14 Treatment provisions

Chapter summary

The Military Rehabilitation and Compensation Act 2004 (MRCA) allows the Military Rehabilitation and Compensation Commission (MRCC) to provide treatment to a serving member, where liability for compensation has been accepted and the member’s Service Chief requests the MRCC to provide treatment. In all other cases, full-time serving members are provided with treatment for injuries or diseases under the Defence Act 1903.

The Committee examined the treatment pathways available. For former members of the Australian Defence Force, part-time Reservists and cadets, an MRCC delegate carries out a needs assessment upon acceptance of liability or when a person claims compensation, and determines whether the claimant should follow Treatment Pathway 1 or Treatment Pathway 2. Treatment Pathway 1 provides reimbursement for the cost of treatment that was reasonable for the person to obtain in the circumstances. It is intended as the pathway for short-term conditions. Treatment Pathway 2 is intended for chronic and permanent conditions, and Repatriation Health Cards are issued to provide access to treatment. Claimants who have more than 60 impairment points or are eligible for Special Rate Disability Pension have an automatic entitlement to a Repatriation Health Card – For All Conditions (Gold Card), and the MRCA also provides a Gold Card to wholly dependent partners and eligible young persons.

It is MRCC policy to encourage its delegates to use Treatment Pathway 2 wherever practical. The Committee believes that proper use of the needs assessment should provide for short-term or resolved cases to remain on a reimbursement system and for those with long-term needs to be issued with a card. The Committee recommends that the MRCC should conduct ongoing quality assurance reviews or team leaders’ analysis of decisions to retain people on Pathway 1. The reasons behind these decisions should be ascertained and codified to allow ongoing analysis.

It has been suggested that the system could be simplified by abolishing the two pathways, and moving all eligible people to the card system on discharge or on acceptance of liability, as in the Veterans’ Entitlements Act 1986 (VEA) system. However, the VEA system itself allows reimbursements of certain medical expenses; that is, for the period from the onset of the condition or injury (or three months before the claim, whichever is the later) until the treatment card is issued. The Committee believes insufficient data are available to determine this question at this stage and it should be reviewed again in three years time, when further data will be available for analysis.

A person with both VEA and MRCA entitlements may have cards from both systems. The Committee recommends that the MRCC review the need to issue multiple treatment cards and, if necessary, seek legislative change for greater simplicity. For example, those with pre-existing VEA conditions or cards could be issued only with a MRCA card.

Introduction

14.1 Chapter 6 of the Military Rehabilitation and Compensation Act 2004 (MRCA) sets out the provisions for compensation for treatment costs. Under its terms of reference, the Review is required to examine the operations of the MRCA to date. The Review did not receive submissions in relation to treatment provided for MRCA clients. However, submissions were received about the differences between the treatment provided via Repatriation Health Cards under the MRCA and the Veterans’ Entitlements Act 1986 (VEA), and the treatment provided under the Safety, Rehabilitation and Compensation Act 1988 (SRCA).
Background

14.2 ‘Treatment’ as defined by section 13 of the MRCA:

means treatment provided, or action taken, with a view to:

(a) restoring a person to physical or mental health or maintaining a person in
    physical or mental health; or
(b) alleviating a person’s suffering; or
(c) ensuring a person’s social well-being.

14.3 For the purposes of providing treatment under the MRCA, treatment includes:

(a) providing accommodation in a hospital or other institution, or providing
    medical procedures, nursing care, social or domestic assistance or transport; and
(b) supplying, renewing, maintaining and repairing artificial replacements, medical
    aids and other aids and appliances; and
(c) providing diagnostic and counselling services; for the purposes of, or in
    connection with, any treatment.

Full-time members of the Australian Defence Force

14.4 A full-time serving member will normally receive treatment for their accepted
injury or disease under regulation 58F of the Defence Force Regulations. However, the
MRCA allows the Military Rehabilitation and Compensation Commission (MRCC)\(^1\) to
provide treatment to a serving member where liability for compensation has been
accepted, and the member’s Service Chief requests the MRCC to provide treatment.

14.5 In all other cases, full-time serving members are provided with treatment for
injuries or diseases under the Defence Force Regulations.

Eligible dependents, SRDP-eligible persons and persons with more than 60
impairment points

14.6 The MRCA provides a Repatriation Health Card – For All Conditions (Gold
Card) to wholly dependent partners of deceased members, and to eligible young persons
who are wholly or mainly dependent immediately before the member’s death.\(^2\) Special
Rate Disability Pension (SRDP)-eligible persons\(^3\) and those who have more than 60
impairment points\(^4\) have an automatic entitlement to a Gold Card.

14.7 These persons are entitled to the same treatment as former members with a Gold
Card. Wholly dependent partners will have ‘War Widow/er’ embossed on their Gold
Card.

---

\(^1\) Sections 272 and 279 of the MRCA.
\(^2\) Section 284 of the MRCA.
\(^3\) Section 282 of the MRCA.
\(^4\) Section 281 of the MRCA.
Former members of the Australian Defence Force, part-time Reservists and cadets

14.8 Upon acceptance of liability, or when a person claims compensation, a delegate of the MRCC must carry out a needs assessment, and then determine whether the claimant should have their treatment costs reimbursed (Treatment Pathway 1) or whether they should be issued with a Repatriation Health Card – For Specific Conditions (White Card; Treatment Pathway 2).

14.9 A decision about which treatment pathway applies is not an original determination and therefore is not a reviewable decision for the purposes of Chapter 8 of the MRCA. However, the decision on the appropriate treatment pathway may be changed following a subsequent needs assessment.

Treatment Pathway 1

14.10 Treatment Pathway 1 provides reimbursement for the cost of treatment that was reasonable for the person to obtain in the circumstances. It is intended as the pathway for short-term conditions.

14.11 The underlying principles for the approval of medical treatment are that the treatment:

• be necessary to improve any conditions for which liability has been accepted;
• do no harm;
• be of a reasonable cost (considering the cost of treatment against the expected gains) in the context of the Medical Benefits Schedule, Pharmaceutical Benefits Scheme, Repatriation Medical fee schedule and Comcare’s schedule of fees;
• be clinically effective (considering the available evidence); and
• be accepted clinical practice (considering current professional opinion).

14.12 Decisions to approve or deny treatment in Treatment Pathway 1, as prescribed in Part 2 of Chapter 6, are reviewable decisions.

Treatment Pathway 2

14.13 Treatment Pathway 2 is intended for chronic and permanent conditions, and Repatriation Health Cards are issued to provide access to treatment. A Gold Card is issued where the person has 60 or more impairment points, or where they become eligible for the SRDP. Otherwise they will be issued with a White Card.

---

5 Section 325 of the MRCA.
6 Section 327 of the MRCA.
7 Sections 345 and 327 of the MRCA.
8 Part 2 of Chapter 6 of the MRCA.
9 Part 3 of Chapter 6 of the MRCA
14.14 Treatment Pathway 2 is governed by three separate legal instruments,\(^{10}\) which provide the authority for deciding the type, frequency and cost of treatment provided to Repatriation Health Card holders under the MRCA.

14.15 Where necessary in a particular case, a delegate may\(^{11}\) consider a written submission from a treating medical practitioner and approve treatment that is outside the scope of the Treatment Principles but is reasonably required by the person due to the nature of their medical condition.

**Military Rehabilitation and Compensation Act supplement for pharmaceuticals**

14.16 If a person or their family member is provided with a Gold or White Card for their treatment, they are eligible to receive the MRCA supplement of $3 per week for pharmaceuticals. This amount is paid irrespective of whether the person accesses prescription pharmaceuticals.

14.17 Repatriation Health Card holders access pharmaceuticals at the concessional rate, currently $5.40 per prescription — this is known as a co-contribution. The MRCA supplement is paid to assist with the co-contribution of $5.40 paid for each prescription item. These are the same arrangements as for VEA cardholders.

14.18 A Safety Net Scheme ensures that a person will pay for only 60 prescription items; after this, prescriptions are free. Therefore, for a Repatriation Health Card holder, the maximum possible expense is currently $324 in a calendar year.

14.19 If a particular brand or drug is prescribed, there may be a brand premium or therapeutic group premium payable; this is the gap between the cheapest or generic brand price and the prescribed item. In these circumstances, the doctor can be asked to prescribe the cheapest or generic brand or, where the doctor has not indicated otherwise on the script, the pharmacist can dispense the cheaper item.

**Review of War-Caused Disabilities and Pharmaceutical Costs**

14.20 Following government funding provided in the 2009–10 Budget, a review process has been undertaken by the Department of Veterans’ Affairs (DVA) in relation to pharmaceutical costs for war-caused disabilities. As part of that review process, a consultation paper was released on 7 May 2010. The scope of the Review was as follows:

In line with the Government’s election commitment, the focus of analysis has been to examine pharmaceutical usage, subsidy arrangements and out of pocket costs for those conditions which were war caused or linked to war caused disabilities. The target population was therefore those veterans who have disabilities resulting from participation in war-time conflicts [i.e. qualifying service].

14.21 Although the analysis focused primarily on veterans covered by the [VEA], the Review noted that there is also a number of former Australian Defence Force members eligible under the [MRCA] who have access to the RPBS [Repatriation Pharmaceutical Benefits Scheme] and have war caused disabilities.

---

\(^{10}\) These are issued pursuant to section 286 of the MRCA: MRCA Treatment Principles (contained in Instrument No. M21 of 2004); MRCA Private Patient Principles (contained in Instrument No. M17 of 2004); and the MRCA Pharmaceutical Benefits Scheme (contained in Instrument No. M22 of 2004).

\(^{11}\) Under subsection 287(2) of the MRCA.
14.22 The public consultation process showed a preference for Option 1 – an annual reimbursement to veterans with a DVA Disability Pension (or MRCA equivalent) and with qualifying service. During the 2010 election the Government announced it would establish the Pharmaceutical Reimbursement Scheme, which equates to Option 1 of the Review.

14.23 The reimbursement will cover the gap between the pharmaceutical allowance component of the Pension and Veterans Supplements, and the cost of the concessional pharmaceutical copayment not covered by the supplements. Reimbursement will be based on individual usage and will apply on a calendar year basis from 2012, with payments occurring in the following year.

14.24 The Committee noted that the Review of War Caused Disabilities and Pharmaceutical Costs has been the Government’s preferred mechanism for dealing with concerns raised in the provision of pharmaceuticals in the Veterans’ Affairs portfolio.

Advantages of Treatment Pathway 2

14.25 For the reasons outlined below, it is MRCC policy to encourage its delegates to use Treatment Pathway 2 wherever practical. The following table shows the current status of healthcare access by all clients receiving treatment under the MRCA (that is, all clients other than serving full-time members).

Table 14.1 Treatment pathways and cardholders as at December 2010

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of clients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Pathway 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Reimbursement</td>
<td>1,685</td>
<td>36%</td>
</tr>
<tr>
<td>Treatment Pathway 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— White Card</td>
<td>2,786</td>
<td>60%</td>
</tr>
<tr>
<td>— Gold Card</td>
<td>173</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>4,644</td>
<td></td>
</tr>
</tbody>
</table>

Administration

14.26 Treatment Pathway 2 (Repatriation Health Card) is governed by the MRCA Treatment Principles. These provide automatic approval for most medical treatment required because of a service injury or disease. Under Treatment Pathway 1 (reimbursement), a person must obtain prior approval on each occasion they require treatment. Therefore, using the card system has workload benefits, in that a delegate of the MRCC does not have to make a decision about a requested mode of treatment.

14.27 The Treatment Principles are based on well-researched and medically proven modes of treatment. Under the reimbursement pathway, delegates of the MRCC are frequently required to assess complex medical information to determine whether the treatment is reasonably required in the circumstances. Delegates are often influenced by the treating general practitioners, who may be advocating for their patients, rather than recommending treatment that is clinically necessary. For example, some therapies, such as massage therapy, may be requested for a patient where there may be little therapeutic benefit to the person’s service injury or disease.
Cost

14.28 Treatment provided via the card system is governed by the DVA schedule of fees. These fees are aligned with the Medicare Benefits Schedule and represent better value for money than charges by medical and allied health providers in workers’ compensation jurisdictions. Additionally, the system for payment of accounts is now streamlined, and medical and allied health providers can electronically invoice DVA via Medicare Australia. This is far more efficient than a provider posting an invoice, and a delegate of the MRCC assessing the invoice and entering payment details into the Defcare database.

14.29 The MRCA Private Patient Principles provide automatic prior approval for hospital admissions within a contracted fee schedule that provides cost benefits and administrative benefits.

Pharmaceuticals

14.30 The RPBS also provides Repatriation Health Card holders with automatic access to a substantial range of medicines. This includes all items on the Schedule of Pharmaceutical Benefits that are available to the general community under the Pharmaceutical Benefits Scheme, and an additional list of items contained in the RPBS.

14.31 Any requests outside the RPBS are individually assessed by qualified DVA pharmacists, and only items approved by the Therapeutic Goods Administration are approved. Under Treatment Pathway 1, requests are frequently received for over-the-counter medicines, such as vitamin supplements, that may or may not be of therapeutic benefit. It can be complex for a delegate to investigate and decide on these requests.

Rehabilitation appliances

14.32 Rather than individual delegate decisions, the Rehabilitation Appliances Program includes a schedule of equipment that may be provided where clinically necessary. The program includes contractual arrangements for the professional assessment and provision of various aids and appliances, as distinct from a delegate of the MRCC being required to assess what is reasonably required in complex medical circumstances.

Community nursing

14.33 Rather than individual delegate decisions, the Community Nursing Program provides a structured contractual arrangement for the assessment and provision of care services to assist a person to remain in their own home. This program contains an efficient and effective assessment service, is cost effective and delivers the care services that are clinically necessary. Under the reimbursement model, there is a statutory limit on the amount of attendant care that can be provided. Services purchased outside the program can be more expensive, as no contractual or bulk purchasing arrangements exist.
Management information

14.34 Records of treatment paid for by DVA under Treatment Pathway 2 are stored with VEA data, and are available for interrogation and use in endeavours such as encouraging the quality use of medicines. For example, the Veterans’ Medicines Advice and Therapeutics Education Services) website\(^\text{12}\) uses data from prescription claims to identify members of the veteran community who may be at risk of medication misadventure, and provides information that may help improve medication management. This information is tailored to an individual doctor’s practice, and there is a logon facility that allows registered medical practitioners to obtain practice-specific information.

Needs assessments

14.35 As discussed, there are procedures within MRCA administration for determining the need to move to Treatment Pathway 2 and the issue of a Repatriation Health Card. This occurs as part of the needs assessment once liability is determined, and at any later relevant review period. Proper use of the needs assessment should provide for short-term or resolved cases to remain on a reimbursement system, and those with long-term needs to be issued with a Repatriation Health Card.

Could there be only one pathway?

14.36 The client numbers on Treatment Pathway 1 compared to Treatment Pathway 2 (Table 14.1) may indicate that delegates are reluctant to move people away from reimbursement arrangements. This suggests to the Committee that Treatment Pathway 1 should be abolished, and that all eligible persons be moved to the card system on discharge or on acceptance of liability, as in the VEA system. This would remove the complexity of having two pathways.

14.37 In practice, however, the VEA system itself allows reimbursement of certain medical expenses; that is, for the period from the onset of the condition or injury (or three months before the claim, whichever is the later) until the treatment card is issued. Reimbursements are also made in extraordinary circumstances after issue of a card.

14.38 Data are insufficient to determine this question at this stage and it should be reviewed again in three years time, when further data will be available for analysis. Costs should be manageable in the intervening period through assessment of needs and management of the transfer to Treatment Pathway 2 in the manner outlined above. Developing a review strategy in the near term would help support this review, especially in terms of data collection.

Veterans’ Entitlements Act and Military Rehabilitation and Compensation Act card system compatibility

14.39 MRCA treatment cards are indistinguishable from VEA treatment cards. The cards have a magnetic strip containing data including the client’s full name and file number, card type and expiry date, with a DVA-registered hologram to enhance security. For non-Commonwealth concession purposes, the MRCA client cards have

\(^{12}\) https://www.veteransmates.net.au/VeteransMATES/VeteransMATESServlet?page=index
‘War Widow’ (in the case of a wholly dependent partner) or ‘TPI’ (for SRDP-eligible clients) printed on the front of the card.

14.40 The MRCA-eligible group are much younger than the Second World War generation, which is still the predominant DVA client group. The Repatriation Health Card system is familiar to healthcare providers who routinely deliver treatment services for elderly and middle-aged patients. Widows under the MRCA have reported that certain medical specialists who usually treat children or younger women often question why such a young person has a Gold Card. There are low numbers of widows under the MRCA compared to other Repatriation Health Card holders, Medicare and private health fund members, so even if a treatment card was differentiated for widows under the MRCA, it may never be widely recognised other than perhaps in regional centres with large ADF population numbers.

14.41 There is no cost-effective option apparent to the Committee that would resolve these matters. The MRCC and DVA, through existing consultative forums with medical and allied health provider organisations and practice managers, will no doubt continue to consider these matters.

Multiple cards

14.42 A person with both VEA and MRCA entitlements may have cards from both systems. Conditions accepted under the VEA and the MRCA could not be combined on a single card, as there are some entitlements, such as medical rehabilitation, transport and home care, where the legislative provisions are quite different. Access is not available under both schemes for the same condition, as the *Military Rehabilitation and Compensation (Consequential and Transitional Provisions) Act 2004* removes this potential anomaly.

14.43 The MRCC should review the need for multiple cards and, if necessary, seek legislative change for greater simplicity. For example, those with pre-existing VEA conditions or cards could be issued only with a clearly identified MRCA card, if legislation and systems were changed to allow this.

Conclusions

14.44 In view of the above stated cost, workload and treatment management advantages, Treatment Pathway 2 is considered to be appropriate for long-term conditions. The available data suggest that former members are being retained on Treatment Pathway 1 for longer than should be necessary. In view of the stated advantages in moving entitled persons to the Repatriation Health Card system, the MRCC should conduct ongoing quality assurance reviews or team leaders’ analysis of decisions made to retain people on Treatment Pathway 1. The reasons behind these decisions should be ascertained and codified to allow ongoing analysis.

14.45 Complexity could be reduced if there were only one pathway. More data would be needed to inform the implications of such an approach. A review of the need to define two pathways should be designed and undertaken in three years time, with a review strategy to be developed in the near term.

14.46 The MRCC should review the need to issue multiple treatment cards and, if necessary, seek legislative change for greater simplicity. For example, those with pre-existing VEA conditions or cards could be issued only with a MRCA card.
<table>
<thead>
<tr>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee recommends that:</td>
</tr>
<tr>
<td>14.1 the Military Rehabilitation and Compensation Commission (MRCC) should continue to encourage a stronger review mechanism for the issue of Repatriation Health Cards, and should conduct ongoing quality assurance reviews of decisions to retain clients on reimbursement of treatment costs (Treatment Pathway 1);</td>
</tr>
<tr>
<td>14.2 the MRCC should review the need for the dual treatment pathways approach in three years time, with a review strategy to be developed in the near term; and</td>
</tr>
<tr>
<td>14.3 the MRCC should review the need for former members with both Veterans’ Entitlements Act 1986 and Military Rehabilitation and Compensation Act 2004 entitlements to hold multiple cards and, if necessary, seek legislative change for greater simplicity.</td>
</tr>
</tbody>
</table>