24 Treatment cards for Safety, Rehabilitation and Compensation Act clients

Chapter summary

Defence-related claims under the Safety, Rehabilitation and Compensation Act 1988 (SRCA) can include medical expenses reasonably required for the compensable condition. This usually occurs through reimbursement of costs, and occasionally by direct billing. The Review received a number of submissions relating to healthcare provisions under the SRCA, including proposals to issue Repatriation Health Cards to Australian Defence Force (ADF) claimants under the SRCA.

Introducing Repatriation Health Cards would bring the SRCA in line with provisions under the Veterans’ Entitlements Act 1986 (VEA) and the Military Rehabilitation and Compensation Act 2004 (MRCA). However, this will mean that access to certain types of treatment, such as remedial massage or gym programs, will be more limited than under the current SRCA provisions. A co-contribution for pharmaceuticals will also be payable.

Many amounts payable under the Department of Veterans’ Affairs (DVA) fee schedule are significantly lower than those under the SRCA, such as standard general practitioner consultations and most specialist consultations. This may lead to provider dissatisfaction, and medical and allied health provider groups, including the Australian Medical Association, should be consulted as part of the development of the expanded card system.

Advantages of Repatriation Health Cards — For Specific Conditions (White Card) for SRCA clients include:

- the convenience of not paying upfront and waiting for reimbursement;
- consistency in provisions across the VEA, SRCA and MRCA;
- greater control and monitoring of treatment and pharmaceuticals; and
- administration and departmental savings.

The Committee therefore recommends that White Cards be issued to defence-related claimants under the SRCA. Provision of cards should be subject to a needs assessment showing long-term treatment needs. The current reimbursement arrangements for the treatment of short-term conditions should be retained. The Committee also recommends that the DVA fee schedule be adopted for treatment provided to defence-related claimants under the SRCA, and that the supplementary payment for pharmaceuticals be extended to SRCA clients with Repatriation Health Cards.

Introduction

24.1 The Committee is required under its terms of reference to examine the level of medical care provided to Australian Defence Force (ADF) personnel injured during peacetime service. In this regard, the Review received a number of submissions relating to the arrangements for ADF claimants receiving treatment under the Safety, Rehabilitation and Compensation Act 1988 (SRCA). This chapter addresses the issues raised in those submissions.
Background

24.2 Under the SRCA, the Military Rehabilitation and Compensation Commission (MRCC) is liable to pay for medical expenses reasonably required for the medical condition associated with accepted claims for compensation.\(^1\) This is equivalent to Treatment Pathway 1 as outlined in Chapter 14. In most cases, MRCC delegates authorise reimbursement of claims for payment of medical expenses. There are some arrangements between the MRCC and individual treatment providers for direct billing (without the need for the claimant to pay in advance).

24.3 The 1997 Inquiry into Military Compensation Arrangements for the Australian Defence Force (ADF), which was commissioned in response to the 1996 Blackhawk Accident, recommended the use of a treatment card system for the military compensation scheme, of a similar nature to that used by the Department of Veterans’ Affairs (DVA) for veterans whose compensable injuries require ongoing medical treatment. The Tanzer Review\(^2\) also recommended that these costs be met through the issue of a specific treatment entitlement card, such as exists under the Veterans’ Entitlements Act 1986 (VEA).

24.4 No action has been taken by government to implement these recommendations. The policy priority in the immediate period after these reports was the development of a new military-specific scheme. In addition, the potential impact of the proposal on the existing larger base of VEA beneficiaries was of concern.

Submissions

24.5 This Review received a number of submissions relating to healthcare provisions. Several other representations (verbal and written) have subsequently been received on this issue.

24.6 The following proposals were raised in submissions to the Review:

- extension of Repatriation Health Cards – For Specific Conditions (White Card) for ADF claimants under Part XI of the SRCA;
- adoption of the DVA fee schedule for treatment provided under the SRCA;
- extension of a supplementary payment for pharmaceuticals to SRCA clients with Repatriation Health Cards; and
- retention of the current reimbursement arrangements for the treatment of short-term conditions under the SRCA.

24.7 The most prevalent argument in the submissions is that SRCA clients should be issued with a Repatriation Health Card for treatment.\(^3\) The Commonwealth & Defence Force Ombudsman also noted that the requirement for pre-approval of medical treatment is a ‘regular source of complaint’.

---

\(^1\) Section 16 of the SRCA.
\(^3\) Ex-service organisations (ESOs) seeking access to treatment cards under the SRCA included the Australian Veterans and Defence Services Council, Injured Service Persons Association, Returned & Services League of Australia and the Australian Peacekeeper and Peacemaker Veterans’ Association.
24.8 Several individuals also argued for treatment cards to be issued. The health care access issues they describe include:

• the need to constantly seek prior approval for treatment and/or medication;
• the need for repeated medical appointments to gather evidence of illness or injury;
• the need to constantly repeat the process for the existing illness or injury;
• the financial impact of payment being required upfront delaying treatments (sometimes indefinitely); and
• long delays in reimbursement of such expenses by DVA.

Legislative provisions

24.9 The SRCA provides compensation for the cost of treatment that is ‘reasonable to obtain in the circumstances’. The definition of what constitutes ‘reasonable’ is based on medical evidence and is determined on a case-by-case basis. Payment for treatment is guided by Comcare’s schedule of fees, which broadly aligns with the Australian Medical Association rates in the state/territory in which the treatment is provided.

24.10 To facilitate the provision of treatment cards, the SRCA would need to be amended for Part XI ADF claimants. The appropriate card would be a White Card. To be consistent with card provision under other legislation in the Veterans’ Affairs portfolio, this would also require provision for payment of a supplement for pharmaceuticals. The Minister responsible for the SRCA would need to agree to any amendments. Wider considerations within government would also be necessary.

Limited access to certain types of treatment

24.11 In some circumstances, the Military Rehabilitation and Compensation Act 2004 (MRCA) treatment principles are more restrictive than the SRCA approach of ‘reasonable to obtain in the circumstances’. Assuming that the use of Repatriation Health Cards under the SRCA would include the use of Treatment Principles in line with those that exist under the VEA and the MRCA, the provision of certain types of treatment that are frequently approved under the SRCA may not be available through the Treatment Principles or the Pharmaceutical Benefits Schemes.

24.12 The most common examples include:

• remedial massage performed by a massage therapist; and
• gym programs.

24.13 Additionally, the Rehabilitation Aids and Appliances Program has much tighter guidelines with respect to hearing aids, medical grade footwear, orthopaedic beds and recliner chairs than currently apply under the SRCA.

Provider issues

24.14 A comparison of fees for the most commonly obtained treatment shows that the amounts payable under the DVA fee schedule are more generous when compared to treatment obtained under the community-standard Medicare Benefits Schedule.

4 L. Lampard, R. Thompson and another individual whose submission was published with the name withheld.
However, most are notably less than the amounts presently available under the Comcare fee schedule applicable under the SRCA reimbursement arrangements. Issuing SRCA defence-related claimants with treatment cards in line with the DVA fee schedule would, therefore, reduce treatment expenditure for the Australian Government.

24.15 Some items attract significantly lower payments under the DVA fee schedule than under the Comcare fee schedule; for example:

• standard general practitioner consultations ($40.15 compared to $66.00);
• initial occupational physician consultations ($111.15 compared to $275.00);
• initial osteopathic consultations ($59.90 compared to $165.20);
• initial psychologist consultations that are longer than 30 minutes, and subsequent psychologist consultations of 46–60 minutes ($140.90 compared to $212.00); and
• most specialist consultations.

24.16 As a result, some providers may refuse to deal with a SRCA client using a Repatriation Health Card. This may lead to provider dissatisfaction, and dissatisfaction of the claimant who may have to leave a preferred provider to find another who will accept the Repatriation Health Card.

24.17 The issue for the client already exists, albeit on a smaller scale, with ADF members on discharge or when DVA administers claimants changing from Treatment Pathway 1 (reimbursement) to Treatment Pathway 2 (treatment card) under the MRCA.

24.18 There is also a concern that, if the cardholder treatment population suddenly increases with the addition of SRCA clients, some providers may refuse to deal with DVA clients altogether. However, the SRCA population is a much smaller number — 5,000 to 6,000 (and just $35.1 million total for all forms of treatment including hospital care, compared to $4.89 billion under the VEA) — compared to the combined number of VEA and MRCA cardholders, a total of 254,401 as at September 2010. Further, the VEA treatment population is decreasing annually with the decline in numbers of the surviving Second World War generation.

24.19 Medical and allied health provider groups, including the Australian Medical Association, should be consulted as part of the development of the expanded card system if it is decided to extend the White Card to SRCA-eligible persons.

**Pharmaceuticals**

24.20 Under the SRCA reimbursement mechanism, all pharmaceuticals provided for an accepted medical condition are reimbursed in full.

24.21 Under the VEA’s Repatriation Pharmaceutical Benefits Scheme and the MRCA Pharmaceutical Benefits Scheme, a claimant co-payment of $5.40 per prescription is required up to the safety net limit of 60 prescriptions in a calendar year, after which all prescriptions are free. This equates to a maximum of $324.00, which is offset by the payment of the MRCA supplement, currently $3.00 per week.

24.22 For consistency, a supplement payment similar to that payable under the VEA and MRCA would need to be paid to SRCA cardholders.

24.23 If treatment cards were provided to SRCA claimants, those who require access to high volumes of prescription medication would incur out-of-pocket expenses by
having to make co-contribution payments. For example, some SRCA claimants would receive $156.00 in supplement payments, but expend $324.00 in co-payments, therefore being out of pocket by $162.00 per year. Others would receive the $156.00 supplement and spend less per calendar year on prescriptions.

24.24 The SRCA claimants that benefit from the provision of White Cards under that Act will have rendered peacetime service only. Therefore the outcomes of the Review of War-Caused Disabilities and Pharmaceutical Costs, which apply only to claimants under the VEA or MRCA who have rendered qualifying service (as discussed in Chapter 14), would not address any out-of-pocket expenses incurred by the provision of a White Card to this group.

24.25 Over-the-counter medicines can be provided to SRCA claimants where this is considered reasonable by a delegate. Some over-the-counter items, where prescribed by a general practitioner, can be provided through the VEA’s Repatriation Pharmaceutical Benefits Scheme but are no doubt more regulated than under the SRCA.

**White Card ‘for life’**

24.26 Current practice under the VEA and the MRCA is for a White Card to be issued to a claimant for an accepted condition with no regular formal review process of the need for treatment to occur. Under the MRCA, the treatment card is issued only after a needs assessment and this would be the proposed method for SRCA clients.

24.27 MRCA Pathway 1 provides the scope for maintaining reimbursement for treatment of a short-term condition. Needs assessment can occur at any time after liability is determined, for example with changes in rehabilitation status, and a White Card can be withdrawn or resupplied as treatment needs change.

24.28 The need for a system that does not involve a lifetime treatment access card is best seen in the example of a minor ankle sprain by a part-time Reservist. The injury is soon resolved and in the meantime reimbursement or direct DVA/provider billing arrangements would adequately cover the situation. Ongoing treatment needs may never arise and in these circumstances it is not appropriate to issue a White Card.

**Serving members**

24.29 Serving members of the Permanent Forces and Reservists on continuous full-time service are generally provided with health care under Defence Force regulations through Defence Health Services. However, under the MRCA some treatment may be provided to these members through DVA, in certain circumstances.

24.30 Repatriation Health Cards are provided to serving members with accepted disabilities under the VEA. However, under the SRCA only limited medical treatment (such as for chiropractic treatment or massage therapy) is provided to serving members via the reimbursement pathway. In these instances, the written recommendation of the member’s medical officer is required before approval is granted.

24.31 Under the MRCA, medical treatment may be provided to serving members, but only at the written request of the relevant senior health officer in the Australian Defence Organisation (Defence). No Repatriation Health Cards are issued to serving members under the MRCA. If Repatriation Health Cards were to be provided under the SRCA, the same provisions should apply for current ADF members as apply under the MRCA.
Residential care

24.32 Under the current provisions of the SRCA, DVA meets all of the fees payable if the person is in residential care because of their accepted disabilities.

24.33 Residential care is provided for in Part 10 of the MRCA Treatment Principles. Where a person has a Repatriation Health Card – For All Conditions (Gold Card) or has a White Card and is in residential care because of an accepted MRCA condition, DVA pays the residential care subsidy, instead of the Department of Health and Ageing. These provisions also mirror the arrangements for VEA beneficiaries.

24.34 This usually means that the person in residential care is responsible for paying the basic daily care fee, an income-tested fee and an accommodation charge or bond.

24.35 Therefore, the provision of Repatriation Health Cards under the SRCA will mean that some people will be out of pocket for residential care.

24.36 However, in exceptional circumstances there is provision in section 10.4.1 of the Treatment Principles for the basic daily care fee and the income-tested fee to be met under the MRCA. In such cases, the resident is still required to pay the accommodation charge or bond.

24.37 Exceptional circumstances apply if the MRCA person:

- is in high-level residential care solely because of his or her service injury or disease; and
- has one or more dependants as defined in section 15 of the MRCA; and
- would be financially disadvantaged by having to pay the basic daily care fee and income-tested fees if payable (income-tested fees are not payable if the person has a dependent child).

24.38 A person is considered to be financially disadvantaged if they have dependants and they are required to maintain a home for their dependants at the same time as paying residential care fees.

24.39 Where exceptional circumstances exist the MRCC may approve the payment of the basic daily care fee and the income-tested fee (where payable) for a MRCA person.

24.40 If Repatriation Health Cards were to be provided under the SRCA the same ‘exceptional circumstances’ provisions that apply under the MRCA for residential care should be put in place for Defence SRCA claimants.

Provision of Gold Cards under the Safety, Rehabilitation and Compensation Act

24.41 Currently the SRCA provides compensation only for the cost of treatment for ‘accepted’ disabilities. The introduction of a White Card for specific conditions under the SRCA would be consistent with these provisions.

24.42 Consideration might be given to implementing a Gold Card under the SRCA for those claimants who qualify for severe injury adjustment compensation under the Defence Act 1903 determination (i.e. those assessed with an impairment rating of 80 per cent or greater). However, this could significantly increase expenditure for
treatment provided to defence-related claimants. Consideration of issuing Gold Cards to this group is not recommended at this time.

**Financial implications**

24.43 SRCA treatment cards would introduce consistency across the SRCA, the VEA and the MRCA. It would also mean less administrative burden on staff regarding treatment approvals and accounts payable functions. This is likely to lead to administrative savings.

24.44 Administration savings would result from the application of consistent Treatment Principles, Private Patient Principles, Pharmaceutical Benefits Schemes and DVA’s contracts and schedule of fees.

24.45 By applying the legislative controls and limitations of Treatment Principles and associated guidelines, and the prior approval mechanisms associated with White Cards, the Departmental forecasts on expenditure can be brought into line with those already associated with White Card expenditure under the VEA and the MRCA.

24.46 The SRCA has a steady volume of between 5,000 and 6,000 treatment claimants per year. Given that the SRCA has been closed off for service rendered after 1 July 2004, it is assumed that most of these claimants will be suffering long-term or chronic conditions. The average annual cost per claimant is around $4,364 per year.

24.47 As at September 2010, there were 50,137 White Card holders under the VEA and MRCA with an average expenditure of $1,700 per cardholder. This figure may be slightly skewed towards a higher cost, given that the VEA treatment population will be on average older than the SRCA treatment population and therefore accessing health care more often.

**Conclusions**

24.48 The extension of White Cards for defence-related claimants under the SRCA would need the agreement of the Minister for Education, Employment and Workplace Relations, as legislative amendments to the SRCA would be required. Wider considerations within government would also be necessary.

24.49 Advantages of the extension of White Cards for defence-related claimants under the SRCA include:

- improved convenience for former members compared to paying up front and seeking reimbursement;
- consistency across the SRCA, the VEA and the MRCA;
- greater control and monitoring of treatment and pharmaceuticals provided; and
- administration and departmental savings.
Possible disadvantages of the extension of White Cards for defence-related claimants under the SRCA include:

- some people may be out of pocket with respect to pharmaceuticals and residential care; and
- Repatriation Health Cards for SRCA claimants may limit access to certain types of treatment.

DVA believes that access to treatment can be managed within the card system to ensure that any negative outcomes are minimised.

The Committee recommends that White Cards be issued to SRCA defence-related claimants on completion of a needs assessment showing ongoing treatment needs for the compensable condition/s. A supplement would also be introduced for pharmaceuticals for those issued with the treatment card.

Consultations with provider groups including the Australian Medical Association would be needed before adoption of this initiative.

Gold Cards would not be introduced under the SRCA. Reimbursement arrangements would remain available for claimants with short-term conditions.

### Recommendations

The Committee recommends that:

24.1 Repatriation Heath Cards – For Specific Conditions (White Cards) be issued to Part XI defence-related claimants under the Safety, Rehabilitation and Compensation Act 1988 (SRCA) to achieve consistency in treatment arrangements for all former Australian Defence Force members. Cards should be provided subject to a needs assessment showing long-term treatment needs, and the current reimbursement arrangements for the treatment of short-term conditions should be retained;

24.2 the Department of Veterans’ Affairs (DVA) fee schedule be adopted for treatment provided to defence-related claimants under Part XI of the SRCA; and

24.3 the supplementary payment for pharmaceuticals be extended to defence-related claimants under Part XI of the SRCA with White Cards.