# 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**

Hilary Shelton, Chief Executive Officer,

Daniella Florio, Policy, Advocacy and Research Officer, and

Tony Massarotti, Member, Australian Podiatry Association; and

Isaac Curkpatrick, State Lead, Victoria *(via videoconference)*, Optometry Australia.

**The CHAIR**: Hello. Welcome back to the next session of the Legal and Social Issues Committee inquiry into the TAC. I am Joe McCracken, Chair of the inquiry. We will go through and introduce our inquiry members as well. I will go to my left, my right and online.

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

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

**Michael GALEA**: Good afternoon. Michael Galea, Deputy Chair and Member for South-Eastern Metropolitan Region.

**Lee TARLAMIS**: Good afternoon. Lee Tarlamis, also a Member for South-Eastern Metropolitan Region.

**Ann-Marie HERMANS**: Hi, I am Ann-Marie Hermans, also a Member for South-Eastern Metropolitan Region.

**Anasina GRAY-BARBERIO**: Good afternoon. Anasina Gray-Barberio, not south-east. I am Northern Metro.

**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 elsewhere and repeat the same things, you may not be protected by the same privilege that exists in here today. Any deliberately false evidence or misleading of the committee may be considered contempt of Parliament.

All evidence is being recorded. You will be provided with a proof version of the transcript, but ultimately it will be made public because it will be put on the committee's website. For the Hansard record, I will ask you to say your name, your title and the organisation you are appearing on behalf of. I will go to people in the room first, and then I will go to you, Isaac, online secondly.

**Tony MASSAROTTI**: Tony Massarotti, registered podiatrist and member of the APodA.

**The CHAIR**: Thank you.

**Hilary SHELTON**: Hilary Shelton, Chief Executive Officer of the Australian Podiatry Association.

**Daniella FLORIO**: Daniella Florio, Policy, Advocacy and Research Officer at the Australian Podiatry Association as well as a practising podiatrist.

**The CHAIR**: Thank you. And Isaac.

**Isaac CURKPATRICK**: Isaac Curkpatrick, Optometry Australia, State Lead for Victoria.

**The CHAIR**: Thanks so much. We have got time for some opening statements, so I will hand over to you guys in the room first, and then I will go to you online if you want, Isaac, but all cool whichever way you go. Welcome. Thanks very much for coming. We look forward to hearing what you have got to say.

**Hilary SHELTON**: Good afternoon. Thank you to the Chair and committee members for the opportunity to appear today as part of the Legislative Council Legal and Social Issues Committee Inquiry into Claims Made

Through the Transport Accident Commission (TAC). The Australian Podiatry Association, also known as the APodA – we will probably refer to it as the APodA today – appreciates the opportunity to contribute to this important inquiry and discuss the experiences of podiatrists and patients interacting with the TAC scheme.

Firstly, we would also like to acknowledge the traditional custodians of the land on which we meet today and pay respects to elders past and present. We acknowledge the contribution of First Nations people to knowledge on health and appreciate the role feet play in connection to land and mobility between meeting places. We extend our respect to Aboriginal and Torres Strait Islander peoples here today.

To introduce ourselves briefly, my name is Hilary Shelton. I am the Chief Executive Officer of the Australian Podiatry Association. I am joined today by Tony Massarotti, who is a practising podiatrist and APodA member representative with experience delivering podiatry services to TAC patients within private practice and rehabilitation settings, and Daniella Florio, a senior policy and advocacy adviser with APodA and also a practising podiatrist.

Podiatrists play an important role within the TAC scheme. They support people recovering from transport-related injuries through assessment, treatment, rehabilitation, mobility support and the prevention of secondary complications that may delay recovery or contribute to avoidable hospital presentations. Within the TAC setting podiatrists assist patients managing foot and ankle injuries, altered gait and mobility issues, chronic pain presentations, pressure-related concerns, biomechanical complications and longer-term rehabilitation needs. Many podiatry services provided under the TAC occur within private practice settings and often form part of broader multidisciplinary rehabilitation arrangements. The APodA acknowledges the important role the TAC plays in supporting Victorians following transport-related injuries and recognises the importance of maintaining scheme integrity, transparency and sustainability.

The feedback APodA has received from members does not indicate evidence of systemic fraud specific to podiatry services within TAC; rather, the issues raised by podiatrists more commonly relate to administrative burden, reporting requirements, delays and maintaining continuity of patient care. Members have described repeated requests for clinical information, inconsistent documentation expectations and administrative processes that can delay timely access to treatment. Podiatrists have also raised concerns that current fee arrangements do not always reflect the complexity, time and operational costs associated with delivering care, particularly in regional, rural and thin market settings. APodA has also received feedback regarding the interaction between the TAC and other schemes, including the national disability insurance scheme, where differing requirements and unclear responsibilities can create duplication, delays and fragmented care for patients. Importantly, our submission and our appearance here today are intended to support constructive discussion around practical system improvements which enhance patient outcomes, improve continuity of care and support sustainable access to podiatry services within the TAC scheme.

We really very much appreciate the opportunity to appear before the committee today and look forward to assisting the inquiry and answering any questions that the committee may have.

**The CHAIR**: Perfect. Thanks so much for that. Isaac, did you want to say anything as well or are you all okay?

**Isaac CURKPATRICK**: I will make a quick intro that I did prepare. I just want to thank you for the invitation to make the written submission earlier this year and thank you for the opportunity to appear here today on behalf of Optometry Australia. Optometry Australia is the national peak professional body for optometrists, representing the majority of Victorian optometrists. Optometry Australia supports members in understanding funding and regulatory professional obligations, and regularly receives inquiries about third-party payer arrangements, including TAC-funded care for Victorian optometrists. Our submission was sort of deliberately modest in scope. We are not seeking to comment on the overall operation of the TAC scheme and we are not asking the committee to determine the clinical merits of individual claims. Our concern is really about the process.

Optometry is clearly part of the TAC treatment pathway. TAC's own public materials recognise that optometric consultation, prescription glasses, contact lenses and some related services can be funded in appropriate circumstances. However, recent inquiries to Optometry Australia from Victorian optometrists suggest that there is uncertainty about how those rules are applied in practice. The key issues raised with us are the inconsistency

in outcomes for apparently similar requests, uncertainty about whether some optical items or treatments are being assessed as standard optometric care or under the non-established, new or emerging treatments and services framework. There is limited visibility of the criteria being applied and uncertainty about what documentation or approval pathway is required when care extends beyond an initial period of funding. From the provider perspective this makes it difficult to advise patients clearly. It can also create delay, confusion and avoidable disputes, particularly when a patient is recovering from a transport accident and may already be dealing with a complex visual, cognitive or functional symptom.

The central point of our submission is that injured Victorians and their treating optometrists should be able to understand in advance what is covered, what evidence is needed, why a request has been declined or only partly approved and what pathway is available to resolve any dispute. To assist with this, we have recommended that the TAC publish a provider-facing optometry guidance document, provide clear written reasons for decisions, clarify when the non-established, new or emerging treatments and services framework applies to optometry-related requests and improve transparency around payment pathways. I have prepared some de-identified case examples that I can talk through, should the committee wish to explore some examples of how these issues arise in practice. Again I thank you for the invitation, and I hope I am able to provide you with some further information that you may need.

**The CHAIR**: No worries. Thanks so much, Isaac. I will go through my questions first, then we will just go back and forth from committee members, and then we will do some online as well. We have heard a bit of testimony in the past, both from consumers and from service providers, that it is difficult to deal with TAC, and sometimes that can even be a disincentive to want to take on clients. Is that real? Is it true? What is the extent of it from your point of view?

**Hilary SHELTON**: That is certainly what we hear from the profession, but I would love to give Tony the opportunity to speak directly to that.

**Tony MASSAROTTI**: I would have to agree with that. The saddest thing to see is experienced practitioners, people that have been in the game a long time, opting to not treat TAC patients for that reason.

**The CHAIR**: Just because it is so hard to get payment, admin –

**Tony MASSAROTTI**: Absolutely.

**The CHAIR**: What are the things that they have to do to jump through the hoops?

**Tony MASSAROTTI**: I have to qualify this. It is not so much the payment, it is often about not being paid for items at all too or for services rendered. I will talk about that later on if I get the opportunity. But there are forms that we are expected to complete and there is no item number to claim, so it is basically non-billable time. Other allied health professions have an item number to be able to claim that. So there is significant disparity between professions as well.

TAC patients can be complicated. These people are suffering from high-velocity motor vehicle accidents. We are operating within that biopsychosocial model as well, so there are a lot of things to consider when treating these people. You have got a workforce, like podiatry, that is already stretched. The throughput at our Victorian universities is low. So if you have got a private patient there that you can see and they are lined up, you are not going to spend your time dealing with TAC because of the barriers that are put in place.

**The CHAIR**: I was going to ask, Isaac, do you have a similar sort of experience from your perspective as well, in terms of the people that you represent?

**Isaac CURKPATRICK**: In optometry, I think it is quite a selective few that deal a lot with TAC, and it is usually optometrists with special interest in neuro-optometry or vision therapy or other such things. I have not heard directly from members who refuse to deal with TAC, but I know, like many other things that create more paperwork and have an administrative burden, there are people that would definitely choose not to deal with TAC. But I do not have any exact examples of that, unfortunately.

**The CHAIR**: That is fair enough. I appreciate that, thanks. In your opening, Hilary, you spoke about inconsistent documentation and how the fee arrangements are inconsistent as well. What sort of impact does that have on the people that you represent?

**Hilary SHELTON**: Again, I would absolutely love Tony to speak to it from a practitioner perspective, who has the real-life lived opportunity, if that is okay.

**The CHAIR**: Sure. Please.

**Tony MASSAROTTI**: Could you state that again, sorry?

**The CHAIR**: Yes. I was just reflecting on inconsistent documentation and varying fee arrangements.

**Tony MASSAROTTI**: Yes, I can speak to that.

**The CHAIR**: What impact does that have on you as someone providing a service?

**Tony MASSAROTTI**: We have a certain period of time where we do not have to apply for treatment approval. In that period of time TAC requests information on treatment plans. I have got one case, if I can refer to that now, and this is an interesting one – it is my first point. We have a patient at the moment who was referred from a surgeon. This patient had a catastrophic foot injury requiring surgical intervention. We were the first practitioner that that person saw after surgery. We put forward a robust treatment plan steeped in level 1, level 2 evidence, which is what we do. We did not have to fill out a treatment approval form, but we did. It went off to TAC. TAC refuted it and said –

**The CHAIR**: On what grounds?

**Tony MASSAROTTI**: We applied for 10 sessions for physical therapy and preapproval for a pair of customised orthotics. They came back with, 'You won't be having 10 in that timeframe, you'll be having four. And an over-the-counter pair of orthotics will do the job.' An over-the-counter pair of orthotics a lot of the time will work. For a patient that has had a one-sided injury and hardware put in place and is not walking for six to eight weeks, that foot is going to look very, very different to the contralateral side. So why on earth would you fit an over-the-counter orthotic into somebody like that? We sent a letter back. Three podiatrists from our clinic got together, pooled all the research and sent a one- or two-page lengthy, detailed document. It was knocked back again: 'TAC's decision will stand.' I would like to know who is making these calls at TAC. I know that they do not currently have a podiatrist on the advisory panel. I checked that on the website only a couple of weeks ago. We are currently at loggerheads with TAC over this particular case.

In the meantime this lady needs to be seen, this patient needs to be seen. At that point in their rehab they are on weekly reviews. Often they are carrying a fair bit of baggage – they have got psychological issues, they just want to get back to their life. They are not touching down weight yet on the ground, so they are non–weight bearing. We continue to see this person not even knowing whether we will get paid for it. Delays in treatment for that sort of an injury will lead, most of the time, to further sequelae of degeneration, whether it be the ankle, the knee, the hip or the foot.

**The CHAIR**: You are saying that delays in that might even cause further problems and maybe cost in the future as well?

**Tony MASSAROTTI**: Absolutely, and it goes on and on. These types of patients usually end up having 12-monthly reviews anyway for an indefinite period of time. And that leads me to my next point, which is that there is more paperwork whenever you see this person 12-monthly and so on.

**The CHAIR**: I have run out of time, I am afraid, but I am sure we will explore some more of these questions through the committee members. Over to Mr Galea.

**Michael GALEA**: Thank you, Chair. Thank you all for joining us here and online. If I can maybe continue on a similar trajectory. I will put this to Ms Shelton and APodA first. In terms of the scheduled fees and the disparity between that and clinical cost, do you have any data as to how many podiatrists deliberately do not engage in the TAC scheme or limit the work they do in the TAC scheme as a result of that?

**Hilary SHELTON**: On the point of the scheduled fees, what we would say is that it is very important that the fees reflect the realities of providing care. To the point of the data, the data around podiatrists providing services within the TAC is not publicly available, and we do not have that data across the profession. It has not been collected. It is not publicly available. But we would strongly encourage that data, to be clear. We do know anecdotally – sorry, you want to ask optometry the same question. Please.

**Michael GALEA**: No, please. I am keen to dive into bit deeper.

**Hilary SHELTON**: We do know anecdotally that practitioners do make the choice not to provide services in the scheme because of the complexities.

**Michael GALEA**: And anecdotally, if I can perhaps go to you, Ms Florio and Mr Massarotti, what is the rough breakdown that you see?

**Daniella FLORIO**: I do not know about the rough breakdown. That would be something Tony may know. But personally, as a podiatrist, I do not see TAC clients, and one of the reasons would be in regard to the fees, the administration costs and the requirements – all those sorts of things actually make it really difficult. I work in a very small practice. It is me and someone who works four hours a month, so it is mainly me. For me to have requirements for TAC and the administration requirements and have all the other funding schemes, it is too difficult for me to actually get involved. There is a choice, and TAC are not one of the funding services I see with clients. Unfortunately that is not great for patients who have actually gone through an injury and need services. It is unfortunate, but I decline to see them.

**Michael GALEA**: Mr Curkpatrick, if I can ask a similar question to you through the lens of optical. Do you have any sense, in your profession, of how many do engage with TAC, how many do not or how many limit it?

**Isaac CURKPATRICK**: Unfortunately, we do not have that data.

**Michael GALEA**: No problem. Going to a particularly challenging market, regional areas – and forgive me, I am not sure where each of you, for those who are practising, practice. What does the typical access look like for your services in those areas, in those parts of the state out of the cities where everything is further away?

**Hilary SHELTON**: Access to podiatry care is very limited in remote and regional areas. There are very thin markets. We have a declining workforce of podiatrists as it is. We do not have enough as it is. So it is even harder, even more difficult if you are living in remote and regional areas. Tony and/or Daniella may have experience of that. They are both currently practising in metropolitan Melbourne, but they may have other evidence to add to that.

**Tony MASSAROTTI**: I would have to agree with that. It is a struggle rurally, definitely. I am in metro, but yes, I would have to agree.

**Michael GALEA**: Very, very anecdotally, I have got a wonderful podiatrist, and I know how hard it can be to get in to see her sometimes. And that is in outer metro Melbourne.

**Hilary SHELTON**: That is right. It is difficult to see podiatrists even in metropolitan areas.

**Michael GALEA**: Regardless.

**Hilary SHELTON**: Regardless, yes.

**Michael GALEA**: And would I be right to assume, Mr Curkpatrick, it is the same picture with optometry?

**Isaac CURKPATRICK**: It is slightly different with optometry. At the moment we are actually headed into a little bit of an oversupply, especially in our major cities and in Melbourne and Sydney. That does have overflow to regional Victoria, where we do have quite good coverage currently. Optometry being a primary eye care provider, we are there where there are other gaps. Optometry is really available in regional areas. I cannot speak for other states currently, but in Victoria we are not too bad.

**Michael GALEA**: That is good to hear. Thank you very much, all.

**The CHAIR**: Thank you. Mr Limbrick.

**David LIMBRICK**: Thank you. And thank you all for appearing today. I have got a couple of questions, first for the APodA. I note that you have recommended in your submission, as have a number of other providers, more transparency of TAC data. In particular you have asked for de-identified administrative data from TAC to inform analysis of claims. What sort of data exactly are you hoping that they might be able to publish, and to what purpose would you use that data?

**Hilary SHELTON**: Broadly, we want any sort of policy and guidelines to be based on evidence-based data. On what we would hope to achieve out of that data, I might just ask my colleagues if we have got any advice on that. Otherwise, it might be a question that we take on notice.

**Tony MASSAROTTI**: I think of data on contributing podiatrists treating TAC patients, and also the types of treatment and the efficacy of treatments that are being implemented.

**David LIMBRICK**: So we are talking about, 'Okay, we've had this type of treatment and it has had this type of outcome,' and you do not have visibility of that because – I mean, you could go to your members, but they would need to provide all that to you –

**Hilary SHELTON**: That is right.

**David LIMBRICK**: and they might not go through the TAC, and the TAC has a very specialised type of clients.

**Tony MASSAROTTI**: Correct. And not all podiatrists are members of the association as well.

**David LIMBRICK**: Of course. Right. So if you had that data from the TAC, that would better inform you of which treatments are actually helping clients and inform – right.

**Hilary SHELTON**: It also takes another workload I guess off the practitioner, because if we are going to the practitioner to seek that data, then we are asking them to do another layer of administration on top of what they are already doing. We would rather they were able to focus their time on delivering care.

**David LIMBRICK**: Understood.

**Tony MASSAROTTI**: If I can just comment: I received an email only yesterday from the TAC with a survey on 'how we're performing'. Did you see that?

**Hilary SHELTON**: No.

**Tony MASSAROTTI**: That came in just last night or the night before.

**David LIMBRICK**: Right.

**Tony MASSAROTTI**: Yes, it was a survey that was sent by the TAC.

**David LIMBRICK**: What did it ask?

**Tony MASSAROTTI**: I did not open it. But it was quite timely, I thought.

**David LIMBRICK**: Yes, very. There have been lots of timely things happen. Isaac as well – would this sort of de-identified administrative data inform your members also? Are you aware of what types of treatments your members are providing in conjunction with the TAC, and do you have visibility of outcomes and things like that? Is that something that is not visible to you?

**Isaac CURKPATRICK**: I think that would be good for members, because the main issue we are having is there is inconsistency in what is actually being provided. I have got one practitioner given two cases a month apart with exactly the same sort of scenario asking for the same treatment. It was provided one month, and then the following month it got completely denied. Any sort of data that helps to sort of show exactly why that is the case would be super useful.

**David LIMBRICK**: Right. Another thing which we have spoken a lot about in this inquiry so far is the delineation between the NDIS and the TAC. I might start with A Pod A – what do you think can be done here to improve that delineation? Because it does appear to be a problem. Many, many people who are TAC clients do become permanently disabled and qualify for either, conceivably. How could that be clarified better from your point of view?

**Tony MASSAROTTI**: I think one thing to note here is that we currently work with seven different compensable schemes. We have got the TAC and the NDIS, and there are another five there. There is a lot of duplication of information and documents. I think one thing that needs to be kept in mind is that we are AHPRA-registered practitioners, and I think that needs to account for a bit as well. How they actually do that, I am not sure, but that is just something to keep in mind. It is a bit of a minefield with documents and back-end work.

**Hilary SHELTON**: Anecdotally, there are conversations that happen within clinics who are delivering across schemes – like daily – around 'what is it we can do for this scheme versus another scheme?' There is a lot of time spent on that administration of I guess understanding the process within each of the different schemes. So if there is any sort of alignment that can occur, it is going to make it a lot easier for health practitioners to be delivering and spending their time with patients.

**David LIMBRICK**: I know I am out of time. I wonder if the Chair would allow Isaac to respond as well if he has something to say on this topic?

**The CHAIR**: Go for it, Isaac.

**Isaac CURKPATRICK**: I have not heard anything about NDIS and TAC relations from the members who have contacted us about the TAC. We are at a slight advantage in this position in that we have direct access to Medicare, so we do have a lot of ongoing care that we can just bill Medicare for rather than the NDIS or other funds.

**David LIMBRICK**: Understood. Thank you.

**The CHAIR**: Thank you. I now go to Ms Watt. Over to you.

**Sheena WATT**: Lovely. Thank you very much, Chair. I might continue with a question for you, Mr Curkpatrick. What has come up is that in having multiple schemes, obviously there is a lot for often small practices to manage. In particular you did some comparisons between the TAC's published optometry framework with the DVA. I mentioned this with an earlier witness around the DVA, and that what we are seeing is an uplift that has been proposed in the federal budget around their scheduled fees. Particularly I am interested to know – I just do not understand the complexity to it; it is just really mind-boggling for me. But can you talk to me about DVA's approach to optometry services and how it is good. What should TAC be looking to perhaps consider applying, and there are some things that just will not work and will not translate particularly well?

**Isaac CURKPATRICK**: Where I made that comparison – optometrists deal with DVA quite a lot so we can bill DVA directly, just like Medicare, for consultations. DVA has a very structured and optometry-facing schedule of fees that we can bill for, certain products – glasses, contact lenses, and different features within these glasses – that are covered and how much they will cover up and to. I made this comparison because TAC does not have anything that can be accessed by optometrists. It has a list of certain products that are available and at what sort of costs. As you can imagine, a pair of glasses has many different components to it. It could be bifocal, multifocal, have a prism, different coatings, all sorts of different things. DVA do a good job of listing what can be included and what they will cover, and for anything that is not on that schedule we can make that case-by-case request, whereas it appears with TAC it is really just making that request every time and getting different answers back each time.

**Sheena WATT**: That must be an enormously frustrating for your members, I imagine. Then I wonder, perhaps for our friends in podiatry, are there examples of some things that some of these other schemes are doing really well, like published fees, for example, and easy approvals that you just wish was easier for TAC clients that you can share with us today? I just want a really simple one that makes sense.

**Tony MASSAROTTI**: I think DVA do a pretty good job in that regard. They recently removed the need for approvals for a lot of their orthomechanical items. They have left it up to the practitioner's discretion to prescribe. I would have to agree. I would say DVA is one that is a stand-out for us.

**Daniella FLORIO**: Yes. The listing of the items is actually very good, and there is quite a comprehensive –

**Sheena WATT**: So similarly to how there is a list of published fees and items?

**Daniella FLORIO**: Yes.

**Sheena WATT**: Is there similarly in podiatry?

**Daniella FLORIO**: With DVA they have a list of items, and it is a bit unclear with the TAC. I think Tony knows more about the TAC.

**Tony MASSAROTTI**: Just on that note, now that we are talking about item numbers – sorry, Sheena.

**Sheena WATT**: I am appreciating this because that is something that has come up.

**Tony MASSAROTTI**: We used to be able to refer off for gym and hydrotherapy memberships. So when patients got to that point in their rehabilitation where they are ready to tackle that activity, we would apply for funding for them. That was removed late last year for some reason.

**Sheena WATT**: From TAC?

**Tony MASSAROTTI**: Absolutely. When we called TAC to find out why, they said, 'Not sure – just send them off to a physio or a GP to be able to fill that form out'.

**Sheena WATT**: Can you just restate that? That was hydrotherapy –

**Tony MASSAROTTI**: Hydrotherapy and gym memberships. We used to be able to apply for memberships on behalf of the patient, so a three-month period, for argument's sake, was covered. We can no longer request that now. They have got to go to another allied health member that has that right or their GP, and often –

**Sheena WATT**: With no reason provided?

**Tony MASSAROTTI**: Often that practitioner would be on the phone to the likes of me or colleagues saying, 'What do I need to do? What are you after?' Now there is another form, too – now that we are on this topic, if I have the floor for a moment.

**Sheena WATT**: Please.

**Tony MASSAROTTI**: There is a form called the allied health treatment and recovery plan. This is required for most patients following 90 days of their initial rehab. It is a lengthy form. Across the top it has the professionals listed, the health professionals that can complete the form. Podiatry is there, to the right, but there is no billable item for it, so there is no item number to complete that form, which can take anywhere from 20 minutes to 30 minutes. When you call TAC to find out how we bill for it: 'There's no number for you. Just use the physio item number'. We talk about fraud in the workplace. That is something we are uneasy doing. So often we will fill that form out and not bill for it.

**Sheena WATT**: And assume that cost in the practice?

**Hilary SHELTON**: That is right – absorb the cost.

**Sheena WATT**: Absorb, sorry.

**Tony MASSAROTTI**: And administration – absolutely. Yes.

**Sheena WATT**: Okay. We have heard that from previous witnesses as well. Thank you very much. I appreciate that.

**The CHAIR**: Thank you. We will now go to some of our members online. I will pass firstly over to Ms Gray-Barberio. Anasina, it is over to you.

**Anasina GRAY-BARBERIO**: Thank you very much, Chair. Thank you, everyone, for being with us this afternoon. Can I just start with that survey that you spoke about, Mr Massarotti? Are you able to provide that on notice? Would you be comfortable in doing that?

**Tony MASSAROTTI**: Not now. I do not have my laptop with me.

**Anasina GRAY-BARBERIO**: Not right now, but later – the secretary will be in touch with you later.

**The CHAIR**: You can just forward it to us on email.

**Tony MASSAROTTI**: I would be more than happy to.

**Anasina GRAY-BARBERIO**: Thank you very much. I appreciate that. Have you also been receiving any other timely correspondence since you made the decision to appear before the inquiry from the TAC?

**Tony MASSAROTTI**: Not that I am aware of, no.

**Anasina GRAY-BARBERIO**: Okay. Thank you. It is actually quite alarming to hear that practitioners are opting out through no fault of their own. I think an argument can be made that the system, in the way that it is designed, makes it really challenging and difficult both for practitioners as well as claimants. The thing is we heard testimony earlier on today that this system, the TAC system, is 'fundamentally sound'. Now, I am disturbed by that because I actually refute that based on evidence that I have read and heard over the last two days around this. Can I ask: have any of you – perhaps you, Ms Shelton, being the CEO – met with the CEO of TAC to address these attrition or participation rates of practitioners?

**Hilary SHELTON**: Not in my time in the role as CEO – that has been the last two and a half years. It is something that we would do, but we have not. No, we have not.

**Anasina GRAY-BARBERIO**: Do you intend to reach out to the TAC CEO and arrange a meeting to raise these really important issues?

**Hilary SHELTON**: Yes, I think that would be a good idea. The other thing that would be very important to us to understand is how many podiatrists are delivering services within the scheme. We are a little bit blind to understanding. Across all of allied health I think most of us do not really know how many practitioners are delivering services in the scheme and, further to the point that was asked earlier, how many are choosing not to. If we had that sort of information, that would be really helpful. But yes, directly taking this up with the TAC is something that we would consider doing.

**Anasina GRAY-BARBERIO**: As a peak body, do you have access to these quarterly meetings with TAC, which we have heard of from other allied health peak bodies? Please, Isaac, feel free to jump in as well.

**Isaac CURKPATRICK**: No, we have not been invited to any of these quarterly meetings, and I have not met with anyone from the TAC. I did send them an email earlier this year with the same sorts of queries before I was invited for this submission, but I am still waiting on a response there. I think they gave me a bit of a vague answer that I would need to follow up on.

**Anasina GRAY-BARBERIO**: Sorry, just to clarify, if I can, are you saying you have requested to meet with them? Was that the nature of your request?

**Isaac CURKPATRICK**: No, I sent them an email just saying we are getting a few queries about a few of the points that I raised in my submission and asking them to clarify what is included in the new and emerging therapies. I am just looking for the email now, but they did get back about a month or two later, and yes, it did not really give us much there. But I can forward that on to the committee if they wish.

**The CHAIR**: Yes, that is fine.

**Anasina GRAY-BARBERIO**: In your professional opinions and obviously from your interactions with TAC, is it a fundamentally sound scheme as it stands right now?

**Isaac CURKPATRICK**: That is the only dealing I have had, literally at the beginning of this year. I have been in my role for about a year. These issues came up late last year for our members, and I followed up on them this year. From what I have seen, I would not call it a sound system.

**Anasina GRAY-BARBERIO**: Thank you.

**The CHAIR**: Do you want to comment too, Hilary?

**Hilary SHELTON**: I can keep it brief and echo Isaac's comment there. I would agree with that.

**The CHAIR**: Okay. Thanks.

**Anasina GRAY-BARBERIO**: You agree that it is not a fundamentally sound scheme?

**Hilary SHELTON**: Yes, that is correct.

**Anasina GRAY-BARBERIO**: Thank you, everyone. I appreciate your time.

**The CHAIR**: Thank you. I will pass on now to Mrs Hermans. Ann-Marie, over to you.

**Ann-Marie HERMANS**: I work hard going towards the end, because all the questions that I have got lined up have been asked. I might start with you, Isaac, because perhaps you have not had quite as much opportunity to share. I heard you mention the inconsistent outcomes that you are having and that you are finding you can sort those out through optometry, through Medicare. Does that mean that you have no concept of how many people are actually accessing TAC for optometry or what the need is?

**Isaac CURKPATRICK**: Yes, I would not have any data on how many optometrists are using TAC or how many optometrists are involved in TAC. I think it is very random from my experience. As an optometrist myself, I have probably done a handful in my eight years of practising. I think the TAC clients tend to go to certain optometrists that have special interest in certain areas that are related to concussion and other brain injuries and facial injuries.

**Ann-Marie HERMANS**: Right. You have also mentioned the limited visibility in terms of criteria. Have you personally encountered that, where you have not known quite what the criteria is going to be in a situation?

**Isaac CURKPATRICK**: Personally, no, because I have not done many TAC consultations myself. But the examples we are getting from optometrists are that they are requesting certain treatments and glasses and then getting that declined in full, saying that it is a non-established and new emerging treatment, whereas part of that request, that glasses part of it, may be new and emerging and limited in evidence – there is certainly a lot of evidence for the use of prism and double vision. So they are declining as a whole rather than declining certain parts of a request.

**Ann-Marie HERMANS**: Again, I mentioned it earlier: you can have a late development of a situation based on a brain injury from a car accident and so on that may not initially come out as a vision situation. Then after everything else has been dealt with, suddenly, 'I haven't actually had my vision restored' or 'I've got an issue here'. Is that possible? From your professional experience, can that happen, and are you aware of any incidents where this has been an issue in a road accident injury?

**Isaac CURKPATRICK**: Yes, that does happen. Like podiatry, we have a certain period of time, I think it is 90 days, where it is much easier to get that funding, whereas if it is past that or six months since any treatment, it can be a lot harder and you have to apply for that. Certainly things can come on down the track depending on the severity of accidents and whatnot. I missed the second part of your question there.

**Ann-Marie HERMANS**: It was just in terms of that ongoing situation, in the later part of it. Do you find that difficult to navigate? Can it happen? Is it possible for there to be something that stems from it later on, and is that hard to navigate through TAC? You may not know this personally, obviously.

**Isaac CURKPATRICK**: Personally, I do not, but absolutely things can come up. The practitioners that I have been talking to are treating some of their patients for many years – it might be on and off – or they will have a certain 10 vision therapy sessions approved and then they will request another five, and it might be declined. So that is the sort of problem we are seeing.

**Ann-Marie HERMANS**: Is that across the board as well for podiatry? Is there something similar in this situation where you think you are getting it, but you really need to be able to see them in six months time or in 12 months time to maybe make changes, because there has been an improvement or it has regressed? Is that possible? How difficult is that with TAC?

**Tony MASSAROTTI**: Absolutely, it is possible. A lot of these patients will go on to develop secondary degenerative problems and then we go through the whole process again. And sometimes it can be accepted, other times it can be rejected. That is the consistency of it.

**Ann-Marie HERMANS**: You do not know what the criteria is. It is basically hit or miss.

**Tony MASSAROTTI**: Sometimes it is very unclear, yes.

**The CHAIR**: Okay, thanks. Time is up there.

**Ann-Marie HERMANS**: Okay. Thank you.

**The CHAIR**: Thanks so much, Ann-Marie. Lee, I will hand over to you now.

**Lee TARLAMIS**: I do not have any questions, Chair, but thank you for your submissions and for coming along and talking to us today.

**The CHAIR**: Okay. Thanks.

**Michael GALEA**: I have just got one, sorry.

**The CHAIR**: Sure.

**Michael GALEA**: Just going back to what we talked about with fees earlier, how often does that increase? Is there a set rate at which it does? Have there been any recent increases?

**The CHAIR**: Like inflation or something like that, or indexation?

**Michael GALEA**: Yes. Have there been any recent adjustments to the payments that TAC makes?

**Tony MASSAROTTI**: I cannot answer that exactly, but I know that it would have been a very small increase. What I can say, though, is that there is a disparity between us and, for argument's sake, physiotherapy. For a standard ongoing appointment we are paid 60 per cent of the rate of what physios are – 60 per cent.

**Michael GALEA**: Thank you.

**Sheena WATT**: Sorry, just further to that rate, is there a real difference in the rates with other comparable schemes?

**Hilary SHELTON**: There often is a difference in the rates. Sometimes they can be the same, sometimes they can vary one way, either higher or lower. What we would say of the consistency that does not exist is that the rates do not appear to be based on the realities of delivering services.

**Daniella FLORIO**: Just in regard to that, if you look at the Medicare rate, the Medicare rate is higher than the TAC rate, and the Medicare rate is actually based on 20-minute appointments. That is a bulk-billing fee. That is much lower for TAC.

**The CHAIR**: Okay.

**Sheena WATT**: That is helpful. Thank you.

**The CHAIR**: Thanks very much. Thank you to Isaac online and also to those who are here in person. You will be provided with a proof version of the transcript before it goes up online. We really appreciate your time and your evidence that you have given today. Thank you very much.

**Witnesses withdrew.**