T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Claims Made through the Transport Accident Commission (TAC)

Melbourne – Wednesday 10 June 2026

MEMBERS

Joe McCracken – Chair
Michael Galea – Deputy Chair
Ryan Batchelor
Anasina Gray-Barberio
Renee Heath
Ann-Marie Hermans
Rachel Payne
Lee Tarlamis

WITNESSES

Rob LoPresti, Chief Executive Officer, and

Caitlin Farmer, President, Victorian Branch, Australian Physiotherapy Association.

The CHAIR: Thank you, and welcome back to the next session of the Legal and Social Issues Committee inquiry into TAC. I am Joe McCracken, Chair of the inquiry, and we will go through and introduce our members now – I will go to my left and then online.

David LIMBRICK: Yes. I am David Limbrick, a Member for South-Eastern Metropolitan Region.

Sheena WATT: Good afternoon. I am Sheena Watt, Member for Northern Metropolitan Region.

Lee TARLAMIS: Lee Tarlamis, Member for South-Eastern Metropolitan Region.

Ann-Marie HERMANS: Ann-Marie Hermans, Member for South-Eastern Metropolitan Region.

The CHAIR: Thank you. All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provisions of the Legislative Council standing orders. Therefore the information that you provide during this hearing is protected by law. You are protected against any action for what you say during the hearing, but if you go somewhere else and say those same things, you may not be protected by that same privilege. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is being recorded. You will be provided with a proof version of the transcript afterwards, but ultimately that transcript will be made public, because it will be put on the committee's website.

Just for the Hansard record, are you able to say your name and the organisation you are appearing on behalf of, please? I will go from my left to right.

Caitlin FARMER: My name is Caitlin Farmer, and I am the Victorian Branch President of the Australian Physiotherapy Association.

The CHAIR: Thank you.

Rob LoPresti: Rob LoPresti. I am the Chief Executive Officer of the Australian Physiotherapy Association.

The CHAIR: Perfect. Rob and Caitlin, thank you so much for coming along today. I understand you have got an opening statement, so I will hand it over to you guys for about 5 minutes or thereabouts, and then we will go to questions. So, welcome.

Rob LoPRESTI: Beautiful. Thank you. Thank you, Chair and members of the committee. We appear on behalf of the Australian Physiotherapy Association, the peak body representing physiotherapists and Australia's fourth-largest health workforce. Physiotherapists play a critical role in restoring and maintaining mobility, function and independence for people recovering from injury, including those navigating transport accident compensation systems. Our members deliver essential care across hospital, community and private practice settings, supporting people to return to work and engage in daily life. I am Rob LoPresti, CEO, and I am joined by Caitlin Farmer, our Victorian Branch President and also a practising physiotherapist with extensive experience supporting people recovering from serious injury.

Physiotherapy is a regulated, evidence-based profession, grounded in best practice and a focus on delivering safe, effective and outcome-oriented care. For compensation schemes to work well, people must be able to access that care at the right time, in the right place and at the level that reflects their clinical needs. Physiotherapists see how the TAC scheme operates in practice day-to-day across the life of the claim. This gives us a clear view of where the system is working well and where pressures are starting to emerge. We have worked constructively with the TAC over many years, with a shared focus on recovery outcomes and the long-term sustainability of the scheme.

At the same time, our members report that current funding and administrative settings do not always support these objectives. Where pricing structures do not reflect the true cost and complexity of delivering high-value, quality physiotherapy services, access can become constrained, particularly for people who need longer term and more intensive support. When settings are out of step with real-world care, the system responds in predictable ways: providers step back, wait times grow and pressure builds on those who remain. These effects are most visible in regional and outer metropolitan communities where workforce capacity is already tight. We are starting to see these pressures emerge within the TAC scheme. In particular, experienced clinicians managing more complex cases are reassessing whether they can continue to participate under current conditions, and that has direct implications for access and to care.

Our members have also raised concerns about administrative burden, delays in approvals and inconsistencies in decision-making. These issues can interrupt care at critical points in recovery. This matters because small delays in the system can lead to much larger problems for recovery. When treatment is delayed or disrupted, the risk of longer term implications increases, and that has consequences both for the individual and for the scheme itself. We recognise and support the importance of strong integrity measures, including safeguards against inappropriate or fraudulent behaviour. These are essential to maintaining public confidence and ensuring resources are directed where they are needed most.

But integrity is not only about fraud control. It is also about how the scheme works in practice, including pricing frameworks, approvals and administrative processes. If these settings are not well calibrated, they can unintentionally make it harder for people to get the care they need and over time reduces the effectiveness of the scheme, even if the intent of the settings is sound. The key issue is about getting the balance right, being targeted and proportional in the approach. It is possible to have strong oversight while still enabling timely, appropriate care, but that depends on system settings that reflect how rehabilitation actually works.

We welcome the opportunity to contribute to this inquiry and to work constructively with the committee to ensure the scheme supports high-quality, sustainable care that delivers the best possible outcomes for those it serves. The APA brings both frontline experience and system-level insight, and we see a clear opportunity to improve how the scheme operates by refining rather than redesigning key parts of the system. Thank you, and we welcome questions and the opportunity to discuss further today.

The CHAIR: Beautiful. Thank you so much for that. I will start off first with questions. We have heard some testimony from others that the TAC is not exactly the easiest organisation to deal with in terms of getting prompt payment for services. Would you agree with that, and to what extent?

Caitlin FARMER: Yes, we get a lot of feedback from members that it takes a long time. Sometimes a claim has run into an administrative bungle or has for some reason been stopped, and the only reason they know is when they are chasing invoices. It definitely comes up fairly regularly that it takes quite a long time in the first place, and then often they are not told when payment has been denied or changed or held back.

The CHAIR: Yes. I can imagine for your members that would be incredibly frustrating, (a) because they obviously want to get paid, but (b) if they have not been paid, why? And the communication is not there.

Caitlin FARMER: Yes. A really common scenario is for physios to spend a lot of their time chasing these things down, and it is all unpaid time. They do it because they care about the patients and they want the patients to get the treatment that they need. But they often have to try and contact the TAC and then are maybe given a bit of a round sort of action, and it takes a long time to figure out what the problem is.

The CHAIR: We have had testimony that GPs just find it easier to deal with Medicare because they pay quicker and it is just a bit more of a streamlined process compared to dealing with the TAC. Given that TAC has a reputation for being, I will say, challenging in that regard, does it put members off wanting to deal with them and do jobs that are associated with the TAC?

Caitlin FARMER: Absolutely. Anecdotally there is a lot of feedback from members, especially the more experienced and skilful physios that are in private practice and have the choice, and a lot of them choose not to see TAC patients because that takes a lot of the admin workload out of their work, and it means they can focus on treating patients, which is what they want to do. It is not because they do not want to treat TAC patients; it is that they want to remove all the admin and workload associated with it.

Rob LoPRESTI: I would just add there is a higher ethical burden for those that are working in rural as well, because those in metro can probably make that choice because of there being wider provider availability. But there is a really strong ethical burden that rural clinicians know in that these patients will not get the care they need unless they do it, and they feel the obligation. That is a pretty unfair thing for them to have to deal with in those regions.

The CHAIR: Yes, that is fair enough. Apart from the payment system involved with TAC, or the challenges associated with that, what are the other touchpoints that your members have with TAC, and do they find them acceptable enough? I will just ask that question – what are the touchpoints, first?

Caitlin FARMER: Probably the most common touchpoint is to deal with a case manager or someone about a particular patient. That is probably the thing that physios deal with on a really regular basis. We have had recent feedback that the timing has changed.

The CHAIR: In terms of?

Caitlin FARMER: When a case manager might ask to speak or change the treatment, which is potentially reducing physios' autonomy in how they choose to manage the patient. But it is ad hoc – that is probably the best word – as it seems to be really variable depending on the practice, the patient, the physio and a lot of different factors that we cannot decipher. That is probably the most common touchpoint. We also meet regularly with the TAC as an organisation to discuss issues. That is our main touchpoint as a Vic branch.

Rob LoPRESTI: There does not seem to be a differentiation between complex, high-risk and routine, low-risk patients. It is a bit opaque, no matter what type of patient people are seeing, and inconsistent, is what we hear.

The CHAIR: Okay, my time is up, but we might have a bit of time at the end to revisit some of that. I will hand over to Mr Limbrick now.

David LIMBRICK: Thank you, Chair, and thank you also for appearing today. And you have provided the perfect segue for what I was going to ask about. One of the recommendations that you have asked the committee to make is to recognise that the Medicare benefits schedule is not an appropriate benchmark. What is the reasoning for that? I do not want to put words in your mouth.

Rob LoPRESTI: We would see that it is not structurally comparable to what we are talking about with these patients. It is episodic. It is designed around chronic disease patients in primary care. For allied health it is a shared scheme where there are basically five sessions across all of allied health that sit within it. Comparing that to multi-trauma, complex patients is a completely different setting, and we would see it as a completely non-comparable element to the patients that are seen in this scheme.

David LIMBRICK: If I am hearing you right, the reason that you believe it is not comparable is because the patients are more complex. Is it also true that there is more administrative overhead required for these patients in dealing with the TAC? Is that another cost?

Caitlin FARMER: There is definitely more administrative burden with TAC patients. They are not comparable patient cohorts at all. Chronic disease is often things like osteoarthritis of the knee that someone has had for a while, and you are giving them an exercise program to help manage that. TAC patients have an acute injury and often have many complexities. They might have multiple injuries that you are trying to manage in one session. They are not even similar patients, I think, when they come into your clinic.

David LIMBRICK: Thank you. We heard some evidence yesterday that some of the disputes between clients and the TAC were around how long they should continue physiotherapy, for example. It was insinuated that the TAC did not accept some of the evidence base of physiotherapy for certain conditions, for certain periods of time and this sort of thing, and that led to some disputes. What is your view on that? Is there general agreement on the evidence base for this type of care and how long it should be, or are there significant disagreements between what the physiotherapy association and TAC believe about the efficacy?

Caitlin FARMER: I am not 100 per cent sure what the TAC believe about the efficacy, but I do know that perhaps sometimes the complexity of these patients is not well understood. Sometimes even just dealing with

the TAC creates complexity for patients if they have had lots of back and forth or they feel like they are maybe not believed by the TAC – that can add complexity. I think the evidence base for lots of them is very clear. Lots of these patients need lifelong physio – they have spinal cord injuries, they have brain injuries, they have conditions that require regular interventions, and I think that can sometimes be where the conflict comes in. I think also there is often a lack of recognition that things can flare up or there can be new reasons why someone might need physio, and that is often disregarded.

David LIMBRICK: Yes. In fact we heard evidence to that effect yesterday, in that the requirements can change over time – someone can be good at one period of their life, and then as they age or whatever they have trouble going back and making a claim because there are disputes over whether that is a natural ageing thing or whether it is actually related to their injury. Do you see many disputes with that sort of thing?

Caitlin FARMER: I think it can be really challenging for physios to get that kind of care approved, yes, absolutely.

David LIMBRICK: Yes, okay. Thank you.

The CHAIR: Thanks. I am now going to hand over to our Deputy Chair, who has just come in, Mr Galea.

Michael GALEA: Hello. Good afternoon. I am terribly sorry for missing the start of your presentation today.

Rob LoPRESTI: That is all right.

Michael GALEA: Thank you for joining us. I would just like to ask – I understand that you have commissioned some independent economic modelling which found that compensable scheme fees frequently do fall below the true cost. We had this discussion with witnesses yesterday encountering this issue and indeed leading to a number of providers refusing to engage with clients of schemes such as the TAC. Have you shared this modelling with the TAC? I would be really keen to hear what feedback you have received from them.

Caitlin FARMER: Definitely we have shared it with them. You might have missed it, but we have quarterly meetings with people from the TAC, with their stakeholder engagement branch. We have shared it with them, so they are very aware of it. There was a recent uplift. The gap still, I think, is around the unpaid admin and the unpaid work that physios do to support clients that need their help and have nowhere else to go, really.

Rob LoPRESTI: We have invested in that piece of work to get independent research done on it, because I think it is one thing to come from the association, but to get an evidence base that looks at the whole market and what this means for sustainability is really important. We have really wanted to utilise that as evidence across all compensable schemes as well.

Michael GALEA: Out of interest, have you done similar modelling for other schemes? So, for example – I know you are a national body – in other states or for WorkCover schemes in various states. Are there any other comparisons you can make?

Rob LoPRESTI: Queensland are probably the closest in terms of how the rate sits, but also recognition of further practice in terms of accreditation of what we term 'titling and specialisation' and having designated rates that appear as part of those. I think that is important, because we actually see some really excellent outcomes from clinicians that have these qualifications that sit there also. I think there are pockets, but there is variability. But for the most part they are probably sitting below where we would like to get to in terms of what a true market rate looks like.

Caitlin FARMER: Probably an example of that is there is a pilot pain program with physios, and they are with titled physios. They have got a masters degree in dealing with people with pain. That has had really excellent results within the TAC, but it is a very small cohort.

Michael GALEA: Sure. That is the unpaid admin work, and obviously I can understand how this would be a very big thing indeed in various different types of allied health and healthcare in general. This committee has done an inquiry into the workload of teachers previously and there are lots of similarities that we see across

very different fields. Is the issue that the current fee schedules do not sufficiently accommodate for that sort of work?

Caitlin FARMER: Yes. I think it is hard to run a small business. Most physio practices are small businesses trying to just see patients and do the right thing by them, and they just need fees that reflect the work that goes into that.

Rob LoPRESTI: Yes, and I think more and more these days there are pressures of looking at what the patient mix is that is coming into a practice and looking at – 'Well, do we need to have a stronger balance of private, fee-paying patients versus what we are taking in compensable schemes or the NDIS and the like? We do not want to get to a stage where clinicians are having to pick and choose to be viable to practise. We want to be able to see patients and give access to all of them, no matter where they come from and what their needs are.

Michael GALEA: Thank you. In terms of that report again, does it find in comparison to, say, equivalent schemes in other states or different methods such as WorkCover that there are any particular unique challenges with the TAC, or indeed any other things that you have that are better than in other cases?

Rob LoPRESTI: It did not go to that level of depth. It was mainly sitting at a raw pricing level rather than kind of trying to understand. We actually commissioned a separate report to look at the NDIS, a methodology that went into how the NDIS arrived at that, but we have not done a deep dive into other schemes as yet.

Michael GALEA: No worries. Thank you very much.

Rob LoPRESTI: Thank you.

The CHAIR: Thank you. I will hand over to you now, Ms Watt.

Sheena WATT: Chair, thank you very much. Thank you to you both for being here and your submission. Clearly there is some modelling and some other expert work that has fed into that that I think is really helpful. In the submission you did talk about anti-fraud scrutiny and how really it has increased beyond what the evidence warrants. Can you talk to me a little bit about perhaps your members and data that you may have from your members who have had claims reviewed for fraud? What is the experience like when it comes to some of these scrutiny measures of the TAC, and how many findings have there been amongst your members? It seems a little disproportionate, and I am interested to know if that stacks up from your experience.

Caitlin FARMER: We have regular meetings with the TAC, and they have never brought up fraud as a widespread problem at all. Can you just repeat the question to make sure I have got it right?

Rob LoPRESTI: I think you are asking for those that may have been identified as having fraud in the process or the investigation that has gone with it, what is the feedback and the experience.

Sheena WATT: Yes.

Caitlin FARMER: I think there is a lot around –

Sheena WATT: Are there lots of investigations of your members into fraud?

Caitlin FARMER: Yes. We do not want fraud in the physio profession at all.

Sheena WATT: No, of course not.

Caitlin FARMER: We would agree that anti-fraud measures need to be in place. But it comes back to how all the stuff around that treatment can be paused or withheld or how payment can be withheld, and the feedback we get is that it is very irregular and unpredictable and takes a lot of work, which is unpaid for physios, to be able to advocate for that patient, explain why and get the right outcome for the patient.

Rob LoPRESTI: In terms of the part around fraud, which I think you were asking there specifically, I am not aware of anyone specifically from the TAC notifying us as the professional body of, 'We're investigating a particular physiotherapist around fraud that sits there.'

Sheena WATT: So that is not coming up in quarterlies or any sort of reporting around fraud findings in your quarterly meetings and such?

Caitlin FARMER: No. We have a very open relationship, and that is not something they have brought up as a challenge for the TAC.

Sheena WATT: But the compliance in terms of testing – basically, it is costing your members time and money –

Caitlin FARMER: Yes.

Sheena WATT: to meet the standards required from TAC into fraud, yet you do not have an uplift in moneys paid. I am just trying to understand really what is going on.

Rob LoPRESTI: I think the gist we are seeing a little bit from members is that they are noting an increasingly risk-averse attitude from the TAC in terms of the approvals that are coming through. They are finding more and more that they are having to justify what should be very basic clinical and transparent treatment that sits there. I think that is frustrating for a clinician that is highly evidence based, that has clinical guidelines and standards to follow, that they are constantly having to justify what they are doing. It is more at that sort of level, the frustration.

Sheena WATT: Is it affecting member attitudes towards TAC clients and taking on clients if they know that there is this additional challenge and unpaid costs of compliance that are met by –

Caitlin FARMER: Yes. I think really common feedback that we get is that members are very aware of the challenges involved in taking TAC clients and think about those complexities before they take them on.

Rob LoPRESTI: I think there is also the emotional burden of supporting the patients themselves that sit within it, because many are not all that health literate in how to navigate the system and they are really looking to their physio and therapist to help them navigate and understand what it means for them and how they can work through the system also.

Sheena WATT: I would imagine the physiotherapists would be one of the most commonly engaged medical and allied health professionals throughout a TAC's client's journey.

Rob LoPRESTI: Yes, absolutely.

Caitlin FARMER: Yes, they are.

Sheena WATT: So that trust would really sit quite strongly, I suspect, with your members for TAC clients, because of the frequency with which they are engaging with the physio versus someone just at the beginning of their journey.

Rob LoPRESTI: Yes. And these are long-term patients as well and clients.

Sheena WATT: So it is some of the health literacy questions and asking, 'What do I do now? This is another issue that I've got coming up' or helping navigate the health system?

Caitlin FARMER: Yes. For most patients, it would be their first TAC claim. But for physios they have done it before, so they know. But then they go in knowing that it is going to take a lot of admin and a lot of support for a lot of the patients just to get them the care that they need.

Sheena WATT: I understand that, and I appreciate your honest reflections. Thank you very, very much. Back to you, Chair.

The CHAIR: Thank you. We are going to go to some questions online. I might pass firstly to Ms Gray-Barberio. You are ready to go, Anasina, so over to you.

Anasina GRAY-BARBERIO: Thank you very much, Chair, and thank you both for being here. We have heard a lot about complexity – complexity in processes, complexity in claims. Can I just get some more

information from you around: do you collect any data at all on the complexity of TAC patients that are coming through via your members and what that patient mix looks like?

Caitlin FARMER: The APA does not, but the TAC does. There is a lot of published data. There are research papers and lots of evidence. There are physios that are leaders in researching these groups. There is a big group at Monash and there are groups in Queensland that look at the complexities associated with a motor vehicle claim. They are often things like psychological – so there is trauma associated with a motor vehicle accident. There can be trauma associated with engaging with the TAC and all those things I talked about before about having to sort of prove that you have this injury and getting the right care in the right time. They are just some of the complexities. Often they also have multiple injuries. Physios have the same time to treat them as they do someone who has knee arthritis or sprains their ankle, and there is a lot more often going on. They might have head injuries or other things that complicate their recovery. So that is just some of it.

Anasina GRAY-BARBERIO: Can I also ask: you mentioned just very briefly before about physios taking on TAC clients. Obviously they have agency to make that decision, but are you hearing any anecdotal evidence around rejection of TAC claims because it is just very complex or perhaps challenging?

Caitlin FARMER: Rejection by the physios, as in they are not taking those clients?

Anasina GRAY-BARBERIO: Yes.

Caitlin FARMER: Definitely anecdotal evidence that there are practices that do not take patients but also that those patients might often be given to the junior physios who are a few years out of school or uni as opposed to someone experienced who has a full list. So definitely, that is a really common scenario from our members.

Anasina GRAY-BARBERIO: Just finally, you mentioned before about TAC taking a risk-averse approach – at least that is what you are hearing from your members – but yet a lot of their work is clinically and evidence-based. Is there a tension here that needs to be ironed out with regard to being risk averse but then also not disadvantaging TAC claimants?

Caitlin FARMER: Absolutely. I think there are a lot of patients just trying to do the right thing that are caught up in the risk aversion 100 per cent – and the physios are caught.

Anasina GRAY-BARBERIO: Do you have any suggestions or recommendations how that can be adequately – what is the word I am looking for?

The CHAIR: Overcome.

Anasina GRAY-BARBERIO: Attended to – yes, overcome – to ensure that power balances, which we have heard about quite frequently, are levelled?

Rob LoPRESTI: I think it is a little bit of a broad-brush approach at the moment. What we need to look at are patterns and targets and we need to be proportional in terms of who we are actually looking at. I think while we might not have the answers specifically for you today, we have a group of clinicians that live and breathe this system that are there who want to engage with the TAC and actually work through those problems collaboratively. I think our members would really welcome the opportunity to get down into the problem-solving and what comes next, and how we can improve it at that more granular level.

Anasina GRAY-BARBERIO: Thank you. And does that mean being around the decision-making table?

Rob LoPRESTI: It does, yes. That is what I am getting at. I think having clinicians who understand the system as part of that will be integral in terms of how we can find a sustainable way forward.

Anasina GRAY-BARBERIO: Thank you very much. Thank you, Chair.

The CHAIR: Thanks, Ms Gray-Barberio. I will now hand over to Mrs Hermans.

Ann-Marie HERMANS: Thank you very much. I think I got a bit of an answer to some things I had just through your last comment. In terms of two things, prioritising early resolution mechanisms and also the focus

on timeliness in terms of maintaining recovery, one of the things I wonder is: when you have a claim and you have got a person coming to you for physio for a few sessions, it appears to me that they get exactly what they need, just a minimal amount – like, 'Okay, you're good to go' – on the TAC. What about the fact that there can be that relapse or there might need to be that check-up a little bit further down the track because of injuries that can take – you can think it is all right now, there is that level of shock and everything else, but then a little bit further down the track, there is a little bit of an irritation or something else clearly from the accident. I am not saying where they are disputable, but where they are clearly from the accident – things that have been noted as being injured at the time – is there no pathway forward? Is this where it would become handy if you guys were at the table?

Caitlin FARMER: Yes, I think that is a really commonly reported thing, and it sort of leaves physios in a bit of a conundrum where they might be ready to discharge someone and say, 'Come back if you need us.' But then they know that if it was six months down the line, the TAC may not approve it, and that patient would have to mount a case. So they may see them a little bit longer to try and make sure they are 100 per cent, or as good as they can possibly be, before they discharge, because there is so little ability for them to come back if it flares or if things change.

Ann-Marie HERMANS: So the process does not have any provision for someone to come back six months later? It is literally, 'We're doing it now, we've got it moving.'

Caitlin FARMER: Yes.

Ann-Marie HERMANS: There is no sense of, 'Well, we could have some repercussions here down the track. We'll make an appointment for three months or six months' time, still on TAC, so that we can make sure that the movement and everything has healed the way that it should have, and see if there is anything more we could be doing.' That does not happen. Is that what you are saying?

Caitlin FARMER: That is my understanding generally. I think there are some nuances to that, but as a general rule, once their treatment episode is complete, it is very hard for patients to get back into the system, even for the same injury.

Ann-Marie HERMANS: So let us say they go back to work – and going back to work is part of the whole process of this – but then in that process, that injury is irritated because they are back at work. There is then no provision at all through the physio?

Caitlin FARMER: No. I mean, physios would often support them back to work, but things can change, or their role might change in a few months and that might aggravate something. There are many reasons why it can flare a little bit later, and they can require often just a little bit of treatment, and that can be really hard to get.

Ann-Marie HERMANS: Just one last question. Delay presents a risk of deterioration. In your experience, what level of delay is taking place? You know, what percentage of delay is taking place? Is it mostly in regional areas? And what causes that delay, I suppose?

Caitlin FARMER: It is anecdotal, and I think it does not seem to have a particular pattern. I could not tell you it is everyone with a knee injury or anything like that. It seems to be all over the place that people get this feedback, and it can be from sort of a few weeks, where there is maybe just an administrative issue, to a really, really long period of time where that patient has lost most of the gains they made in physio and they are starting again once they get the TAC claim back.

Ann-Marie HERMANS: Right. Thank you very much. No further questions.

The CHAIR: Thanks. You have timed that beautifully, Ann-Marie. I will hand it over to you now, Mr Tarlamis.

Lee TARLAMIS: Thank you, Chair. You recommend the TAC co-design process improvements with frontline clinicians. Are you aware of existing co-design mechanisms the TAC has used with physiotherapy associations, and what specifically do you believe has been missing from those practices?

Caitlin FARMER: I am not aware of lots of co-design, but like we said, we meet regularly with them. We have some input into things that happen, and we can provide some feedback. I do not think we have had a really, truly co-designed thing for some time. Before my time as President I believe there might have been something, quite a number of years ago. That would be more than four; this is my fourth year. I think it needs to involve consumers as well. It needs to involve clinicians and consumers to understand the full picture of what is going on.

Lee TARLAMIS: Are there any specific points that you want to make that could be picked up through that at this time for this inquiry?

Caitlin FARMER: In terms of co-design? I mean, I think having physios that are treating TAC patients every day is a really important thing to understand all the different challenges they face. I think it is a long process with many challenges, so like Rob said, rather than nitty-gritty, I think having someone involved in that process over time is going to be really helpful to patients and to the clinicians that treat them.

Rob LoPRESTI: I think having access to data and outcomes is probably another area as well. I think it is quite aggregated at the top level. We would like to see more on: what is this meaning for physiotherapy? What are we seeing in trends in provider rates; is there anything where we are seeing drop-offs that sit there; what is the consumer quality feedback looking like around some of those things; and what are the dispute timelines that are sitting there? We want to be part of the solution together, but we are not probably seeing good granular data on a regular basis that is specific that we can help with, comment on and work with. I think that is probably the other area, as well as looking at those procedural points, that would be a good opportunity.

Lee TARLAMIS: Thank you.

The CHAIR: That brings an end to our questions. But just as a way to finish up, we are obviously an inquiry. We are put together to make recommendations to government. I know some members have asked you about various things that you would recommend. What is the one key message you want us to take away from your appearance here today that could lead to lasting change that would benefit the system?

Caitlin FARMER: I think it is that recognition of the unpaid labour that physios put into TAC clients, and that they really care about their clients and they want to get the best outcomes. The system as it is can make that really challenging for physios.

The CHAIR: In terms of unpaid labour, you are talking about the time it takes to deal with –

Caitlin FARMER: The admin, the advocacy they do for patients – often patients that are not in a position to advocate for themselves. They have injuries that mean they do not have the capacity to do that, and someone needs to do that, so it is physios doing that every day, talking to case managers and doing it just because they care about the patient and they want the outcomes. I think that is something that is really hard for lots of physios.

Rob LoPRESTI: I think it is just being able to look at the patient that sits in front of them and know that they can deliver their skill set to that patient without having to think of: what scheme are they in, what process do I need to follow? I think if we can get to a point where we are not having to worry about those things, those are taking care of themselves because we have got the system right, that would be the ultimate outcome.

The CHAIR: Because you want to obviously be looking after the person that is in your care.

Rob LoPRESTI: Yes.

Caitlin FARMER: Yes.

The CHAIR: All right. Thank you very much for that. I appreciate it. Thanks for your time today. As I said, you will get a proof version of the transcript in draft form, and if there are any minor changes you can obviously make them. But from us: thanks very much.

Witnesses withdrew.