopted to improve care coordination, to sharpen the focus on improvement in client outcomes and to ensure value for money in government expenditure.

More recent data analysis indicates some changing trends

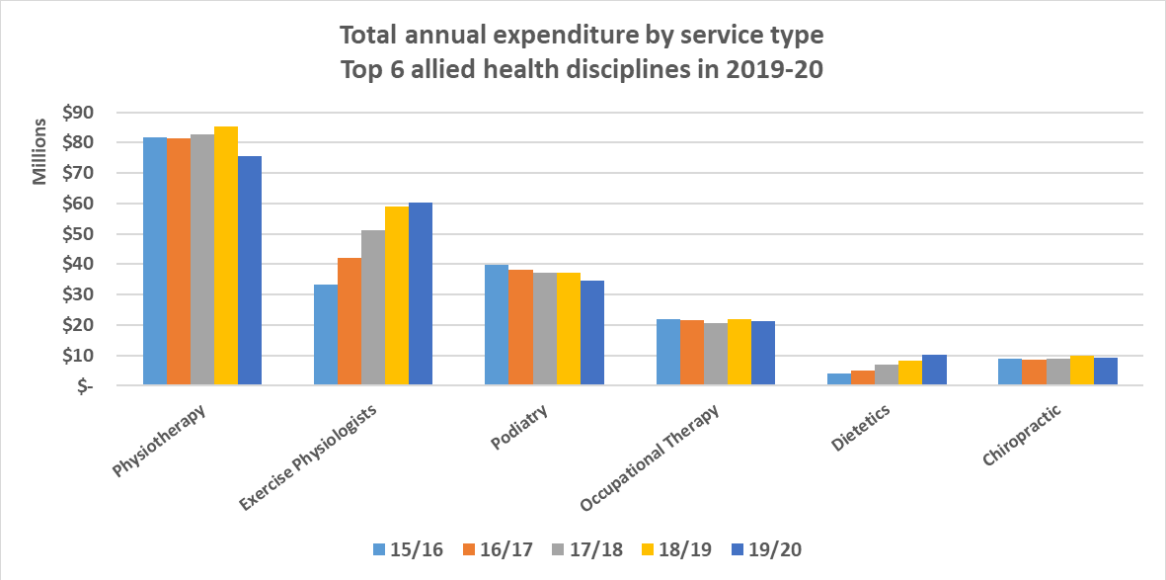
This analysis of options for moderating the payment mechanism for allied health services has been informed by review of early data on the impact of the October 2019 treatment cycle on trends in

[3] https://www.dva.gov.au/sites/default/files/notes-allied-health-providers-section-1_10_december_2020.pdf

expenditure and patterns of service delivery for DVA clients across the allied health disciplines. The full impact of the treatment cycle measure may not be evident in the available data given its recency.

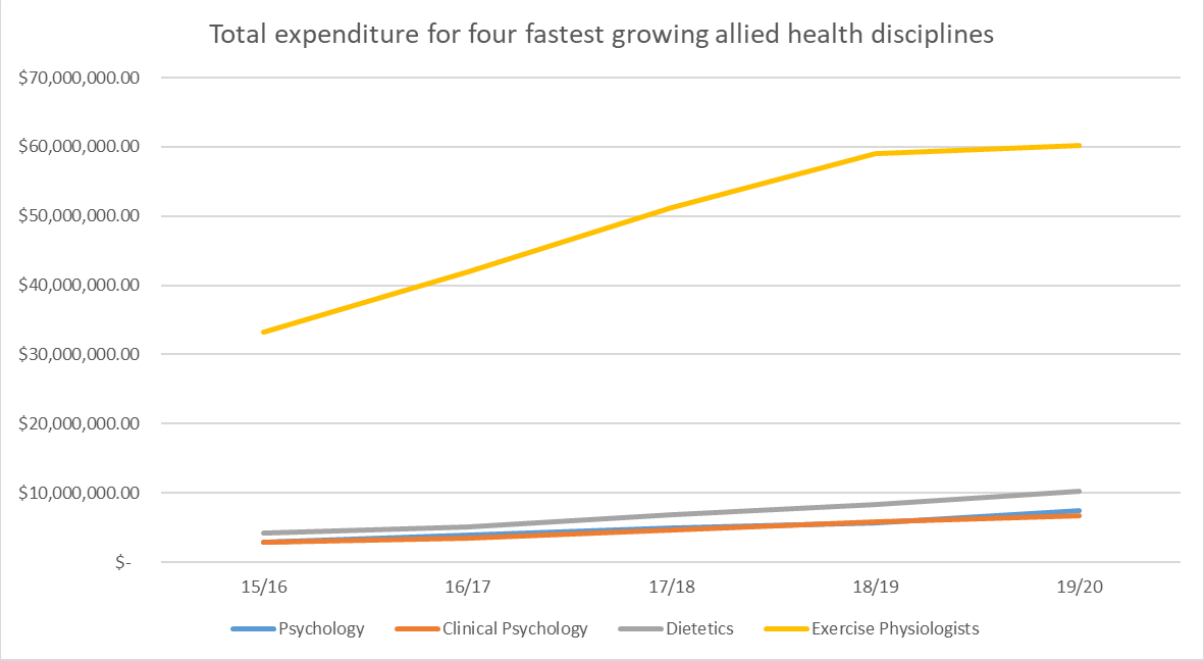
Currently available data suggests that across the top six allied health disciplines, by total expenditure in 2019-20, there has been a reduction in or status quo levels of expenditure in all major disciplines apart from exercise physiology and dietetics.

Figure 4 | Total expenditure for allied health discipline categories FY15/16-19/20



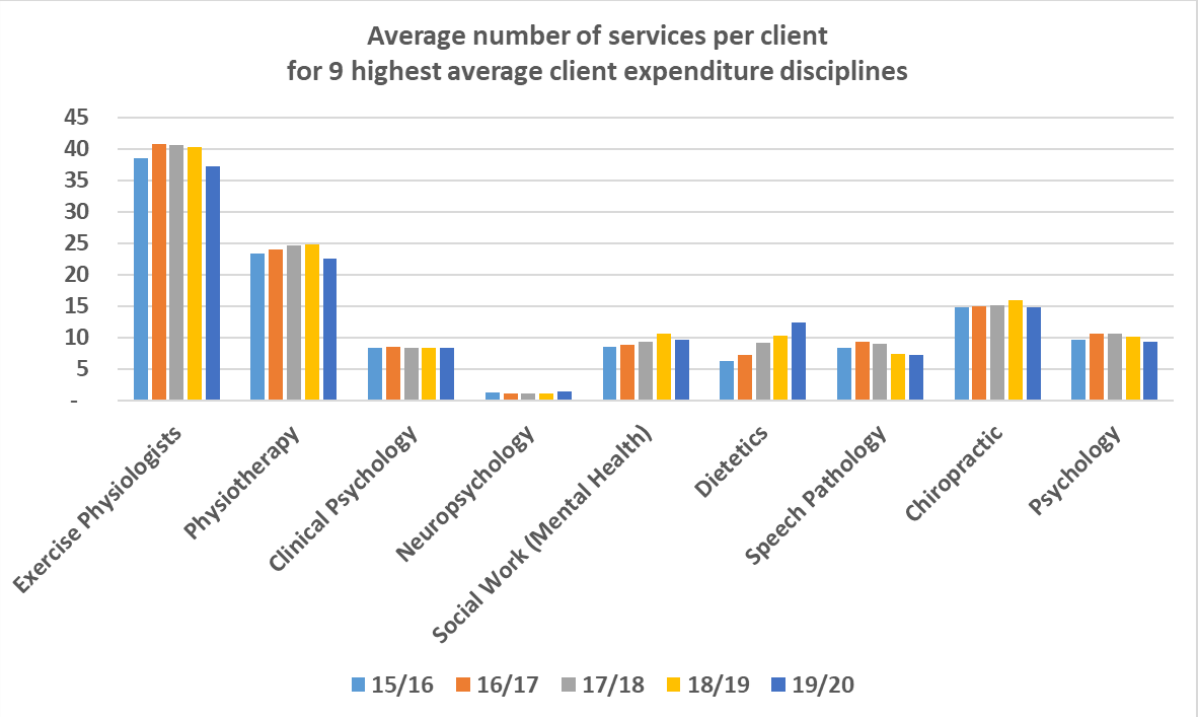
Exercise physiology and dietetics are two of the four fastest growing areas of allied health expenditure since 2015-16. Psychology and clinical psychology have also grown over the period to 2019-20, however, at a slower rate and from a lower base. This may be influenced by a range of other policy interventions, such as expanded access to non-liability health care in 2017.

Figure 5 | Total expenditure for four fastest growing allied health disciplines



A key driver of the annual expenditure by allied health disciplines is the average number of occasions of services provided per client. This is most evident in the provision of exercise physiology where the average number of services per client was 37 in 2019-20, compared to an average of 14 services per annum across all allied health disciplines. As shown in Figure 6, the number of people receiving Exercise Physiology has consistently been more than double the number of services per client across other disciplines.

Figure 6 | Average number of services per client in key expenditure disciplines



The number of services provided per client by discipline may reflect the nature of persistent and chronic conditions of the clients being referred for that treatment modality. There is no data currently available to marry the data on trends in expenditure and service patterns with the outcomes of the care provided.

Though the treatment cycle model was one step towards placing the GP at the centre of coordinating and managing referrals for allied health treatment of DVA clients, additional steps could be taken to bolster this objective. The following alternative funding models for allied health services could be adopted to improve care coordination, to sharpen the focus on improvement in client outcomes and to ensure value for money in government expenditure. It can include spending more on preventive health to get better outcomes in the long run.

4 Types of funding models identified

Through this research, a set of broad types of funding models emerged. These are summarised below.

4.1 Fee for service

A scan of the funding model types for allied health services used in different contexts revealed that most models were variations of a fee for service model. The key differentiation factors for the fee for service models were:

- the extent of care coordination or gatekeeping before the treatment is approved
- the attention paid to outcome measurement, particularly prior to further treatment
- the extent to which participants are required to contribute to the cost.

In this report, fee for service funding refers to payment by the funder for clinical care delivered by AHPs on the basis of individual occasions of care. In the broader health system, fees are generally set by the length of time of a consultation (short or long consultations) and are not tied to outcomes or aggregation into an episode of care. Some fee for service payments arrangements use other mechanisms such as a standard fee. Service fees are generally specific to a profession or a particular provider.

Within the broader health systems, there are a range of variations on the fee for service model including:

Simple fee for service

This model is a core funding mechanism for health care services in Australia and elsewhere including for allied health services. A health care provider charges a fee for the delivery of a specific intervention which is paid (in whole or part) by the patient, a health insurer or a government program such as those operated by DVA or the Department of Health. The fee for service model may be blended with and augmented by other mechanisms, such as those set out below.

Approval for referral (gatekeeper model)

Refers to fee for service funding with a gatekeeper, where access needs to be approved (for example, as is seen through GP referrals in the current treatment cycle). Referral aims to ensure that patients are receiving the right quality, quantity and type of treatment. The cost of this is a payment to the gatekeeper (GP) for the approval session, and an administrative task for the GP to refer the patient. As additional GP appointments may be required, the model also imposes a small opportunity cost on the DVA client. This model is often associated with a requirement for both the treating professional and the approver to produce and review a report on the treatment undergone prior to further treatment being approved. Models differ as to whether a payment is provided to the gatekeeper of the allied health provider for the administration components, including preparation of a treatment plan or reporting the outcomes.

Treatment plans

The treatment plan approach is essentially an expansion of the approval referral model, generally used for more complex or chronic conditions. A treatment plan is a structured document prepared by a GP usually in consultation with other professionals such as AHPs, often with the patient also involved, to describe the planned approach to provision of treatment services to achieve measurable treatment goals. It can have most utility in planning and coordinating treatment services for clients with chronic and/or complex health conditions. A treatment plan would normally include a precise clinical description of the patient's injury or condition to be treated. A plan would describe the goals of treatment with a focus on measurable

improvement in function and activity. It would describe the number and type of services to be provided over a defined period. Treatment plans also include collection of baseline and progressive outcome measures to enable review of progress and effectiveness of treatment. A range of standardised outcome measurement (SOM) tools are currently used in Australia, such as the Neck Disability Index, Client Specific Functional Scale, Oswestry and the 10-metre walk test.[4] As in the case of the approval for referral model, an additional payment is generally required to ensure that providers are sufficiently reimbursed for the time designing and approving treatment plans or reporting on the outcomes.

Implementation examples

The current DVA Treatment Cycle model

The Treatment Cycle model recognises the GP as the primary care provider responsible for DVA client-focused care and places the GP as the 'gatekeeper' of allied health service delivery. The model is intended to encourage the GP and the veteran to determine health and wellbeing goals for treatment, with the GP making referral/s to specific AHPs or practices. The model provides an entitlement of up to 12 sessions of treatment with the referred provider, or treatment for 12 months, whichever comes first[5]. If the card holder uses all these sessions, another treatment cycle can be obtained, following a review of their treatment and if necessary, through a further referral from the GP. Clients may have as many treatment cycles as their usual GP determines are clinically necessary. They may also have treatment cycles with multiple types of AHPs at the same time. The eligible veteran books consultations with the referred providers and the costs of treatment are paid by DVA under an allied health fee schedule. Allied health service providers must meet basic requirements such as recognised professional qualifications, membership of a professional provider association and/or regulatory body and having an ABN.

Chronic Disease Management Plan

Chronic Disease Management Plans (CDMPs) are a Department of Health initiative available through the Medicare Benefits Schedule (MBS). This model provides funding for coordination of care for patients with complex or chronic conditions, as well as providing funding for up to six allied health appointments. There is no strict list of who is eligible for a CDMP and it is up to the GP to determine if the patient is eligible. Depending on the needs of the patient they will be eligible for:

- a GP Management Plan: if they have a chronic condition, however, do not require multidisciplinary care.

[4] **Neck Disability Index**: The Neck Disability Index (NDI) is designed to measure neck-specific disability. The questionnaire has 10 items concerning pain and activities of daily living including personal care, lifting, reading, headaches, concentration, work status, driving, sleeping and recreation. The measure is designed to be given to the patient to complete and can provide useful information for management and prognosis of those with neck pain. Source: *Cf. Vernon H, Mior S. The Neck Disability Index: a study of reliability and validity. J Manipulative Physiol Ther 1991 Sep;14(7):409-15.*

Client (or Patient) Specific Functional Scale (PSFS): The PSFS is a self-reported, valid, reliable and responsive outcome measure for patients with back, neck, knee and upper extremity problem. It has also been shown to have a high test-retest reliability in both generic lower back pain and knee dysfunction issues. It is also clinically responsive to changes over time with chronic pain patients. This questionnaire can be used to quantify activity limitation and measure functional outcome for patients with any orthopaedic condition Source: Cf. Maughan EF, Lewis JS. *Outcome measures in chronic low back pain. European Spine Journal. 2010 Sep 1;19(9):1484-94.*

Oswestry: The Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire) is an extremely important tool that researchers and disability evaluators use to measure a patient's permanent functional disability. The test is considered the 'gold standard' of low back functional outcome tools. *Source: Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52;* (Cited in https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0014/23036/oswestry-low-back-disability-questionnaire1.pdf)

10 metre walk test: The 10 Metre Walk Test is a performance measure used to assess walking speed in meters per second over a short distance. It can be employed to determine functional mobility, gait and vestibular (body orientation) function. *Source: https://www.physio-pedia.com/10_Metre_Walk_Test*

[5] https://www.dva.gov.au/sites/default/files/files/providers/healthcycle/guide-to-the-treatment-cycle.pdf

- Team Care Arrangements: if they have a chronic condition *and* require multi-disciplinary care. These patients are also eligible for a GP management plan.

CDMPs cover case coordination and conferencing. The GP is responsible for leading treatment planning, and all care providers involved in the case conferencing and plan development can claim a payment. Payments are made through MBS item codes.

Transport Accident Commission (TAC) Victoria

The TAC is a government-owned organisation to support people injured in road transport accidents. It is open to people who have been injured in traffic accidents and TAC clients are automatically eligible for treatment within 90 days of the accident. If further treatment is required after 90 days, this requires approval against an Allied Health Treatment and Recovery Plan. Treatment must be in line with the Clinical Framework, and the plan must include measurable outcomes and a Clinical Panel oversight and review. Payment is fee for service against a provider specific schedule. The TAC uses a suite of SOM tools to assess and review progress and effectiveness of allied health treatment. Further information on the selection and interpretation of SOMs is at tac.vic.gov.au/providers/working-with-tac-clients/clinical-resources/outcome-measures.

New Zealand Department of Veterans' Affairs

The New Zealand Department of Veterans' Affairs (NZDVA) funds allied health services for veterans who have completed a relevant service and have a condition relating to that qualifying service. To receive ongoing treatment, veterans must apply for a treatment plan which approves the funding for treatment and sets out what the veteran is eligible for. The assessment process, conducted by an assigned NZDVA case manager, includes determining the nature and severity of the injury or illness, the generally accepted means and other means of treating the injury or illness in NZ, whether the treatment sought is necessary and appropriate, and the potential or harm through delay. The treatment plan operates within the fee for service model and veterans with a treatment card can present it to their health practitioner so that invoices for approved treatments are sent directly to Veterans' Affairs.

New Zealand Accident and Compensation Commission (ACC)

The ACC is a statutory body which contributes to the costs of treatment arising from accidental injuries on a 'no fault' basis. Anyone who incurs an injury from an accident in New Zealand, including visitors, is eligible. Claims are against a fee for service model by individuals for a registered provider including a range of allied health professionals. Payments may be claimed by an individual or by a registered service provider including a specified range of allied health professionals. Treatment providers and registered health professionals register with the ACC to be involved.

The ACC funds a list of eligible care professions, established by regulation and updated periodically. Some of the treatments on the list of eligible services need to be pre-approved, by the ACC, before they are delivered, and this process is managed by the registered health care provider. Payments can be claimed before or after the treatment is provided.

4.2 Payment for outcomes

Payment mechanisms for providers are sometimes tailored to achieve specific defined outcomes, such as specific functional improvements, established under treatment plans. Payment for outcomes is sometimes a component of comprehensive treatment plans or it can translate into bonuses to providers when outcome targets are met (i.e., in a blended payment arrangement).

The key issue with this funding model is that determination of whether the outcome has been met relies on outcome measures to be established and measurable and then to be expertly assessed by an independent party. It could potentially rely on using patient reported outcomes or GP review to determine

if outcomes have been met. However, it is the relevant allied health professional who has the greatest expertise in both setting and reviewing outcomes.

The desktop review did not identify any examples where payment for outcomes has been implemented or evaluated for allied health services.

4.3 Bundled/block payments

Bundled payments provide a block payment for a set of services to address a specific health need. Bundled payments could be focused on a specific discipline, specific diagnostic group, health condition or treatment type. The key advantage of bundled payments is that they reduce administrative costs by covering the full episode of care to be provided to treat a specific condition in a defined period. If constructed carefully they can remove incentives for inappropriate or excessive servicing and can be weighted or tailored to reflect severity/acuity of health conditions. They can also serve to provide weighted payments in 'thin markets' where there is a limited supply of AHPs. On the other hand, a fixed bundle might constrain flexibility to tailor care to patients' needs, particularly in complex cases or cases with overlapping conditions.

A bundled payment can be based on the use of evidence based clinical pathways in line with profession-developed or endorsed optimal clinical pathways for treating specific health conditions. This would require an extensive process for development, testing and endorsement of condition-specific clinical pathways.

The main context in which clinical pathways have been used as a funding model is to set requirements for consumers to use less intensive (including preventative) treatments such as physiotherapy before being approved for funding for expensive surgeries (especially ones with inconsistent or only moderate outcomes such as some knee surgeries). For example, the Canterbury model in NZ (see in Appendix A) funds a course of physiotherapy to avoid acute hospital care, rather than as a funding model for allied health per se.

Implementation Examples

New Zealand Canterbury District Health Board (CDHB) musculoskeletal bundle

CDHB developed a musculoskeletal package of care program in outpatient physiotherapy. CDHB patients in need of knee replacement were referred instead by CDHB doctors to community-based physiotherapists (rather than to outpatients). The bundled fee allows for approximately four to six treatments over a six-month period, with the main criteria being that the agreed outcome measures are gathered at assessment and discharge for each patient. Effectiveness is measured by quality-adjusted life years per $1m cost. Clinical assessments or estimates of functional improvement for each patient are aggregated and compared with the aggregate cost.[6]

4.4 Accountable payment to card holder

This funding model provides the eligible person with authorisation to spend up to a pre-determined amount on specified types of healthcare services. It has the benefit of providing the eligible person with a degree of autonomy over the services they choose and includes a pricing signal that the treatment is not a free good. It could potentially operate in conjunction with other types of funding models. It can be implemented through providing a card which authorises a certain total amount of funding for a set of approved services (for example exercise physiology, physiotherapy or massage therapy). This model is

[6] Evidence Based Physiotherapy in Primary Care' – *Physiotherapy for New Zealand June 2020.*

informed by the NDIA approach to 'choice and control' for participants and by the ADF Families Health model.

Implementation example

ADF Families Health

ADF Families Health provides health coverage assistance to the dependents of permanent ADF members or full-time continuous reservists. Each dependent receives a card which they can use to pay for up to $400 of eligible allied-health services a year. This $400 fills the gap in funding between the total cost of a service and what is funded by other insurance including Medicare. Card holders can use the $400 on any eligible allied health services without any other approval or eligibility checks. Eligible services include specific services under the allied health disciplines including audiology, dental, chiropractic, dental, exercise physiology, occupational therapy, physiotherapy and podiatry.

As the only eligibility test is of whether the individual qualifies as a dependent, this means the administrative burden of this funding model is relatively small. Currently, Defence contracts delivery of this program to the insurer Navy Health and it operates similarly to private health insurance. Card holders can claim at the point of service, although when there are system issues the card holder is required to pay out of pocket and apply for Defence to reimburse them. Use of the card notifies the allied-health provider to directly charge the Department. This form of funding has been very popular, partly because its operation like a private health insurer means that card holders understand how it works and how to use it.

5 Proposed Models

Drawing on the range of models identified in Section 4 and the findings of the 2018 Review, this review has identified some key criteria that have been demonstrated to improve the quality of allied health services and potentially limit any over-servicing. While not all of these may be suitable for DVA to adopt, they include:

- effective mechanisms to coordinate care across silos, particularly for chronic and complex care
- an effective means of assessing the outcomes of treatment and the ongoing need before approval is provided for further episodes
- a price signal that motivates the individual consumer and/or providers to ensure quality care is provided and deters unnecessary, or habitual, treatment.

The Treatment Cycle model was developed 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 AHPs. At the end of the Treatment Cycle, the allied health provider was expected to provide a report back to the GP to determine whether a further treatment cycle of up to 12 sessions should be undertaken.

The 2018 Review concluded that more tailored funding models for allied health services should be explored.

The following sections describe a suite of options that this project has considered. Each model is analysed against KLEs that reflect DVA's requirements for the models. DVA's intention is that one or more models could be developed through consultation with stakeholders and piloted to assess whether they improve quality of care for DVA clients and represent better value for money for DVA.

In brief, the alternative models are:

- Model 1: CTRPs for eligible veterans with chronic or complex conditions
    - Model 1 (a) Delegation of CTRP development and review to an AHP.
- Model 2: Extension of CVC to include an AHP as coordinator of care as an alternative to a practice nurse or the GP.
- Model 3: Bundled payments to fund specified courses of treatment, designed to produce clearly defined outcomes.
- Model 4: Introduction of a Wellbeing/Preventive Health Card to provide eligible veterans with capped access to particular types of allied health services without need for any referral or prior approval.

5.1 Model 1: Coordinated Treatment and Recovery Plans (CTRP)

The research and analysis undertaken for this report suggests that the criteria for quality could be further addressed by the adoption of funding model pilots which distinguish between clients with short term acute care needs and those with complex and/or chronic health conditions – essentially a triaged model. This would also allow resources to be re-directed in line with need.

Drawing on the 2018 Review and the 2019 introduction of the treatment cycle, this first model proposes a more structured and coordinated approach to improve outcomes for veterans with chronic and complex conditions. It could be developed as a targeted refinement of the current GP-led treatment cycle model.

Under the current treatment cycle model, the GP is identified as the primary care provider, with the client as the centre of care. The treatment cycle is intended to support a more collaborative approach to the care of DVA clients through better coordination and communication between GPs, AHPs and the DVA client. The GP is responsible for assessing the health and wellness goals of DVA clients and providing a referral to relevant AHPs. The AHPs are separately responsible for preparing a Patient Care Plan (PCP) for the eligible veteran and providing an End of Cycle Report to the GP (which attracts a $30.70 fee for the allied health provider) for review and assessment of whether extended or repeat referrals are required under a fresh treatment cycle.

Discussion with DVA clinical advisers suggests that some GPs may not be adopting a more coordinated approach to referral to AHPs under the treatment cycle model, and that some, may not be taking up the opportunity to personally review the PCPs and End of cycle reports provided by AHPs. The GP does not receive any additional funding for this task and it is likely that in some instances other staff within the GP practice deal with the referrals and the repeat referrals. Evaluation of the Treatment Cycle is ongoing, and so it is not yet clear whether the treatment cycle approach, as currently applied to all eligible veterans, is meeting the objective of ensuring better coordination of care and communication between the team of providers for the veteran.

The central plank of the Coordinated Treatment and Recovery Plan model is a more comprehensive, consulted and coordinated plan for access to allied health services beyond a particular threshold. The operation of this model would be facilitated and enhanced by the provision of funding to support case conferencing and seed funding to support the setting up of local networks, referral protocols, and familiarisation with roles and responsibilities.

Setting the threshold

There are a number of options for setting this threshold.

- If the CTRP is introduced within the context of the current treatment cycle, a limit could be set on the number of treatment cycles a GP can approve before a CTRP must be undertaken. For example, a CTRP could be required after one or two[7] treatment cycles (i.e., 12 treatment episodes) in a year.
- An alternative threshold could be set based on the number of concurrent treatment cycles with different provider types. For example, a CTRP could be required when a client has treatment cycles with three or more provider types.
- A further option for the threshold would be to introduce guidelines similar to those for the MBS CDMP, however, with access to more occasions of service than the CDMP provides[8] and a DVA fee schedule.

Development of the CTRP

Development of the CTRP would require a much greater degree of consultation and coordination between the GP and AHPs. This could be modelled on the provisions in the CDMP or the arrangements in place in the TAC or other insurers. It would likely require a payment to the AHPs (and the GP) for the time taken to develop the coordinated plan (as is the case with the MBS CDMP), such as an initial case coordination meeting between GPs and AHPs. In order to be effective, the model would need to provide clarity on the roles and responsibilities of the coordinator and other health professionals involved in developing the CTRP. This includes:

[7] Dependent on data analysis about number of Cycles used after introduction of the Treatment Cycle model.

[8] https://www1.health.gov.au/internet/main/publishing.nsf/content/F17F6787B14E6CF1CA257BF0001B0AEC/$File/Fact%20Sheet%20-%20CDM%20-%20Patient%20Info%20-%20Feb%202014.pdf ; https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement

- clarity of function
- clarity about the results expected
- ensuring members of the team have capacity to carry out allocated functions
- single line of responsibility in care coordination team.

The PCP template could be adapted to become an overarching plan for the client, to guide referral to or treatment by AHPs and provide a baseline assessment tool for reviewing the progress and outcomes of treatment. The plan would be prepared by the relevant AHPs and the GP (or their delegate) and would be provided to all parties as part of the referral process to frame the treatment.

Reviewing/reporting on outcomes

At the end of the CTRP the outcomes would again be reviewed by the team involved in Plan development, including the GP and AHPs (or delegated AHPs – see Model 1 (a)). Payment for end-of-CTRP cycle review would be built into the fee structure. The review process could set out specific criteria for CTRP extension, against the original health and wellness goals in the PCP, and could require DVA prior approval for an additional modified CTRP.

Payment/Costs

As is currently the case for CDMP, the care team, including the GP and the AHPs involved, would need to be reimbursed for the extra time involved in the development of the coordinated Plan and its review. This additional cost could be balanced by a reduction in repeat treatment cycles where chronic or complex needs are not present. There is also potential for these plans to reduce the number of allied health services required by clients with a CTRP, as outcomes-focused services should increase the quality of outcomes and the efficiency of reaching those outcomes.

Payment for the treatment by the providers in the Plan could be either on an episode basis, or through a bundled payment arrangement (see Model 3 below).

Short term non-complex treatment

For eligible veterans not requiring a CTRP, the treatment cycle approach would continue, however, repeat referrals would be limited (potentially to one Cycle[9] per year).

Streamlining with the MBS CDMP

An option that was considered by the review, though discounted, would be to rely on eligible veterans accessing the MBS CDMP and top up the number of occasions of service for veterans, as a veteran 'add-on'. However, this would introduce complexities given the DVA fee schedule for AHPs is different to the MBS fee schedule (due largely to the lack of a veteran co-payment). If introduction of a co-payment were to be considered by DVA, this option would streamline and simplify administration across the Department of Health and DVA. As all Australians are eligible to access MBS items, it would only be the 'add-on' that would require the veteran to show their eligibility. One potential solution to the co-payment issue might be to use the concept of a Preventive Health/Wellbeing Card to provide the veteran with capacity to make the co-payments.

Model 1(a): Delegation of CTRP activities by a GP to an AHP

An option within this model would be to allow the GP to be able to delegate (or refer) the development and review of the CTRP for an individual veteran to a selected, or 'registered' AHP. The registered AHP would then work with that individual and with other AHPs involved in their care to understand and plan

[9] Dependent on data analysis about number of Cycles used after introduction of the Treatment Cycle model.

the full suite of needs to achieve the treatment goals. This means that registered AHPs in some allied health professional disciplines (such as OT, social worker or physiotherapist) would be responsible for coordinating the work of others involved in delivering the care plan. The registered AHP would take on responsibility for review of the outcomes of all allied health service providers.

This option would add capacity and greater tailored expertise to the CTRP model including for the review of the outcomes. It is likely to lead to a more considered and quality assessment of the veteran's allied health needs.

This approach could utilise or draw on the allied health rural generalist pathway, developed by SARRAH (Services for Australia Rural and Remote Allied Health) for veterans in rural and remote areas. An accreditation system for rural generalist education and training for the allied health professions in Australia was drafted in 2018.[10]

While stakeholder consultation would be needed to assess the feasibility of this model and the likelihood of its acceptance by allied health disciplines, preliminary ideas for registered treatment planners include:

- Where the condition is primarily musculoskeletal, a physiotherapist would be an appropriate registered treatment planner.
- Where foot care is required, one of the multiple professional disciplines who deal in foot care (most likely a podiatrist) could be the registered planner.
- Where a range of allied health services are appropriate for the veteran, either an occupational therapist or a social worker could be considered as the registered provider - for example psychology, speech therapy and occupational therapy could be coordinated by a registered occupational therapist.

The aim of delegation is to improve patient outcomes, collectively and individually. Delegating tasks does not transfer all responsibility for them and in this model ultimate responsibility and authority would remain with the GP. Responsibility for the quality of the tasks carried out under delegation is generally shared, however, primarily located with the delegate carrying out the assigned tasks.

Detailed guidelines governing this would need to be developed and agreed. There are existing models of delegation in health care, for example in delegating nursing tasks and responsibilities, which could inform such development. Consultation with relevant professions, including GPs and AHPs through, for example, their peak bodies, would be needed to fine tune and finalise delegation rules and procedures in this context.

Delegation in health care is common with success factors focussing on the need for clarity in the responsibilities of delegators and delegates covering issues such as the following:

- clarity about the function being delegated
- clarity about the results expected
- ensuring that the delegate has the authority to carry out delegated functions
- single line of responsibility from the delegate to the delegator
- defining the limits of delegated authority.

The operation of this model would be facilitated and enhanced by the provision of funding to support case conferencing and seed funding to support the setting up of local networks, referral protocols and familiarisation with roles and responsibilities.

The model would also support allied health professionals to work together on complex cases and facilitate a more tailored approach to meeting veterans' needs. It would also relieve some GPs from undertaking

[10] https://www.health.qld.gov.au/__data/assets/pdf_file/0028/720496/ahha-accreditation.pdf

some of the time-consuming tasks involved in development and review of the Plans where the condition may not warrant such attention, while paying greater attention to more serious chronic conditions where a treatment plan will be a more significant input to the veteran's ongoing care.

Strengths

The CTRP model has the potential to strengthen multi-disciplinary client-centred care and improve the outcomes for veterans by paying greater attention to the holistic needs of veterans with chronic or complex conditions. CTRPs will set out goals for the allied health provider/s to work and report against, which helps ensure that treatment remains outcome rather than activity focused. Setting overarching treatment goals is consistent with the practice of AHPs under the PCP requirements, however, squarely sets the goals of individual providers within a coherent plan. This model involves the AHPs more closely in designing a fit-for-purpose plan in aspects of a veteran's care where they are expert. It also encourages the GP and allied health professionals to work together to meet the veteran's needs rather than in separate silos. It provides a paid and structured incentive for better coordination and review of care for veterans with chronic or complex health conditions.

The strengths of Model 1(a) where the coordination function is delegated to a registered AHP are similar. In addition, this option has the added strength of applying the specific skills of the registered AHP to areas of treatment whether they have greater expertise than GPs. It also reduces the time required by the GP to prepare the CTRP (which GPs would likely welcome) and ensures a more considered Plan. If used in conjunction with the rural allied health generalist approach, a specific strength would be its focus on the holistic needs of veterans in rural and remote areas.

Weaknesses

For Model 1, GPs would require extra time to prepare CTRPs and review the outcome reports prepared by AHPs, which time-poor GPs are unlikely to welcome. This would likely need to be offset by payment of a fee. The design of the model and incentives would need to be well targeted to ensure the plan does not become an administrative task that does not improve client outcomes or quality of care.

For Model 1(a), AHPs would need to be registered and supported with the development of criteria and guidelines to undertake the delegated coordination role. The selection of some allied health streams as potential delegates and not others could be a source of conflict which would need to be managed.

What would be the additional administrative burden/cost?

This model could be introduced through additional items on the fee schedule, without requiring complex back of house changes. The accompanying change to limit GPs to one (or two) treatment cycles per year may require a prior approval process where a GP sees a need to provide additional cycles.

Payment of a fee for the preparation and review of the treatment plan for the cohort of patients who will receive greatest benefit would add to the costs of the services to DVA. However, the removal of an ongoing requirement for veterans to visit their GPs for multiple treatment cycles would help to offset these costs. The current $30.70 payment to AHPs for the end of cycle review report would be replaced by a more meaningful payment reflecting the need for more substantial review of complex multi-disciplinary cases.

If relevant data is available, modelling could be undertaken to understand any savings from fewer repeat treatment cycles that could offset the cost of the administration payments.

Is it feasible and appropriate in DVA's context?

Based on the experience of accident insurance agencies in the use of this model, it would seem to be very appropriate where veterans have complex multi-disciplinary needs for allied healthcare.

There would be minimal additional time cost (travel time and appointment time) for the veteran, who already needs to attend their GP for a new treatment cycle.

How would this model work in a trial?

Prior to trial, it will be necessary to work up draft guidelines for what constitutes a condition that should be identified CTRPs. For Model 1 (a) arrangements would be needed to determine the registration process for 'registered' AHPs to whom GPs can delegate development of the plans. Adapting the PCP template into an overarching Treatment Plan template and the associated fee structure would also be required.

A trial could focus on a limited number of specified chronic health conditions that require referral to multiple AHPs. The trial could then assess whether the CRTP approach enhances access, achieves more rigorous care coordination and review by GPs or their delegates and delivers better health outcomes against relevant SOM tools.

The trial could be focused in two streams, delegated or directly GP-conducted plans. This would inform the scope for broader development and national roll-out. Evaluation of the delegated Model 1(a) would inform decisions about broader roll-out.

Trials could also test different formats for care coordination including on-line options for sharing GP and AHP-led Treatment Plans and allied health provider End of Cycle reports.

A potential area in which to trial two streams of CTRPs, delegated or GP conducted, could be musculo-skeletal conditions which have been subject to high rates of growth in recent years. One option would be to nominate physiotherapists as potential delegates in the first instance. Similarly plans for foot care could be delegated to podiatrists.

5.2 Model 2: Extension of the CVC Program to include AHPs

The CVC program provides a payment to GPs who undertake the preparation of a care plan for veterans with complex care needs. The payment amount is increased where the GP employs a practice nurse to undertake the coordination. While the care plan may include referral to AHPs, any AHP services are funded separately (through the treatment cycle).

A possible extension to the CVC program would involve approving the involvement of an AHP instead of a practice nurse to undertake the coordination where this is appropriate.

The objective of this model is to use an existing DVA mixed-primary care practice as the base and potential pilot sites, for delivery of care coordination to a larger cohort of eligible participants.

For this extension to be feasible, it would involve the AHP being a part of the GP practice. While this is not as common as the engagement of practice nurses within GP practices, the model would provide an incentive for this more multi-disciplinary approach. It would be particularly appropriate in the new Wellbeing Centres which DVA is establishing across Australia.[11]

Strengths

The extension of the CVC to include the use of AHPs to provide the care coordination would encourage the provision of more multi-disciplinary care and the inclusion of AHPs within primary care practices. It also benefits from building on an existing program, which reduces the effort required for DVA to establish the program, and fits into a program which is already understood by GPs and GP practices. As an expansion of an existing program, it would be easy for DVA clients to understand the service being

[11] https://www.dva.gov.au/health-and-treatment/work-and-social-life-programs/work-and-social-support/veteran-wellbeing

offered. The capacity to use AHPs as care coordinators would expand the applicability of the CVC including the range of conditions that would benefit from coordinated care through an AHP.

Weaknesses

The CVC model does not have a high uptake and this extension might be seen as making the model more complex. Feedback from some GPs suggests that the CVC model is considered by many GPs to be overly complex from an administrative point of view and so there may not be significant uptake of this amended model. As most GP practices do not employ an AHP, it would only be available to a relatively small number of practices, although it is likely to encourage hiring of an AHP which would then potentially increase multi-disciplinary care.

What would be the additional administrative burden/cost?

May potentially extend the number of GP practices who enrol for the CVC program, which would increase the CVC payments to GP practices. There would not need to be a change to the current payment arrangements.

Is it feasible and appropriate in DVA's context?

As an extension to the current CVC model, no issues arise for DVA. As the CVC program is due for review in 2023, it may not be appropriate or feasible to amend it before then. However, a pilot or trial in response to an Expression of Interest, would allow the concept to be tested prior to the 2023 review. This could lead to its consideration as a potential option in the 2023 review and may provide an indication of whether the expansion is likely to increase demand outside of what would otherwise be expected.

How would this model work in a trial?

This model could be trialled in the Wellbeing Centres or in CVC practices who respond to an Expression of Interest.

5.3 Model 3: Bundled Payments (A focus on outcomes)

There is potential for DVA to use bundled payments to fund specified courses of treatment, designed to produce clearly defined outcomes. A bundled payment model is particularly appropriate for short term treatment, for example for musculo-skeletal issues where the patient is likely to make a full recovery.[12] It may also be appropriate for episodes with milestones in a longer treatment plan. The bundled payment could take the form of a new item or items on the allied health fee schedule for a specific AHP for a defined course of treatment for a DVA client.

This funding model would be most applicable to short term injuries, illness, or rehabilitation where there is sufficient clinical data and service utilisation to derive a standard course of treatment. It is unlikely to be appropriate for addressing chronic conditions with requirements for ongoing care where there is inherent variability in the course of treatment for DVA clients. It could also be used in some fields where there is clinical evidence on a standard number of appointments needed for each patient, for example dietetics, to reduce the incentive for providers to overservice.[13] However, further work is required to understand the

[12] Meghan A. Piccinin, Zain Sayeed, Ryan Kozlowski, Vamsy Bobba, David Knesek, Todd Frush, Bundle Payment for Musculoskeletal Care: Current Evidence (Part 1), Orthopedic Clinics of North America, Volume 49, Issue 2, 2018, Pages 135-146, ISSN 0030-5898, ISBN 9780323583121, https://doi.org/10.1016/j.ocl.2017.11.002.

[13] This article looks at bundled payments for post-surgery care, finding the potential for this model to both reduce costs and increase the quality of care; https://pubmed.ncbi.nlm.nih.gov/28438453/

benefits and risks of this broader application of a bundled payment to allied health, as the majority of existing research is focused on hospital care and rehabilitation.

The fee level set for bundled payments would reflect evidence-based assessment of the standard course of treatment for specific health conditions. It would provide a disincentive for over servicing if the referral under the treatment cycle approach is framed as paying for an episode of care over a defined period. At the end of this period, a report on the outcomes would need to be provided to the GP before payment is made. DVA could set the bundled fee at a level that provides some recompense for the delay in payment and the provision of a report on outcomes.

Given that the bundle is intended to produce a measurable outcome, it would not be appropriate for a GP to provide a second or subsequent referral for the same bundled item. This would require a prior approval step prior to a GP referring a second identical bundled item. Clearly defined benchmarks and outcomes are key to ensuring that a new cycle of care is not approved if the treatment goals have not been achieved. This incentivises the provider and would help protect quality of care.

Payments could be weighted by complexity or co-morbidity of the DVA client's health condition to ensure that the bundled payment does not provide a disincentive for quality of care or promote cherry picking between care for clients with a complex or routine course of treatment. If successful, it could be expanded to more treatments with an expected lifecycle of less than 90 days.

Payment for care bundles could be aggregated across a given client population allowing providers to balance the resource requirements of different clients without needing adjustments in funding levels. If the relevant data is not available from historical records, this may require a period of 'dummy running' to establish the range of clients' needs and the factors influencing variations in resource needs. While this may slow the full introduction of a bundled payments system, it would replicate the approach taken to activity-based funding in acute care.

Periodic reviews of the pricing of particular treatment pathways, and modifications arising from changes in allied health practice, could be undertaken. Development of this model has broader relevance across the health system, such as in mainstream health financing and review of the MBS. Assessing the effectiveness and cost of different uses of the bundled payments may be possible and useful in the longer term.

Strengths

In comparison to the existing fee for service and treatment cycle model, there are four key strengths of bundled payments:

- The capacity of the model to facilitate a greater outcomes focus.
- The potential to simplify administration of payment for services for AHPs and DVA.
- The potential to improve the consistency of allied health care by defining payment against a standard course of treatment for specific health conditions.
- Discouragement of overservicing by reducing provider discretion over the number of occasions of care claimed because there is no incentive for the provider to conduct more sessions than are necessary to achieve the outcome.

Weaknesses

The key weakness of bundled payments is that they can act as an incentive for AHPs to underservice clients as the payment is not linked to a specific number of treatments. This has the potential to lead to veterans receiving a lower quality of care from some providers. DVA could set a minimum number of occasions of care within the episode to ensure a base level of service, as a deterrent to underservicing, however, this may become the *de facto* course of treatment. Instead, the success of the model will rely on

development of a robust and agreed set of procedures for the assessment of outcomes to counter the risk of underservicing.

What would be the additional administrative burden/cost?

The principal additional costs arise in the development and implementation phase associated with analysis of service utilisation data to derive the bundled payment for a course of treatment for a specific health condition. This analysis would inform the price for specific bundled payments in the allied health fee schedule.

There would be limited recurrent or ongoing administrative costs to the DVA, or additional administrative burden placed upon GPs or AHPs.

There would be costs associated with periodic review of the bundled payments, possibly in line with the cycle for fee schedule review, or as data becomes available on changes to standard allied health practice for specific health conditions.

Aside from the initial development and implementation costs, this model may create some efficiencies for DVA administration as it would reduce the call upon processing repeat provider payments for individual occasions of care.

Is it feasible and appropriate in DVA's context?

The use of a new temporary item number for each bundled payment would allow this model to be accommodated within DVA's current backend administrative arrangements.

How would this model work in a trial?

The bundled payment model could be trialled for short term health conditions where there is reliable data on the standard course of treatment and a clear understanding of the desired outcomes.

A good candidate for trial would be post-surgery rehabilitation (for example knee surgery) as bundled payments are already used in some hospitals (see the NZ Canterbury model for example). This makes post-surgery rehabilitation a potential trial option for DVA as there is already a base of clinical evidence on standard courses of treatment.

Trials of this kind should be targeted towards providers who do a lot of the same type of service as the success of bundled payments is partly reliant on the time spent with patients balancing out over the cohort (i.e., if there is one patient who is particularly tricky and requires a lot more treatment this leaves the provider out of pocket, as compared to if they are one of a group some of whom will need less than the standard course of treatment).

There is also potential to develop a trial based on conditions which require a very consistent level of service – say dietetics which might require about one appointment per month.

5.4 Model 4: Wellbeing/Preventive Health Card

This funding model is based on the ADF Families Health scheme, outlined in Section 3. Eligible veterans would be provided with a preventive health card that would enable them to spend up to a pre-approved total annual amount on certain specified allied health services at the lower end of the cost range. Each use of the card would not require any other approval and if the total amount was reached DVA would not cover any additional spending on the specified services. If further allied health treatment (i.e., a Treatment Cycle or a CTRP as in Model 1) became required, this would require a prior approval process.

This model is seen as a 'baseline' model for allied health treatment, with a specific focus on prevention and maintenance. It does not seek to track outcomes directly; its goal would be prevention and the lower incidence of negative outcomes.

The amount available on the card would be set at a level lower than the cost of a treatment cycle for the specified conditions.

The card could potentially cover services such as dietetics and exercise physiology (or even massage therapy) to encourage DVA card holders to invest in maintaining and protecting their health so that they do not require greater levels of support or more intensive treatment in the future. This would return more autonomy to veterans and support them to look after their own health and wellbeing. The initial set of services, or total amount set, could be changed over time as the needs and success of the program is assessed.

An alternative use of this card could be to offer an expansion of health cover for White Card holders who are only eligible for health services related to an accepted condition. In this case, it could be for White Card holders to cover cost of allied health treatment unrelated to their accepted conditions.

Strengths

This funding model would support positive health outcomes for many DVA clients and has a strong potential to improve card holder wellbeing. This is because the card holder can use the money in the way they think will provide the best outcomes for them, so they have would have a greater degree of control over their own health maintenance and well-being. This is a key benefit outside of strictly clinical outcomes, as it has been shown that greater autonomy and choice increases feelings and reports of wellbeing – and satisfaction with the system.[14]

The key strength of this model compared to the fee for service treatment cycle is therefore that it gives autonomy to the veteran so that they feel more in charge of their own care, which is likely to increase their wellbeing and satisfaction with the system. It is also more appropriate, and requires less resources, to address the needs of card holders who may only need a few sessions to address an illness or injury, rather than going through the treatment cycle and getting access to 12 sessions.

As the payment would be aimed at preventive measures it could benefit all allied health disciplines by both diverting some demand to lower level though effective treatments and reducing some of the demand for more intensive or higher-level services.

Weaknesses

This model carries a risk that DVA card holders might not use the funds for the services and treatments they most need. However, as it has low administration costs and returns autonomy to the card holder, the advantages likely outweigh the risks. Since it is a capped amount, there is no risk of over-spending. There

[14] "The psychological experience of autonomy facilitates self-regulation and is associated with improved health and well-being" Deci EL and Ryan RM (2000) The "What" and "Why" of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry* 11(4): 227–268

is some risk of demand for an increase in the capped amount if this card is introduced, however this has not been the case in the Defence Families Health context.

What would be the additional administrative burden/cost?

This model is based on the Defence Families Health card, for which the administration is outsourced to a private insurer, Navy Health. A similar arrangement with an insurer would streamline administration for DVA although it would require ongoing payment to the insurer for administration of the card.

Is it feasible and appropriate in DVA's context?

The Preventive Health Card fits into the broader suite of DVA programs as a way of taking pressure off GPs spending time providing referrals to allied health professionals when the DVA card holder only needs a very limited number of treatments. This relaxation of pressure will allow GPs to spend longer developing treatment plans and coordinating care for patients whose needs are more complex.

The Card would be likely to be supported by the veteran community given the increasing control, flexibility and choice it would create for them. The administrative burden on card holders would be very low. Defence Families Health noted one of the key benefits of outsourcing administration was that users were already familiar with how to use the private health insurance system and so did not find the program difficult or confusing to use.

It would also be likely to be supported by allied health professionals, as the treatment would be outside of the treatment cycle.

How would this model work in a trial?

DVA will not be able to run a trial for this model as DVA's governing legislation does not allow DVA to fund allied health services without a GP referral[15]. Amending the legislation just for a trial would not be practical.

Rather than running a trial, this is a model that could be introduced at a low level to test its success, and then be scaled up accordingly. This could look like starting with a low limit on the card or restricting the type of allied health services that are eligible – for example to Exercise Physiology.

DVA would be able to draw on the rich data from the Defence Families Health program to assess whether the model is likely to be successful in a DVA context.

While it would be difficult to generate detailed data on the outcomes generated, it would be possible to measure change in reported card holder satisfaction, and any change or trends in the level of servicing required by card holders before and after receiving a preventive health card. Analysis of the trends in the overall DVA allied health data could also be used to inform what services should be offered through the wellbeing card.

[15] The Treatment Principles provide the authority for DVA to pay for allied health treatment and require the treatment to be provided in accordance with the Provider Notes. The specific requirements for referrals are part of the Provider Notes. The legislative basis for a wellbeing card will need some legal advice and may require establishing a provision in the treatment principles or another legislative instrument.

Appendix A Literature scan table

Whose model is it?	Relevant context	Who is eligible?	How is eligibility determined?	What approval processes are required to access treatment?	Which services are funded?	How is it paid?	Has there been any evaluation?	Source
Australian funding models								
Victoria TAC	Government-owned organisation to support people injured in road transport accidents. Funded through charge on vehicle registration scheme.	People injured in transport accidents (drivers, passengers, cyclists and pedestrians).	Automatic eligibility for TAC clients requiring treatment within 90 days of accident. Approval against Treatment Plan required for clients to receive continued services after 90 days.	Provider registration, approval of Allied Health Treatment and Recovery Plans for treatment after 90 days. The treatment must be in line with Clinical Framework, have measurable outcomes, and is subject to Clinical Panel oversight and review.	Defined range of allied health and mental health services: *Allied health and physical therapies* Acupuncture, audiology, chiropractic, dietetics, exercise physiology, occupational therapy, optometry and orthoptic services, orthotic and prosthetic, osteopathy, physiotherapy, podiatry, speech pathology *Mental health and wellbeing:* Psychology/neuropsychology*, psychiatry, social work	Fee for service paid against provider-specific schedule. Out-of-pocket costs for clients permitted. Treatment plans and clinical review focused on treatment goals and measurable outcomes.		TAC (n.d.) Transport Accident Commission. https://www.tac.vic.gov.au/
Australian Defence Force (ADF) Defence Family Healthcare		Permanent ADF members and continuous reservists full time. Or listed as a dependent by Defence.	Recognised dependent of a current ADF member – put in an application are eligible for all listed services up to capped amount.	Eligibility for specific services not required. Once in the scheme have access to any listed services up to set overall amount.	Allied services (ADF Family Health Program pays the gap, assumed to be from Medicare). For audiology, chiropractic, dental, exercise physiology, medically prescribed appliances, occupational therapy, optical, osteopathy, physiotherapy, podiatry and chiropody, psychology, remedial massage, emergency department consultation, Medicare eye test.	Lots of things funded without much oversight, however, each family has an allocation of funds that is drawing from. $400 per dependent. Not for those actually serving – they get everything for free including allied health.		Australian Government Department of Defence (n.d.) ADF Family Health Program https://adffamilyhealth.com/eligible-services/
Reformed National Disability Insurance	A plan budget will be determined for each individual based on an independent assessment by an allied health	Anyone who is assessed as requiring services using the assessment tools.	Independent Assessment by an allied health professional.	None.	Whatever the participant chooses using their budget.	To the service provider.	No. Still under development.	National Disability Insurance Scheme (2021) Personalised Budgets.

Whose model is it?	Relevant context	Who is eligible?	How is eligibility determined?	What approval processes are required to access treatment?	Which services are funded?	How is it paid?	Has there been any evaluation?	Source
Agency (NDIA) model	professional (who is paid for the assessment). The assessment will use mandated Assessment Tools that determine access as well as the budget for that individual. Participants can then spend that budget as they choose (choice and control over the spending).							https://www.ndis.gov.au/media/3127/download
Queensland Rural Allied Health Generalist Program	An allied health rural GP responds to a broad range of healthcare needs of a rural or remote community. Strategies used by rural GPs to maximise local service access and quality. • Telehealth • Delegation to clinical support workers (i.e., allied health assistants) • Extended scope of practice including skill sharing. Partnerships supporting the implementation of a 'generalist scope' for complex or low frequency clinical presentations.	People living in rural and remote communities.	Residential address.	Allied healthcare is either provided by the allied health rural GP directly or clinical support workers.	Their definition of allied health can include: audiology, dietetics, medical radiation, occupational therapy, pharmacy, physiotherapy, podiatry, psychology, social work, speech pathology. Although the exact services provided depend on the qualifications and capabilities of the specific GP.	Australian Government – total investment of over $550 million over 10 years (Stronger Rural Health Strategy package). Bulkbilling.	Mid-way evaluation (PDF 2MB) released in October 2020 of the education program.	SARRAH (n.d). Recourse 2: Rural generalists in the allied health professions https://sarrah.org.au/sites/default/files/docs/resource_2_-_rural_generalists_in_allied_health_professions.pdf
Department of Health CDMP GP Management Plans (GPMG) and Team Care	Available through Medicare for patients with complex conditions. Funds up to six allied health sessions. Medicare program for patients with a chronic condition to help coordinate patient care. A	Individuals a GP judges are eligible as they have a chronic or complex condition. Chronic conditions are likely to last for six months or longer.	GP determines eligibility. Eligible for GPMP if they have a chronic condition, however, don't require multidisciplinary care. If they have a chronic condition and also require multidisciplinary	GP approval.	Up to six allied health services. The GP is also paid for developing the treatment plan, and all care providers involved in the case conference and review of the treatment plan can claim a payment.	Claim on a set of item codes through Medicare. Limit on how often an item can be claimed (every 12 months for preparation/coordinat		https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement

Whose model is it?	Relevant context	Who is eligible?	How is eligibility determined?	What approval processes are required to access treatment?	Which services are funded?	How is it paid?	Has there been any evaluation?	Source
Arrangements (TCA)	multidisciplinary team must be consulted when developing a TCA and each team member must be providing a different type of ongoing treatment service.	Medical conditions that have been, or are likely to be, present for at least six months, including asthma, cancer, cardiovascular disease, diabetes, kidney disease, musculoskeletal conditions.	care eligible for both a GPMP and TCA. No strict list of eligible conditions; GP's professional judgement call.		Preparation of a GPMP, Coordination of the development of TCAs, contribution to a multidisciplinary care plan, review of either a GPMP or TCA.	ion) and every three months for contribution or review.		https://www.servicesaustralia.gov.au/organisations/health-professionals/topics/education-guide-chronic-disease-gp-management-plans-and-team-care-arrangements/33191
DVA CVC Model	Wraparound program that funds coordination of care for some DVA card holders. Is not a model of funding the services themselves. Coordination is carried out by a GP or delegated to a practice nurse.	Veteran Gold card holders with a chronic condition and white hard holders with accepted mental health conditions. They cannot be aged care residents.	GP conducts initial assessment of eligibility, or they can delegate this to a practice nurse.	GP assessment and review of need for ongoing support every 90 days. Must be fully renewed at least once a year.	GP is paid a lump sum for care coordination. This amount is greater if the practice has a practice nurse.	Lump sum payment at the beginning for initial assessment and care plan. Payment made every 90 days to GP. Any allied health services are reimbursed as through the treatment cycle.	Yes, there was a 2015 evaluation. It found positive qualitative outcomes and while there had not been cost and hospitalisation reductions they may occur in the future.	https://www.dva.gov.au/providers/health-programs-and-services-our-clients/coordinated-veterans-care/coordinated-veterans-0#who-can-take-part https://www.dva.gov.au/sites/default/files/files/providers/cvc/grosvenor-independent-monitoring-and-evaluation-cvc-program-final-report-aug2015.pdf
International systems								
New Zealand New Zealand Department Veterans Affairs		Those who completed a relevant service and have a condition related to your qualifying service.	Includes treatment plans and goals, listing the conditions, medicines and treatments will fund for. Veterans need to apply for treatment plans/ongoing treatment. All veterans receiving funding for treatment must have a	Treatment plans lay out what is eligible for each veteran. Some additional services such as medicine, lab tests and accommodation may also be approved. Treatment provider means a chiropractor, dentist, medical laboratory technologist, nurse,	Appears to be funded in the same treatment cycle as Australia: 12 sessions or 12 months (the lesser) and continued treatment requires a full report from the provider (with the right to ask for the department to seek a second medical option).	All veterans with an acceptable disability will have a treatment card they can present to their health practitioner to advise them to send their invoices for approved		Veterans' Affairs New Zealand (n.d.) https://www.veteransaffairs.mil.nz/a-z/treatment/ Veterans' Affairs New Zealand (2020) https://www.veteransaffairs.mil.nz/assets/Policy/Treatment-policy.pdf

Whose model is it?	Relevant context	Who is eligible?	How is eligibility determined?	What approval processes are required to access treatment?	Which services are funded?	How is it paid?	Has there been any evaluation?	Source
			treatment plan. Department will then assess: • severity of injury/illness • the generally accepted (and other) means of treating the injury or illness in NZ • whether the treatment sought is necessary, appropriate and of the quality required to treat the injury or illness • whether treatment is one off or ongoing. • the potential for harm through delay (e.g., a risk to life, ongoing deterioration).	nurse practitioner, occupational therapist, optometrist, osteopath, physiotherapist, podiatrist, or medical practitioner.		treatment to veterans' affairs.		
New Zealand New Zealand Accident and Compensation Commission (ACC)	Statutory body which *contributes* to the costs of treatments arising from accidental injuries on a 'no fault' basis.	Anyone who incurs an injury from an accident in New Zealand, including visitors. Work based injuries from an incident or over time are in scope including for serving and ex-military personnel.	Claim basis against fee for service. By individuals or registered provider including a specified range of allied health professionals. Treatment providers and registered health professionals register with the ACC.	Some treatments need to be pre-approved. This is managed by the health care provider.	A list of eligible care professions is established by regulation and updated periodically. As is the schedule of payments for fee for service. Loss of income up to 80% may be paid.	Payments can be claimed before or after the treatment is provided.		ACC (n.d.) https://www.acc.co.nz
New Zealand CDHB Physiotherapy	CDHB developed a musculoskeletal package of care programme' for outpatient physiotherapy.	CDHB patients in need of physiotherapy.	CDHB doctors refer patients to community-based physiotherapists (rather than to outpatients).	Determined by CDHB.	Physiotherapy.	A set fee, which allows for approximately four to six treatments over a six-month period, with the main criteria being that the agreed outcome measures are gathered at	Effectiveness measured by quality-adjusted life years per $1m cost. 19 gained for knee osteo and 47 for	Physiotherapy New Zealand (2020) Physiotherapy for NZ. https://pnz.org.nz/Folder?Action=View%20File&Folder_id=1&File=Physiotherapy%20for%20New%20Zealand.pdf

Whose model is it?	Relevant context	Who is eligible?	How is eligibility determined?	What approval processes are required to access treatment?	Which services are funded?	How is it paid?	Has there been any evaluation?	Source
						assessment and discharge for each patient.	lower back pain.	
Canada Health system	Canada has a decentralised, universal, publicly funded health system. Health care is funded and administered primarily by the country's 13 provinces and territories. Fee for service is the primary form of physician payment, although there has been a movement toward alternative forms of payment, such as capitation (2016-17).	Everyone.	No eligibility.	No approvals required.	Under universal health care: physician provided mental health care is covered under Canadian Medicare in addition to a fragmented system of allied services. Private complementary coverage: vison, dental, prescription drugs, allied professionals, private hospital rooms. All other: private healthcare.			Tikkanen, Osborn, Mossialos, Djordjevic & Wharton (2020) International Profiles of Health Care Systems. https://www.commonwealthfund.org/sites/default/files/2020-12/International_Profiles_of_Health_Care_Systems_Dec2020.pdf
Canada Veterans Affairs Canada	Multiple programs consisting of a range of different allied services (with different eligibility requirements) • Rehabilitation program • Treatment Benefits Program.	Served in the Canadian Armed Forces. *Rehabilitation program*: have a barrier to re-establishment which is a health issue (temporary or permanent) related to your service that prevents your full participation at work or home.	Eligibility is for service-related illness or injury.	Service must be prescribed by a physician to be approved by Veterans Affairs Canada.	*Rehabilitation program:* medical and psychosocial rehabilitation – treatment and therapies. *Treatment benefits (incl related health services).* • occupational therapy • physiotherapy • massage therapy • chiropractic • acupuncture • speech language pathology • psychological counselling.			Veterans Affairs Canada (n.d.) https://www.veterans.gc.ca/eng/health-support
United States Veterans Affairs-VA	Claims 'most extensive system of assistance for veterans of any nation in the world'. VA operates many of its own facilities and services.	Active-duty service members, veterans and their families.	Eligibility determined by service status and 'appropriate health care professional'.	Determined by 'appropriate health care professionals'. Many services are operated by VA.	Comprehensive list of services with exclusions of abortion, non-approved drugs, gender alteration surgery, spas and health clubs and where another government agency is responsible.	Co-payments apply to some vets: $15 for an outpatient visit and $50 for a specialist o/p consult.	Office of Programming Analysis and Evaluation in Office of	Veterans of Foreign Wars (2020) VFW Guide for Post Service Officers Part 3 Health Care https://vfworg-cdn.azureedge.net/-

Whose model is it?	Relevant context	Who is eligible?	How is eligibility determined?	What approval processes are required to access treatment?	Which services are funded?	How is it paid?	Has there been any evaluation?	Source
						Many Vets, are exempt from this (e.g., ex-prisoners of war; those with a disability gained in active service, Vets with a Purple Heart).	Management has oversight.	/media/VFWSite/Files/Assistance/VFW-Guide-for-Post-Service-Officers---Part-3---Health-Care.pdf?la=en&v=1&d=20201221T180930Z
Germany General health insurance		Insured patients (statutory health insurance or private) and dependents (nonearning spouses and children).	• N/A – health insurance is mandatory.	Non-physician care may be ordered only if a disorder can be recognised, healed, or mitigated or if aggravation, health damage, endangerment of children or the risk of long-term care can be avoided or decreased.	Insured patients (SHI or private) are entitled to therapeutic services of allied health professionals other than physicians, such as physiotherapists, speech and language therapists and occupational therapists.	General wage contributions to sickness funds – every working person contributes a percentage of their wage.		Source: Tikkanen, Osborn, Mossialos, Djordjecvic & Wharton (2020) International Health Care System Profiles Germany. https://www.commonwealthfund.org/international-health-policy-center/countries/germany World Health Organisation (2017) https://www.who.int/health-laws/countries/deu-en.pdf?ua=1
Denmark General health insurance			Danish residents choose from two schemes: (1) gatekeeping – GP controls access to specialist and diagnostic services, which are free following referral (2) direct access – involves co-payments for visits to both GPs and specialists.	Referral from GP.	Physiotherapy, dental care and pharmaceuticals prescribed in a primary care setting are only partly covered. Other services are partly or fully covered according to specific rules, in some cases depending on referral from the general practitioner or type of health problem. CAM therapies are usually not covered. Chiropractic services may be partly reimbursed (for specific conditions). Patients do not require a referral.	Scheme 1: Government. Scheme 2: Co-payments patient and Government.		Ettelt, S., Nolte, E., Mays, N., Thomson, S., McKee, M., & World Health Organization. (2006). *Health Care Outside Hospital: Accessing generalist and specialist care in eight countries* (No. EUR/06/5065596). Copenhagen: WHO Regional Office for Europe.
Finland	Most municipalities charge patients for consulting a health centre physician (client fee).	Everyone.	Requires a referral by a doctor.		Acupuncture and other alternative therapies are reimbursed by the National Health Insurance if they are	Reimbursed by the National Health Insurance.		Ettelt, S., Nolte, E., Mays, N., Thomson, S., McKee, M., & World Health Organization.

Whose model is it?	Relevant context	Who is eligible?	How is eligibility determined?	What approval processes are required to access treatment?	Which services are funded?	How is it paid?	Has there been any evaluation?	Source
National Health insurance	These are either fixed or dependent on income.				provided by a doctor. Consultations with a registered chiropractor, osteopath and naprapath (a type of manual therapist) are covered if the patient has been referred by a doctor.	+ Small client fee.		(2006). *Health Care Outside Hospital: Accessing generalist and specialist care in eight countries* (No. EUR/06/5065596). Copenhagen: WHO Regional Office for Europe.

Appendix B Extended methodology

For the purposes of this project the allied health services in scope are based on the 2018 Review of Dental and Allied Health. For the purposes of this work, we propose that dental and optical services are excluded because these services are treated differently in that they do not require GP referral or involvement, and this approach has been confirmed with DVA.

- chiropractic
- clinical psychology
- diabetes education
- dietetics
- exercise physiology
- neuropsychology
- occupational therapy
- occupational therapy (mental health)
- orthotists (this profession has been added to DVA allied health arrangements since the Dental and Allied Health Review.)
- osteopathy
- physiotherapy
- podiatry
- psychology
- social work
- social work (mental health)
- speech pathology

B.1 Key lines of enquiry

KLEs will guide our research approach for potential allied health funding models DVA could trial. This will ensure we have collected the sufficient breadth and depth of information about the model to understand what kind of outcomes it creates, how much it costs and its feasibility in this context. The full set of KLEs is shown in Table 1, and respond to the overarching question 'What funding models will strengthen the quality of care for DVA card holders and represent better value for money for DVA?' The KLEs may be further refined if the evidence identifies common themes to be considered when assessing funding models. Nous will also provide DVA with the opportunity to add to or refine these lines of enquiry once Nous has presented its preliminary findings, to ensure that the final report explores all the nuances required for DVA to make an informed decision about running trials.

Table 1 | KLEs

KLE	Sub-level questions
Would this funding model drive health outcomes and wellbeing for DVA clients?	How will this model enable outcome-based health care (as opposed to occasions of care)?
	Does the funding model enable equitable access across veteran cohorts?
	Does the funding model enable outcomes across disciplines of allied health?
	Does the funding model have any dependencies with other aspects of the health system?

KLE	Sub-level questions
	What levers are in the model which provide incentives or disincentives to providers to deliver outcomes-based healthcare?
	Is the data required to understand outcomes available or able to be obtained?
	Is the funding model flexible for different patient and care needs?
	Does the funding model have any features or benefits outside of direct clinical outcomes for veterans?
What would be the additional administration burden/cost?	What administrative or operational controls would DVA require to support the model?
	What are the administrative requirements (resourcing or cost) of the model to AHPs or clients?
	What are the costs of introduction for DVA? For AHPs?
	What are the operating costs/requirements? (For DVA and for AHPs)
	Does the model require need for investment in reporting or control mechanisms?
	What are the costs of collecting data to measure outcomes?
	What resources are required to trial or implement the model?
	Will the model target DVA's expenditure on allied health treatment?
Is it feasible and appropriate in DVA's context?	Is the funding model consistent with DVA's legislation?
	Is the funding model aligned/compatible with other DVA programs?
	Is the model likely to be supported by the veteran community?
	Is the model likely to be acceptable to AHPs?
	Is the model likely to be acceptable to government?
	Is it able to be appropriately tested in a trial or pilot?
How would this model work in a trial?	Who would run the trial?
	What would a control group look like?
	Where would a trial run?
	Would the trial focus on specific cohorts of DVA clients?
	Would the trial focus on a particular allied health disciplines?

B.2 Approach to initial scan

The purpose of Nous' initial scan of funding models is to establish what types of models are used in other health and veterans' affairs contexts. The depth of research will be sufficient to make a preliminary assessment of each model against a set of criteria to determine if the model could be successful in a DVA context.

Scope of the initial scan

Nous conducted a broad scan of the allied health funding model options that have been implemented or trialled in other jurisdictions. As such, we investigated:

- allied health funding models used by international departments of veterans' affairs
- allied health funding models used in comparable health systems
- funding models for other types of health services (for relevant characteristics)
- aspects of DVA's existing funding models in other programs
- potential variation to the existing treatment cycle

To investigate these thoroughly, we will use a structured research approach using the set of search terms set out below:

Table 2 | Search terms for research approach

Countries to investigate	Funding model types	Health systems or companies with overlapping characteristics
In relation to both their health and department of veterans' affairs funding models: • Canada • New Zealand • Any Scandinavian countries • United States • Germany • Australia (other funding models and approaches)	• Fee for service payments • Value based care • Managed care • Coordinated care • Navigating care • Health payment systems • Allied health payment systems and payment cycles • Funding for value • Health care homes • Targeted case payment • Coordinated care • Payment on achievement of health outcomes • Bundled payments • Treatment cycle	• Workers' compensation (TAC, iCare) • Rehabilitation • Private health insurance (for characteristics such as bundling, funding criteria and arrangements) • Value for money in allied health • ANAO health funding reviews • Productivity Commission reports, including but not limited to on 'A better way to support veterans' • Primary Health Networks

Selection of the key alternative funding model options

Nous will employ a selection framework to determine which funding models are most appropriate for deeper analysis. This will ensure that the models selected are at least potentially appropriate to a DVA context. This process will reduce the list of funding models for further analysis to three to five key options.

The selection framework will be based on the KLEs outlined in Table 1, with the three key questions as:

- Would this funding model create good/better outcomes for DVA cardholders?
- Would there be significant additional administration burden/costs?
- Is it feasible and appropriate in DVA's context?

These three questions form the basis of the KLEs outlined in Table 1 and so the sub questions listed will determine whether the funding model meets the criteria.

The initial intention was to test each option found in the initial scan against the KLEs outlined in Table 1 in a matrix format. Once Nous began the research however, it became clear there was not enough diversity in the funding models used to make this productive. Instead, Nous has provided a long list of the implementation examples investigated, and a brief summary of their key features. This can be found in Appendix A. The four proposed models have all been tested and analysed against the KLEs.

These characteristics will be carried into the detailed analysis stage of the research, driving analysis of the key funding models selected for further investigation and possible trial in stage two.

B.3 Approach to detailed analysis of funding options

Nous analysis will provide a snapshot of each key option in our preliminary findings, which will be further built out in the draft and final report. For each funding model we will more deeply consider the funding model against each key line of enquiry, as well as comparing its performance against DVA's existing allied health funding model.

Preliminary findings

The preliminary findings report will present Nous' working to date and a snapshot of each of the funding models selected for deeper analysis.

- Summary of the initial scan, long-list approach and justification of why we chose the set of models for deeper analysis that we did.
- Snapshot of each funding model option including a finding against each key line of enquiry and a summary of the key benefits and weaknesses of each model. Brief comparison against the existing funding model.
- Summary of analysis of what 'better outcomes for DVA card holders' looks like in practice.