Part Two

Audit Findings and Conclusions

1. Introduction

Audit background

1.1 Veterans may receive hospital care at Repatriation Commission expense where they satisfy certain eligibility requirements. This audit focuses on Arrangements for veterans who satisfy these requirements. The ANAO notes that, in common with the general community, veterans and their dependants can also receive public hospital care under Medicare.

1.2 For over seventy years hospital services for eligible veterans and their dependants were provided primarily by institutions owned by the Repatriation Commission. In 1989 the Commonwealth Government decided that the Repatriation General Hospitals (RGH) should be integrated into State public hospital systems. Since then the Repatriation Commission has entered into Arrangements with some State governments to provide for the treatment, care and welfare of eligible persons. Hospital services for veterans would be provided by public hospitals under the Arrangements.

1.3 The Arrangements with the States are in two phases, as detailed in Table 1.

Table 1
Commonwealth-State Arrangements

State	Arrangement		
	Commencement date	End of Phase 1	End of Phase 2
Tasmania	1 July 1992	30 June 1995[1]	30 June 2002
New South Wales	1 July 1993	30 June 1998	30 June 2003
Victoria	1 January 1995	31 December 1998	30 June 2005
South Australia	9 March 1995	30 June 1999	30 June 2006

(1) With the end of Phase 1 in Tasmania, a transitional bed rate payment mechanism was implemented to allow for the development of a Casemix funding arrangement beginning in 1998-99.

1.4 In the first phase States other than Tasmania receive block payments, with an agreed level of funding and an agreed volume of services. The second phase envisages a move towards a fee for service basis, with DVA having much greater freedom to use other suppliers if they can provide similar quality services at a lower cost. The first phase was designed to give the States time to achieve the savings expected from the integration of the former RGHs into State hospital systems. It was also designed to

give both the States and DVA time to develop the systems needed for a more competitive environment. The first phase of the Arrangements with the States for the provision of hospital services is coming to a close. This audit was primarily undertaken to provide a timely examination of the Arrangements in part with a view to drawing lessons for better practice in the future.

1.5 Purchases of hospital services for veterans and their dependants totaled $766m in 1996-97, with $418m being provided by public hospitals and $349m by private hospitals. For 1997-98, DVA anticipates that the expenditure on services provided by public hospitals will be in the order of $399m, while expenditure on private hospital services is expected to be about $443m.

Audit objectives and scope

1.6 The objectives for the audit were to assess:

- the economy, effectiveness, administrative efficiency and accountability of DVA's management of the purchase of hospital services from State and Territory governments; and
- the strategies adopted by DVA to manage change in its purchase of hospital care services from State and Territory governments.

1.7 The scope of the audit was limited to DVA's purchase of State public hospital services. It did not cover the purchase of hospital services from private hospitals because these were covered in two previous ANAO reports[2].

Audit methodology

1.8 Audit criteria encapsulate the auditor's expectations of sound management and administration. Criteria are reasonable and attainable standards of performance and control against which the adequacy of systems and practices and the extent of economy, efficiency and effectiveness of operations, programmes, or activities can be assessed. The following criteria were used for this audit:

- DVA had identified and analysed the risks associated with the purchase of hospital care services from State governments;
- the Arrangements (agreements) with State and Territory governments had firm specifications, clearly stated objectives and the Commonwealth's interests were protected;

[2] ANAO Report 28 1993-94, DVA *Use of Private Hospitals*, AGPS, Canberra, 1994; and ANAO Report 28 1996-97, DVA *Use of Private Hospitals, Follow up Audit*, AGPS, Canberra, 1997.

- DVA had mechanisms in place to ensure that it was getting value for money for all Arrangements entered into;
- DVA was benchmarking its management of the purchase of hospital care services from State public hospitals;
- DVA had quality standards in place and was reviewing performance against these standards;
- DVA regularly evaluated the purchase of hospital care services from State governments and made the results or summaries of the results public;
- DVA published statistical and other data on the purchase of services from State public hospitals on a periodic basis for the information of Parliamentarians and other stakeholders;
- DVA had a strategy in place to manage change in its purchase of hospital care services from State and Territory governments; and
- DVA had IT systems in place capable of providing timely and accurate financial and management data.

1.9 The main methods of enquiry used in the audit were:

- a review of relevant DVA documents; and
- interviews with:
  - officers of the Department of Veterans' Affairs;
  - persons with a knowledge of the management of the purchase of hospital services. These included officers of State health departments, officers of private health funds and academics; and
  - some members of the veteran community.

1.10 Fieldwork was conducted between July and September 1997. The audit fieldwork comprised work undertaken in DVA's National Office in Canberra as well as in those States where DVA has entered into Arrangements for the purchase of hospital services.

1.11 The audit complied with ANAO auditing standards. It cost $310 000.

Lessons for other Federal agencies purchasing services from State governments

1.12 The audit identified a number of lessons for Commonwealth agencies purchasing services from State governments. A summary is at Appendix B.

2. Background

This chapter gives a brief history of Repatriation hospitals in Australia, and presents some background on the current environment for the provision of hospital treatment for eligible veterans and their dependants.

Repatriation General Hospitals[3]

2.1 The legislative provision for the repatriation of returned World War I soldiers was the *Australian Soldiers' Repatriation Bill, 1917*. The Repatriation Department was established in March 1918. Initially veterans were treated in the large network of military hospitals which the Government had established throughout Australia. However, in 1921, the Commonwealth Government transferred the control of these hospitals to the Repatriation Commission. The Commission began a role that was to last some 70 years - that of a direct provider of hospital care for veterans.

2.2 There was an increasing demand for repatriation hospitals during and after the Second World War, not only because of the acute treatment required by returning servicemen, but because of the aging of First World War veterans. As a consequence, a second wave of Army base hospitals was built in all States except Tasmania. In 1947, the Commonwealth transferred control of these hospitals to the Commission. The hospitals transferred were located at Greenslopes (Brisbane), Concord (Sydney), Heidelberg (Melbourne), Springbank (later known as Daw Park - Adelaide) and Hollywood (Perth) and became known as Repatriation General Hospitals. The only other RGH was Repatriation General Hospital Hobart. The Repatriation Commission never owned any hospitals in the Northern Territory or the Australian Capital Territory.

2.3 Many of the older hospitals from the First World War era became Repatriation Auxiliary Hospitals and provided care for tuberculosis patients; and, later, rehabilitation and convalescent care. See Appendix A for further information.

2.4 The Commonwealth is no longer a direct provider of hospital care for veterans. From 1992 to 1997 the Commonwealth transferred to the States, sold, or closed all Repatriation General Hospitals (RGHs) and Repatriation Auxiliary Hospitals. The Commonwealth now purchases hospital services from State governments and from the private sector.

[3] For further details readers may wish to refer to the book: Lloyd, Clem and Rees, Jacqui, *The Last Shilling, A History of Repatriation in Australia,* Melbourne University Press, Melbourne, 1994.

Brand report

2.5 Various Commonwealth Governments have appointed or conducted reviews of the RGHs. In 1971, Mr Justice Toose recommended that the RGHs should eventually be integrated with community health facilities. The Toose Report, as quoted in the Brand Report, recommended that 'to keep Repatriation hospitals fully viable, both medically and economically, any spare capacity should be used for the benefit of the community'[4]. This led to DVA adopting a policy that up to 20 per cent of the patients in a RGH could be non-veteran community patients.

2.6 The major review foreshadowing the eventual divestment of RGHs was the Review of the Repatriation Hospital System, chaired by Dr Ian Brand. His report was released in June 1985. The Brand Report gave several reasons why the RGHs should be integrated into State hospital systems. A major concern was veteran access to appropriate hospital services. As veterans and their spouses aged and cities grew, they were experiencing difficulties getting to the centralised RGHs. The Brand Report noted examples of aged wives travelling considerable distances to visit veteran patients. Access was especially difficult for those family members who were reliant on public transport to visit their partners in hospitals.

2.7 All the RGHs were general teaching hospitals and had established themselves as centres of excellence. However, the Brand Report commented that the RGHs were 'increasingly gaining the reputation of being hospitals for geriatric care and were losing their attractiveness to top level specialist professional staff'[5]. The Brand Report commented that, without community patients, the RGHs would not have been able to operate effectively as acute and general teaching hospitals.

2.8 The Brand Report discussed rationalising hospital resources in metropolitan areas. The Report commented that further investment in the RGHs would have an impact on, and would need to be coordinated with, State hospital systems. The Department of Finance's view at the time was that 'it is a long term objective of the Government that the management and development of the Repatriation system should involve a rationalisation of Repatriation hospital activities with those of relevant State authorities with a view to eventual integration with the State hospital systems consistent with the effective use of resources and overall policy objectives'[6].

4 *Review of the Repatriation Hospital System: Final Report*, (the "Brand Report"), [Melbourne], June 1985, p. 8.

5 *ibid*, p. 43.

6 *ibid*, p. 25.

2.9 The Commonwealth Government accepted the findings of the Brand Report and began planning for the divestment of the RGHs.

Divestment

2.10 The 1989 decision of the Commonwealth to divest itself of the RGHs was predicated on Arrangements with State governments to:

- provide veterans with access to a greater range of hospital and specialist services;
- improve the access of veterans and war widows to hospital services closer to where they lived; and
- enable the retention of the RGHs as viable institutions.

2.11 The location of two RGHs and an auxiliary hospital did not make them attractive to the States as complements to their existing networks. These hospitals were sold to the private sector.

Potential cost savings

2.12 Subsequent to the decision to divest, DVA identified $1bn in potential savings to the Commonwealth over 10 years. The estimate compared the expected cost to the Commonwealth of continuing to operate the RGHs with the expected cost of purchasing a similar level of services from State governments or (in the case of hospitals sold) from the private sector. The Arrangements also provided an opportunity for the Commonwealth Government to assist in the rationalisation of public hospital resources.

2.13 DVA has not quantified the cost savings achieved to date. However, departmental documentation indicated that:

- outcomes (number of veteran public hospital separations and payments to the States) are in line with the projections in the savings estimates; and
- DVA expenditure per separation is declining.

2.14 Given that outcomes to date are in line with projections, DVA is satisfied that significant savings have been achieved and sees no need to expend resources (on what could be an extensive exercise) to quantify savings. Also, it would be impossible for DVA to quantify savings achieved until the completion of the State data reconciliations currently under way by DVA. The ANAO is satisfied that significant savings have been achieved, but is unable to verify their full extent due to the limited supporting documentation available.

Funding

2.15 Funding for the purchase of hospital services for veterans is a component of sub-program 2.3 (Health Care Services) of the Veterans' Affairs portfolio. Funds allocated to this sub-program in 1996-97 were $1.6bn (see Table 2).

Table 2
Components of DVA's sub-program 2.3 - Health Care Services, 1996-97

Sub-program 2.3 components	Budget Paper Estimate $m	Actual $m
Maintenance of patients in non-departmental institutions	840.8	810.9
Payments for Local Medical Officers and specialist consultations and services to veterans	415.9	405.0
Payments for allied health services	176.0	166.6
Pharmaceutical services	160.8	160.7
Other	1.4	1.2
Running costs	74.8	66.8
Sub-total	1 669.7	1 611.2
Miscellaneous revenue (deduction)	0.4	1.2
Total	1 669.3	1 610.0

Source: DVA, Budget Related Paper No. 1.3B, Portfolio Budget Statements 1997-98, pp 15-32 and DVA.

2.16 The column 'Budget Paper Estimate' shows budget line items from Budget Paper No.1.3B. These figures are estimates arrived at before the financial year had finished. The column labelled 'Actual' shows unpublished actual figures obtained from DVA. Funding for hospital services is included in the component 'Maintenance of patients in non-departmental institutions'. Also included in this component is $50m of Nursing Home services and $9.2m of Psychiatric Hospital services.

2.17 Hospital services for eligible veterans are an entitlement. That is, the funding of hospital services varies with veterans' demand for hospital treatment.

2.18 Table 3 shows DVA's expenditure on hospital services for the last five years by sector.

Table 3

DVA hospital expenditure[1] by sector - in current and constant[2] prices

Year	Public hospitals (including RGHs)			Private hospitals			Total DVA hospital expenditure	
	current prices $ 000	1996-97 prices $ 000	% of DVA total hospital expen.	current prices $ 000	1996-97 prices $ 000	% of DVA total hospital expen.	current prices $ 000	1996-97 prices $ 000
1992-93	585 023	653 566	83.3	117 634	131 417	16.7	702 657	784 983
1993-94	600 110	658 273	78.9	160 454	176 003	21.1	760 564	834 276
1994-95	570 134	606 173	70.7	236 886	251 859	29.3	807 020	858 032
1995-96	432 729	441 478	59.9	290 101	295 968	40.1	722 830	737 446
1996-97	417 764	417 764	54.5	348 566	348 566	45.5	766 330	766 330

(1) Excludes Psychiatric Hospitals and Nursing Homes.

(2) Deflated using the CPI All Groups index number.

2.19 Points of interest to note in Table 3 include:

- total DVA hospital expenditure in constant prices rose by 9.3 per cent from $785m in 1992-93 to a peak of $858m in 1994-95. That was the year when the last of the former RGHs were either sold to the private sector or transferred to State governments;
- total DVA hospital expenditure in constant prices fell by 10.7 per cent from $858m in 1994-95 to $766m in 1996-97. This is consistent with the realisation of the potential savings identified by DVA which were mentioned earlier in this chapter; and
- the large decrease in the percentage of DVA total hospital expenditure going to the public sector and the corresponding increase in expenditure in the private sector. In 1992-93, 83.3 per cent of DVA's total hospital expenditure related to public sector hospitals (including the RGHs) and 16.7 per cent related to private sector hospitals. By 1996-97, as a result of the divestment of the RGHs and other factors, 54.5 per cent of DVA's total hospital expenditure related to public sector hospitals and 45.5 per cent related to private sector hospitals.

2.20 Table 4 separates public sector expenditure from Table 3 into expenditure on hospitals owned by State governments (public hospitals) and expenditure on hospitals owned by the Commonwealth (the former RGHs).

Table 4
DVA public sector hospital expenditure - current prices

Year	State government owned		Commonwealth Government owned (RGHs)		Total public sector expend.	Total DVA hospital expend.
	$ 000	% of DVA total hospital expend.	$ 000	% of DVA total hospital expend.	$ 000	$ 000
1992-93	102 247	14.6	482 776	68.7	585 023	702 657
1993-94	260 658	34.3	339 452	44.6	600 110	760 564
1994-95	351 281	43.5	218 853	27.1	570 134	807 020
1995-96	432 729	59.9	0	0.0	432 729	722 830
1996-97	417 764	54.5	0	0.0	417 764	766 330

2.21 Points of interest to note in Table 4 include:

- in 1992-93 nearly 70 per cent of DVA's expenditure on hospital services was on services provided by Repatriation Hospitals; and
- veterans were being treated in public hospitals before the RGHs were integrated into State hospital systems. This is reflected by the $102m of expenditure of public hospitals in 1992-93 shown in Table 4. However, the $102m also includes $24m relating to the integration of RGH Hobart and other public hospital services in Tasmania. The latter hospital was integrated into the Tasmanian public hospital system in July 1992.

2.22 Table 5 shows DVA expenditure on services provided by privately owned hospitals separated into expenditure on services provided by privately owned former RGHs and services provided by other private hospitals.

Table 5
DVA private sector hospital expenditure - current prices

Year	Privately owned former RGHs		Other private hospitals		Total public sector expend.	Total DVA hospital expend.
	$ 000	% of DVA total hospital expend.	$ 000	% of DVA total hospital expend.	$ 000	$ 000
1992-93	0	0.0	117 634	16.7	117 634	702 657
1993-94	16 198	2.1	144 256	19.0	160 454	760 564
1994-95	66 042	8.2	170 844	21.2	236 886	807 020
1995-96	90 301	12.5	199 800	27.6	290 101	722 830
1996-97	100 221	13.1	248 345	32.4	348 566	766 330

2.23 The main point of interest in Table 5 is the rapid increase in expenditure on services provided by private hospitals other than the former RGHs. Expenditure has increased from $118m (16.7 per cent of total expenditure) in 1992-93 to $248m (32.4 per cent of total expenditure) in 1996-97. Reasons for the trend towards the private sector include:

- the admission of some veterans to private hospitals due to resource constraints and waiting lists in the public sector. Waiting times increase in importance with the aging of the veteran community;
- the increase in the number of private day surgery facilities with the advent of new technology; and
- the gradual shift of veterans away from the former RGHs, to benefit from public and private hospital services closer to their place of residence and support.

Separations

2.24 Table 6 shows the average cost per separation[7] for the last five years for the States with which DVA has entered into Arrangements. The first major State where an RGH was integrated was New South Wales, from 1993-94. By 1995-96 all the RGHs in the four States, which had entered into an Arrangement with the Commonwealth, were integrated into the public hospital systems. See Chapter 3 for more details.

[7] A separation, as defined in the Arrangements, is a complete episode of care and may involve stays in more than one hospital. Readmission to hospital within 24 hours of discharge counts as only one separation.

Table 6

Public hospital (including RGH) separations for New South Wales[1], Victoria, South Australia and Tasmania in total - in current and constant[2] prices

Year	Separations (preliminary estimates)	Expend. (current prices)	Cost per Separation	
		$ 000	(current prices) $	(1996-97 prices) $
1992-93	96 930	436 624	4 505	5 032
1993-94	93 806	452 535	4 824	5 292
1994-95	95 855	467 360	4 876	5 184
1995-96	92 737	414 187	4 466	4 557
1996-97	90 908	399 764	4 397	4 397

(1) A breakdown of this Table by State is at Appendix C.

(2) Adjusted by the CPI All Groups index number.

2.25 Points of interest in Table 6 include:

- the number of public and RGH separations fell from 96□930 in 1992-93 to 90□908 in 1996-97;
- the cost per separation in current prices peaked at $4□876 in 1994-95 and has fallen since then to $4□397 in 1996-97; and
- in 1996-97 prices the cost per separation has fallen by 12.6 per cent from $5□032 in 1992-93 to $4□397 in 1996-97. The decline in the cost per separation is consistent with the potential savings discussed earlier in this chapter.

2.26 Table 7 shows total separations across all States and Territories for the public and private sectors. The public hospital totals include separations relating to the RGHs prior to their integration or transfer.

Table 7

Total separations - public and private sector - all States and Territories

Year	Public sector	Private sector	Total
1992-93	127 412	52 263	179 675
1993-94	121 566	67 373	188 939
1994-95	115 467	95 905	211 372
1995-96	107 510	111 640	219 150
1996-97	105 655	123 730	229 385

2.27 Points of interest in Table 7 include:

- the growth of 28 per cent in the total number of separations, from 179□675 in 1992-93 to 229□385 in 1996-97;
- the decrease of 17 per cent in separations provided by the public sector (including RGHs), from 127□412 in 1992-93 to 105□655 in 1996-97; and
- the growth of 137 per cent in separations provided by the private sector from 52□263 in 1992-93 to 123□730 in 1996-97.

Repatriation Private Patient Principles

2.28 The Repatriation Private Patient Principles are prepared under section 90A of the *Veterans' Entitlement Act 1986*. These Principles set out the circumstances under which veterans and their dependants receive private patient hospital care. The primary objective is to ensure that entitled persons obtain access to services in the nearest suitable hospital. The Commission had identified the following order of preference for hospital admission:

(i) public hospitals and former Repatriation Hospitals;

(ii) contracted private hospitals; and

(iii) other private hospitals.

2.29 The Repatriation Private Patient Principles are shown in full at Appendix□D.

Repatriation Private Patient Scheme

2.30 The Repatriation Private Patient Scheme (RPPS) was established following the transfer of the RGHs from the Commonwealth to various State governments or the sale to the Ramsay Health Care Group. The Scheme provides eligible veterans and dependants with free treatment at any public hospital or privatised Repatriation Hospital, as private patients, in shared wards, with choice of their own doctors. The Repatriation Private Patient Principles require that access to and the quality of hospital care are monitored. As a consequence, the Repatriation Commission established a National Treatment Monitoring Committee (NATMOC) and a Treatment Monitoring Committee (SATMOCs) in each State and Territory.

2.31 DVA has recently completed a review of the current RPPS arrangements relating to the hospitalisation of veterans and their eligible dependants. The RPPS Review concluded that:

- among veterans generally there was a high degree of satisfaction with their hospital treatment. However, it was noted that certain segments of the veteran community perceived a reduction in the quality of veteran care in some State public hospitals;

- DVA should continue to maintain the current Treatment Monitoring Committee structure; and
- DVA needs to maintain strong links with the broader health industry including the private insurance industry.

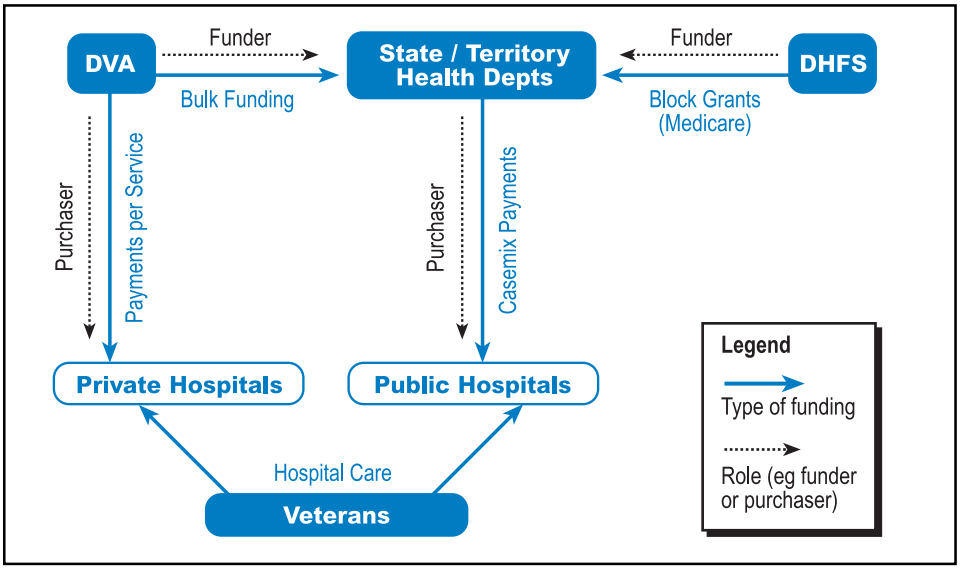
2.32 The Review recommended that veterans should be given easier access to selected private hospitals.

2.33 The findings of the RPPS Review are consistent with the ANAO findings as detailed in this report.

DVA Purchasing model

2.34 Diagram 1 offers a simplified description of the relationship between DVA and providers of hospital services. The diagram illustrates that DVA is a direct purchaser when purchasing services from private hospitals. When obtaining services from public hospitals DVA is an indirect purchaser through State health departments. The distinction between DVA as a purchaser of public hospital services and DVA as a funder of public hospital services is not clear cut.

Diagram 1
DVA's Hospital Services Purchasing Model



2.35 The Arrangement with Tasmania presents a variation on the model. See Chapter 3 for more details.

2.36 There are significant differences in the funding of public hospitals from State to State. For instance in NSW, the Department of Health funds individual health areas, basically on a demographic basis. These in turn fund and purchase services from hospitals. In Victoria, South Australia

and Tasmania, the States fund hospitals directly using variations of a Casemix formula.

2.37 The Victorian formula differentiates funding for the treatment of veterans in public hospitals from funding for the treatment of the general public. Funding for general community patients is capped; funding for veterans in not.

2.38 There is a strong preference among State health departments that Commonwealth funding for the treatment of veterans in public hospitals should continue to flow through them.

2.39 Because it has a direct relationship with private hospitals, DVA has good information on the services delivered and is in a position to influence these services. Because of its indirect relationship with public hospitals, DVA has much less influence over, and less information about, the services delivered.

2.40 Former RGHs are the only public hospitals with which DVA has a direct current relationship. Accordingly, former RGHs offer DVA a valuable window into developments in the treatment of veterans in State public hospital systems. Consequently, there are clear benefits in DVA maintaining close liaison with the former RGHs.

Possible future developments

2.41 DVA could maintain its role as a funder or indirect purchaser of services to veterans in public hospitals, or it could consider a more direct purchasing role with public hospitals. A more direct role is a less likely option because of the preference, as stated above, of State health departments for funding to flow through them.

2.42 There will always be a substantial proportion of veterans treated in public hospitals, as most tertiary[8] hospitals are public hospitals. For instance, in Tasmania there is only one tertiary teaching hospital in the private sector. Also, in country areas throughout Australia, usually the only hospital available is a public hospital.

2.43 The current RPPS policy gives first preference for treatment of veterans to public hospitals. The recent RPPS Review (1997) recommended that the present preference for public hospitals be amended to enable DVA to 'enter into preferred arrangements with hospitals that are best placed to provide a high quality and efficient service to the veteran community'. This suggests that, subject to maintaining veteran access, DVA should chose between public and private hospitals, depending on which offers the best service to veterans and the best value for money for the Commonwealth.

[8] Tertiary hospitals are teaching and research hospitals which offer a full range of acute surgical and medical care.

3. Arrangements with the States

This chapter discusses DVA's Arrangements with State health departments and DVA's provisions to ensure that the Commonwealth receives value for money.

Introduction

3.1 When disposing of the RGHs the Commonwealth's original preference was that they would become integrated with State health systems. In Queensland and Western Australia, the location of the RGHs did not make these hospitals attractive to the States, and the hospitals were sold to a private hospital operator.

3.2 The Commonwealth entered into 10-year Arrangements with four States to incorporate RGHs into their State health system, as shown in Table 1 in Chapter 1.

3.3 As mentioned in Chapter 1, the Arrangements are broadly split into two phases, with the first phase lasting between four and five years. The first phase is based on the Commonwealth 'block funding' the State governments, while the second phase is anticipated to be based around Casemix funding. The Tasmanian Arrangement is an exception, as ongoing payments for hospital services are made on a fee for service basis. Casemix is discussed in Chapter 5.

3.4 There was an exchange of letters with the Western Australian government in early 1994 regarding the provision of heart surgery services to veterans and block payments for all other public hospital care. There are no Arrangements with Queensland, the Northern Territory and the Australian Capital Territory.

3.5 Most veterans in Queensland and Western Australia are treated in private hospitals, including the former RGHs, Greenslopes and Hollywood. In the Northern Territory most veterans are treated in a private hospital, or are flown to Brisbane or Adelaide for specialised treatment. In Western Australia a significant majority of eligible veterans treated in public hospitals are treated under block funding arrangements. In the Australian Capital Territory veterans are treated in public and private hospitals and the more complicated cases are sent to Sydney. Treatment of veterans in public hospitals in Queensland, Western Australia, the Northern Territory and the Australian Capital Territory is on a fee for service basis.

3.6 Under the Arrangements with New South Wales, South Australia and Victoria, there is an agreed level of funding for each year of the first phase, with an agreed number of separations. In these States, separations beyond the agreed levels attract further Commonwealth funding. The funding provisions for the first phase reflect the expected efficiencies anticipated through integration and which were alluded to in the previous chapter. Appendix E has further information on DVA's expenditure on hospital services by State.

3.7 When preparing for introduction of the Arrangements with the States, DVA anticipated a need for comprehensive data to allow it to assess the performance of State hospital systems as suppliers of services to veterans. Accordingly, it included provisions for the supply of this data into the Arrangements. At the time the latter took effect the States were not in a position to supply this data. One of the intentions of the two phase Arrangements was to give the States (and DVA) time to design and put in place the necessary systems.

3.8 When the Arrangements were being negotiated, Casemix had only just begun to be introduced as a method of funding public hospitals. The Arrangements anticipated that Casemix would be a key part of the funding mechanism for the second phase. If Casemix funding is introduced as part of phase two, DVA intends to move away from block funding (agreed volumes and agreed funding levels) towards fee for service payments. There is a clause in the Arrangements applying to the second phase which gives DVA the ability to use the most cost effective suppliers, whether they are in the private or public sector.

3.9 With the end of Phase 1 in Tasmania, a transitional bed day arrangement was implemented pending current discussions to determine a suitable Casemix payment arrangement.

3.10 The Arrangements are discussed under two major sub-headings:

- the form of the Arrangements; and
- value for money.

The form of the Arrangements

Legal basis for Arrangements

3.11 The Commonwealth-State Arrangements define the responsibilities and obligations of the parties involved, but do not have the status of a contract. If there is a dispute, the 'dispute resolution' clause in the Arrangements becomes active. Resolution is initially sought at officer and departmental level, then with the respective Ministers. If still unsolved, the dispute is referred to an Arbitrator, who is to be an expert appointed

for that purpose, by the President of the Institute of Arbitrators of the State concerned. The dispute resolution process does not envisage resort to the courts.

3.12 The relevant legislation for the legal basis for the Commonwealth-State Arrangements is Part V of the *Veterans' Entitlements Act 1986*. The Repatriation Commission is empowered to enter Arrangements under section 89 of the Act; which gives it powers to arrange for the provision of treatment for veterans and other eligible persons:

(a) at a hospital and other institution operated by the Commission (section 89(1)); and

(b) at another hospital or other institution with which the Commission has entered into an arrangement under the powers conferred by the Act (section 89(1)(b)).

State Arrangements

3.13 Payments under the Arrangements to New South Wales, Victoria and South Australia are by block funding, payable monthly in advance. Block funding, in this context, refers to a fixed amount of funding given by DVA to the State governments for an agreed volume of separations. The degree of complexity of the hospital treatment performed on the veteran is not taken into account until the number of separations claimed exceeds the trigger point. For example, an ingrown toe nail operation would count as one separation, as would a triple by-pass cardiac operation.

3.14 The target number of separations for the above States is as follows:

Table 8
Target number of separations

State	Target separations[1]	Comment
NSW	39 000	The level of payment is adjusted if the actual level of separations varies from the target by more than 10 per cent.
Victoria	26 600	Payment adjustment is required for any variation from the target.
South Australia	11 050 - 11 700	Payment adjustments are required only if the actual separations are outside the target range.

(1) Refer to Table 9 for the number of separations claimed.

Tasmania

3.15 Payments in Tasmania are on a fee for service basis. Hospitals provide services to veterans and then bill DVA. There are five payment rates:

- acute care accommodation;
- rehabilitation bed accommodation;
- nursing home type patient accommodation;
- procedure fee; and
- outpatient attendance.

3.16 DVA is billed directly by hospitals for services rendered. There is no block funding. As referred to above, DVA is currently negotiating with the Tasmanian Department of Health and Community Services for a move to Casemix funding beginning in 1998-99.

Clearly defined penalties and incentives

3.17 The Arrangements are a form of agreement that requires performance by both parties. The Arrangements, like any comprehensive agreement, require clearly defined penalties for non performance and incentives to encourage superior performance. If there are no penalties in a contract a party to the contract can ignore a provision which proves to be onerous. If there are no incentives there is no reason for a party capable of superior performance to perform above the level specified in the contract. While there are penalties and incentives in the current Arrangements, the ANAO considers there is scope for improvement.

Penalties

3.18 There is one area of the Arrangements where there is an effective penalty in place. This is the provision to reduce payment to the States if the agreed level of separations is not reached. There are two other areas where effective penalties would have been useful.

3.19 The first of these concerns the provision of data for payments reconciliations on the quantity of services provided to veterans. There is no penalty in the Arrangements for not providing this data. If the number of separations provided does not lead to a variation of DVA's payment to the State there is no reason for the State to provide reconciliation data. However, without the data DVA is unable to confirm that the number of separations claimed is correct.

3.20 The second concerns the provision of data to allow DVA to assess the quality and the cost effectiveness of the services provided to veterans. The Arrangements make provision for data on the treatment of veterans,

classified on a Casemix basis, to be provided to DVA. However, the Arrangements contain no penalty for withholding this data.

3.21 The ANAO considers that there is room for further use of penalties in the second phase of the Arrangements. Penalties which have been identified and which could be included in the second phase of the Arrangements include:

- withholding payments if certain conditions are not met;
- the reduction of payments by an increasing percentage scale if satisfactory data is not provided by required times; and
- making payments retrospectively as opposed to in advance if particular undertakings are not honoured.

Incentives

3.22 The Arrangements contain three financial incentives relating to the provision of hospital services to veterans. These are the prospect of individual States receiving additional Commonwealth monies for treating additional veterans in public hospitals, the States retention of any savings represented by any reduction in the average length of stay, and their retention of any other savings achieved as a result of administrative efficiencies.

3.23 The ANAO considers that there is room for further use of incentives to encourage superior performance from States in meeting the conditions in the Arrangements. It should be noted that any incentive is likely to involve a cost. DVA must be satisfied that there was a demonstrated cost benefit to any incentive offered.

Recommendation No.1

3.24 The ANAO recommends that the Department seek the introduction of a more comprehensive penalty regime and additional incentives to encourage superior performance in all future DVA Arrangements with the States, to strengthen the Commonwealth's capacity to achieve its objectives.

DVA response

3.25 **Agreed.** The Department is actively working towards this aim. The exact mix of penalties and incentives achieved will be a consequence of negotiations with State governments.

Capital funding

3.26 As part of the Arrangements the Commonwealth made payments to a number of States to improve facilities at former RGH's. Two payments were made to the South Australian government for the construction of a

rehabilitation facility at Daw Park Repatriation General Hospital in Adelaide. These payments were:

- $5m in July 1995; and
- $8m in July 1996.

3.27 DVA's expectation was that the rehabilitation facility would be built, or at least commenced, fairly quickly after transfer in March 1995. At the time of the audit (late 1997) the facility had not been built. The delay in the construction of the facility has been a source of complaint and disappointment by the veteran community and has been the subject of correspondence by DVA.

3.28 DVA was required under the Arrangement to pay these funds in July 1995 and in July 1996. The Arrangement did not specify the time frame within which the $13 million payment should have been spent by the South Australian government. Further, the Arrangements contained no provisions which would have allowed DVA to withhold or reclaim the payments if the money was not spent as intended. However, DVA has actively monitored State plans to develop the rehabilitation facility, and the use of Commonwealth funds for that purpose.

3.29 The ANAO considers that where Commonwealth money is paid to a State for a particular purpose there should be clearly defined terms and conditions. The terms and conditions should include a provision that specifies action if the money is not spent as intended.

Recommendation No.2

3.30 The ANAO recommends that, where possible, in instances where Commonwealth money is paid to a State for particular purposes, such as for capital programs, the Arrangement and/or the supporting documentation should include details of:

- the purpose for which the payment is made;
- the time frame in which the money is expected to be spent; and
- the consequences if the purpose or time frame is not met.

DVA response

3.31 **Agreed.**

Value for money

Accounting for services

3.32 DVA's Arrangements with New South Wales, South Australia and Victoria involve block payments based on the number of veteran separations in any one year. Establishing the number of separations that

should be counted for payment purposes involves a reconciliation process between the separations claimed by each State and departmental eligibility and approval records, as well as the exclusion of any episodes that are outside the scope of the Arrangements.

3.33 Determining eligibility is a two step process. The first step is to determine whether the person treated was an eligible veteran. DVA issues eligible veterans with a card which can be used instead of a Medicare card. A veteran entering a public hospital who produces his or her DVA card will be treated as a private patient.

3.34 The second step is to determine the veteran's level of eligibility. The majority of veterans have a Gold Repatriation Health Card, which entitles them to treatment for all conditions. Other veterans hold White Cards, which limit their entitlement for treatment to conditions accepted by the Repatriation Commission as war caused[9]. Before treating a White Card patient, hospitals are required to seek confirmation from DVA that the treatment proposed is treatment which relates to the condition for which the veteran is eligible. An acceptable separation record for a White Card holder should match to a record indicating prior financial authorisation (PFA) on DVA's computer system. A claimed separation for White Card hospital treatment costs which lacks PFA will be rejected.

3.35 The Arrangements link payment amounts with the number of eligible veteran separations provided. However, no documented reconciliations of these separations had been achieved for any year in any State at the time of the audit field work. Table 9 gives information on the status of the reconciliations.

3.36 In New South Wales, although the number of separations claimed has exceeded the target in every year, they have not exceeded the trigger point of 39 000 plus 10 per cent (42 900). As a consequence no further payment from the Commonwealth has been required.

3.37 In Victoria the number of separations claimed has exceeded the target level. During the audit, DVA was about to conclude its reconciliation of separations for the first year of the Victorian Arrangement (1995). Because of the delay, DVA had made an interim adjustment payment of $9m to the Victorian Department of Human Services for separations in 1995.

[9] An example is a veteran with a service-related knee injury. As a White Card holder this veteran would not be entitled to treatment for an arm injury. All Australian veterans are also eligible for treatment for malignant neoplasia, pulmonary tuberculosis and post-traumatic stress disorder regardless of their card type, where DVA has accepted a claim for treatment of those conditions. Allied veterans from New Zealand, the United Kingdom, South African and Canada are only issued with a White Card for treatment of conditions accepted as war caused.

3.38 In South Australia the number of separations claimed has exceeded the trigger point in every year. At the time of the audit in 1997, discussions were under way with the South Australian Health Commission to agree on the level of separations for the 1995-96 year.

Table 9

Separation reconciliations[1]

	Block payments made		Target separations	Services claimed (estimate)	Final adjustment due	Final adjustment payment made
	Year	$m				
NSW	1993-94	188 025	39 000	39 224	31-12-94	not required
	1994-95	190 654	39 000	39 700	31-12-95	not required
	1995-96	171 344	39 000	42 800	31-12-96	not required
	1996-97	157 501	39 000	41 000	31-12-97	not required
VIC[2]	1995	130 859	26 600	31 750	30-6-96	no
	1996	143 510	26 600	31 250	30-6-97	no
	1997[3]	73 872	13 300	15 500	30-6-98	not due
SA[4]	1994-95	17 843	3 654	3 923	30-6-96	no
	1995-96	56 690	11 700	13 574	30-6-97	no
	1996-97	54 801	11 700	14 272	30-6-98	not due

(1) Payment in Tasmania is on a fee for a service basis. It is not included in this Table as there are no block payments.

(2) Victorian Agreement based on calendar years.

(3) To 30.6.97.

(4) First year separations in South Australia cover the period 9 March 1995 to 30 June 1995 (calculated on a daily basis). The target is adjusted accordingly.

3.39 There is no pressure on DVA to conduct separation reconciliations where they are not needed to establish payment levels. This was the case in New South Wales, due to the level of separations claimed not reaching the trigger point for extra payments. It is up to DVA to decide whether to undertake reconciliations in such instances. However, the ANAO noted that the number of separations claimed by that State has been increasing and by 1995-96 had almost reached a level where further payments would be required. The ANAO considers that DVA would be prudent to consider its options for 1997-98 and have an appropriate contingency plan in place. Verified cost information is also needed to assess the performance of State hospital systems and for benchmarking purposes (discussed later in this report).

3.40 A factor contributing to the delays in reconciliations was that DVA had not been receiving timely verifiable public hospital separation data from the respective State health departments. For example, New South

Wales data for 1994-95 was received in September 1996, and Victorian data relating to the year ending December 1995 was still being received in December 1996. The situation did not significantly improve in 1997. The South Australian government, under the SA State Arrangement, is required to provide DVA with separation data within three months of the end of each quarter. The SA government has not provided timely data. Its first electronic transmission of trial data did not take place until January 1997, despite the fact that the Arrangement was current from March 1995. The State's claim for services was made on 30 June 1997 for services provided in 1994-95 and 1995-96. Departmental documentation indicated that the States are now beginning to provide data in a more timely fashion.

3.41 The Arrangements with the States specify the time frame within which DVA is to complete reconciliations. The time frames are specified in Table 9. DVA has not yet met these targets. The ANAO acknowledges that there were various teething problems encountered between the DVA and the respective State governments that led to delays. However, a lack of appropriate DVA IT systems in place at the commencement of each Arrangement has also contributed to the delays, including those caused by the non-receipt of timely and useable data from the States. This is discussed further below. The ANAO considers that DVA should now be completing reconciliations within the specified time frames.

3.42 In summary, there are two main factors that have contributed to DVA's difficulties in conducting timely reconciliations and meeting Arrangement requirements for effecting final adjustments by specified times:

- lack of receipt of timely verifiable public hospital separation data from the respective State health departments; and
- lack of appropriate DVA reconciliation systems at the commencement of each Arrangement to allow the data to be processed when received.

Recommendation No.3

3.43 The ANAO recommends that, where accurate and timely data is received, DVA complete reconciliations of public hospital separations data within the time frames specified by the Arrangements with the States, to ensure that the Commonwealth pays the correct amounts to State governments for the provision of their services.

DVA response

3.44 **Agreed.** The Department has had repeated discussions with State stakeholders regarding the format and timing of separation data transmissions, and is hopeful that the difficulties identified will be overcome in 1998.

IT systems

3.45 State hospital systems provide to DVA the records of over 90□000 every year. Accounting for and benchmarking these services will involve processing a significant volume of data. Accounting processes and benchmarking would be difficult without the support of appropriate IT systems. DVA has recognised this and taken steps to develop and progressively refine suitable systems. During the development process, DVA has consulted State health agencies, each of which has a different data system.

3.46 As noted above, DVA's lack of appropriate reconciliation systems at the commencement of each Arrangement contributed to the delays in completing reconciliations. Examples of the problems noted were:

- DVA has had to develop a separate reconciliation system for each State;
- while specifications for a mainframe reconciliation system with South Australia have been developed, the system has not yet been built and current reconciliation efforts are still centred on a non-integrated application on a personal computer;
- apart from systems development lag-times, misunderstandings between DVA and Victoria about data format requirements also led to delays; and
- in NSW, DVA staff experienced difficulties caused by the complicated nature of some of DVA's IT reports.

3.47 While initial teething problems can be expected at the commencement of any agreement, the ANAO considers that these problems should have been resolved by DVA and the respective State governments by now.

3.48 In looking to future Arrangements, the ANAO considers that DVA's interests and management requirements would be better protected if it had the capacity to process in a timely manner information provided by the States. The reconciliation process requires appropriate IT support, and DVA should work towards ensuring that appropriate IT systems are in place shortly after the commencement of new Arrangements with the States.

Recommendation No.4

3.49 The ANAO recommends that DVA, to facilitate reconciliations, ensure that appropriate IT systems are in place at the latest shortly after the commencement of new Arrangements with the States.

DVA response

3.50 Agreed.

Responsibilities

3.51 DVA operates in a devolved management environment. During audit field work, various levels of DVA National and State Office staff suggested that their responsibility was limited to only particular aspects of stages within the overall reconciliation process.

3.52 The ANAO considers that there is scope for more focused ownership and responsibility for the various stages within the reconciliation process. It is to be expected that the responsibilities of National Office and State Office managers would change with devolution. However, their responsibility to ensure that required processes are performed remains.

Recommendation No.5

3.53 The ANAO recommends that DVA review its current allocation of responsibilities for the reconciliation of Commonwealth and State data.

DVA response

3.54 **Agreed.** The Department will review the allocation of responsibilities for the reconciliation process and clarify the roles of all relevant managers.

Cost effectiveness

3.55 The objective of the DVA sub-program under which public hospitals provide services to veterans through the Arrangements is 'to provide access to quality, cost effective health care services to entitled persons'. DVA does not have a working definition of cost effectiveness in its program guidelines but uses a definition formulated by the Department of Finance and Administration. DVA is primarily interested in which provider can supply quality services at the lowest price, subject to maintaining veteran access and service quality requirements. To identify a preferred supplier, DVA needs to be able to compare the price that one supplier charges for a procedure with the price that another supplier charges for the same procedure. The ANAO recognises that the varying scope for competition between hospitals in some parts of Australia would limit the extent to which DVA can pursue cost-effectiveness goals, or measure its performance in achieving them.

3.56 The Arrangements that DVA has with the States allow veterans to be treated as private patients in shared accommodation in public hospitals. The funding in the Arrangements purchases private patient status, but does not cover the full cost of the treatment provided. There is also another Commonwealth contribution via the Department of Health and Family Services' block grants to States as part of the Medicare agreements. In the past, the portion of the Medicare block grant that flows to the treatment of

veterans has not been known, even at a global level. As a result DVA was not in a position to make fully informed judgements on a total cost to Commonwealth basis as to whether private sector suppliers can supply services at a lower cost than the public sector.

3.57 In February 1998, Cabinet considered a proposal regarding the funding of hospital care for eligible veterans. Work on this proposal has led DVA to be better informed about the total cost to the Commonwealth of treating veterans in public hospitals. From 1 July 1998, DVA will be better placed to make judgements on a total cost to Commonwealth basis, about the placement of veterans in public or private hospitals.

3.58 As indicated in Chapter 1, in the first phase of the Arrangements DVA is purchasing public hospital services in bulk. The Arrangements are with State governments, not with individual hospitals. There is an agreed level of funding for each year of the first phase, with an agreed number of separations. DVA does not have the latitude to use alternate suppliers during the first phase.

3.59 In the second phase of the Arrangements DVA will have a greater ability to select the supplier offering the lowest cost or best value for money. That is, within some constraints DVA will have the ability to shift from using public hospitals to private hospitals if the latter can provide a quality service at a lower cost. Alternatively, it will have the opportunity to purchase more services from public hospitals. In anticipation of this opportunity, DVA has asked for information from State Departments of Health to allow it to make informed judgements on the cost of alternate suppliers from the point of view of the Commonwealth Government. The ANAO concludes that if DVA is to use the lowest cost supplier possible, consistent with the provision of quality services and the maintenance of veteran access to hospital services, it will need better data on the cost of services than has so far been available from public hospital systems.

Recommendation No.6

3.60 The ANAO recommends that future Arrangements with the States should include provisions to ensure the supply of the public hospital data required by DVA to make informed judgements on the cost and quality of alternate suppliers of hospital services.

DVA response

3.61 Agreed.

Conclusion

3.62 The ANAO concluded that there were mechanisms in place to ensure that DVA is getting value for money. However, if DVA had a full

knowledge of the cost to the Commonwealth of treating veterans in public hospitals, these mechanisms could operate more effectively. The ANAO noted that the cessation of block funding could provide opportunities to the Commonwealth to seek more cost-effective and efficient Arrangements. The ANAO also noted that there was a need for the Arrangements to have effective penalties for non-compliance and incentives to reward superior performance.

4. Performance Assessment

This chapter discusses the methods used by DVA to assess its performance in purchasing hospital services from State governments, and how DVA reports its performance to Parliament, the veteran community and to other stakeholders.

Performance indicators

4.1 Department of Prime Minister and Cabinet guidelines require departments and agencies to develop performance indicators for each of their sub-programs. The purpose of these performance indicators is to allow an assessment of an agency's performance in meeting program and sub-program objectives.

4.2 As mentioned earlier, the purchase of hospital care services from State governments falls under sub-program 2.3, Health Care Services. The objective of this sub-program is 'to provide access to quality, cost effective health care services to entitled persons'. This section of the report discusses the performance indicators in place for the purchase of hospital care services from State governments against the elements of the relevant sub-program objective; that is, against quality, cost effectiveness and entitlement.

4.3 Table 10 below gives expenditure on the purchase of services from public hospitals as a percentage of sub-program, program and portfolio expenditure. This Table shows that expenditure on public hospitals is a significant segment of DVA's' expenditure. Refer to Table 2 for the components of DVA's sub-program 2.3 - Health Care Services.

Table 10
DVA's expenditure on public hospitals in 1996-97

Expenditure category	1996-97 $m	%[1]
Purchase of services from public hospitals	418	-
Sub-Program 2.3 - Health Care Services	1 610	26
Program 2 - Health Care and Services	1 740	24
Portfolio (total DVA)	6 392	7

(1) Purchase of services from public hospitals as a per cent of other expenditure categories.

4.4 In 1996-97 and 1997-98 there were 10 performance indicators for sub-program 2.3[10]. Three of these performance indicators covered aspects of the purchase of hospital services from State governments. Two of these indicators were quality indicators, while the third covered risk. The other seven performance indicators do not relate to the purchase of hospital services from State governments and cover such aspects as private hospitals, pharmacy, health care plans, health care providers, and the processing of prior financial authorisations.

Performance indicators for quality

4.5 There are two performance indicators relating to quality. The first performance indicator relates to the incidence of hospitalisation cases where discharge planning was inappropriate or absent. This indicator focuses on the continuity of care aspect of quality and directly measures the performance of hospitals. It is also indicative of the success of DVA's efforts to improve discharge planning. However, DVA does not have access to sufficient current data to allow effective reporting against this performance indicator.

4.6 The other DVA performance indicator requires 100 per cent of complaints to Treatment Monitoring Committees (see Chapter 5) to be investigated and relevant strategies developed in a timely manner. In its 1996-97 annual report[11], DVA notes that 100 per cent of complaints were investigated in a timely fashion. This indicator is a measure of DVA's effectiveness in responding to complaints and addressing the underlying causes.

4.7 The performance indicator does not include data on the number of complaints. ANAO review of departmental data revealed that the number of veteran complaints that DVA receives is very low compared to the number of hospital services provided to veterans. There is no publicly available information that would give readers of DVA's annual report any indication as to whether the level of complaints represents a serious problem or is relatively low. It would be useful if DVA published the number of complaints received in order to better allow readers of its annual report to understand the performance indicator.

4.8 DVA, when this matter was discussed with them, commented that complaint statistics need to be treated with caution as they vary in nature and significance. A possible complaint about shared accommodation would not be of equal weight with one regarding a serious infection contracted in

[10] *DVA Annual Report 1996-97*, Commonwealth of Australia, Australian Government Publishing Service, Canberra, 1997, p. 136.

[11] *ibid*, pp. 136, 137.

a hospital. The ANAO's experience with other agencies confirms that complaints can often cover a broad spectrum of issues. Given the generally minor nature and low level of complaints received by DVA, a detailed analysis may not be applicable. However, publication of the number of complaints received would be useful.

Recommendation No.7

4.9 The ANAO recommends that DVA include in its annual report the number of complaints received by Treatment Monitoring Committees, to allow readers to more fully understand DVA's performance indicator on the investigation of these complaints.

DVA response

4.10 **Agreed.**

4.11 As well as receiving complaints, Treatment Monitoring Committees also receive letters of compliment from veterans and their dependants on the services they received in public hospitals. Compliments and complaints received by the committees provide DVA with useful information on the performance of hospitals providing services to veterans. Perusal of the minutes of Monitoring Committees indicates that the majority of complaints are about:

- access;
- continuity of care;
- hotel services (such as accommodation, catering, laundry, cleaning); and
- patient focus.

4.12 The Committees also receive some complaints on the clinical quality of the care received.

4.13 DVA can no longer directly influence the quality of veteran hospital care as it no longer owns and operates its own hospitals. Any performance indicator published by DVA would be measuring the performance of public hospitals and would be based on information supplied by these hospitals or their respective State or Territory governments. This information would cover not only the quality of clinical care provided to veterans but also other patients treated in public hospitals. Currently, within the health industry, there is considerable effort being devoted to the development of a common set of quality of care performance indicators to judge the performance of hospitals. When these developments mature, DVA will be better placed to publish performance indicators on the quality of clinical care provided by public hospitals. DVA has a legislative requirement to monitor health care provided to veterans. How DVA discharges this responsibility, and the information available to it, is discussed in Chapter 5.

Performance indicators for cost effectiveness

4.14 Part of the sub-program objective is 'to provide access to cost effective health care services'. As stated in Chapter 3, DVA is primarily interested in which provider can supply quality services at the lowest price possible. To develop a performance indicator for cost effectiveness of public hospitals, DVA would have to know the full cost to the Commonwealth of treating veterans in public hospitals. As mentioned in Chapter 3, DVA only pays part of the cost to the Commonwealth of treating a veteran in a public hospital. A substantial proportion of the cost is paid through the Medicare Agreement with the States. Without knowledge of the total cost to the Commonwealth it was not possible for DVA to develop a performance indicator which measures its success in purchasing quality services at the lowest possible cost. With the decision to rationalise the funding of hospital care for veterans, DVA will know the full cost of purchasing veteran health services. DVA will then be in a position to develop a performance indicator for cost effectiveness.

Performance indicators for entitlement

4.15 DVA has mechanisms in place as part of the reconciliation process mentioned in Chapter 3 to ensure that only entitled persons receive treatment in public hospitals at Commission expense. State health departments are required to provide DVA with sufficient details of veterans and their dependants to allow DVA to verify entitlement. All separations where entitlement is suspect are checked, and if entitlement cannot be verified the separation is rejected. For example, recent DVA entitlement checks, in one major State, resulted in approximately six per cent of claimed entitlements being rejected.

Claims processing

4.16 Given that DVA's processing of reconciling claims to date has not been timely, an administrative performance indicator in this area would be useful. The administrative aspect to be measured is the average time taken by DVA to reconcile separations submitted. This would be an indicator of DVA's performance if measured from the time valid data is received from State health departments. The recommendation below supports Recommendation 3. This indicator would also assist in confirming that the verification of claims discussed above is occurring.

Recommendation No.8

4.17 The ANAO recommends that DVA ensure that it has adequate systems in place to monitor progress in data reconciliation, and develop a performance indicator to allow an assessment of the timeliness of its performance in reconciling claims submitted by the States.

DVA response

4.18 Agreed.

Risk management

4.19 DVA has also developed a performance indicator to assist in establishing the effectiveness of DVA in managing the risks associated with expenditure on institutional and other health services, which includes the purchase of hospital care services from State governments. Each State Office is required to review 80 per cent of the 10 health care components identified as high risk. Components are categorised as high risk because of:

- the level of expenditure;
- the ease of access to the service;
- the high rate of access to the service; and
- the high cost of individual services.

4.20 In its 1996-97 annual report, DVA commented that 'while some State Offices have recorded good activity in this area others have performed at less than the required 80 per cent'.[12]

Conclusion

4.21 DVA has three performance indicators to monitor its performance in purchasing hospital services from State governments. There are two performance indicators which cover aspects of quality which are within DVA's control. There are incomplete data available for one of these, while the other indicator is incomplete because of the exclusion of data on the number of veteran complaints about quality. The third performance indicator is designed to assist DVA in managing the risks associated with expenditure on the purchase of hospital services. It is only indirectly relevant to the purchase of services from public hospitals.

4.22 DVA faced some difficulties in developing further performance indicators in that:

- quality is an outcome of the performance of hospitals which is under the control of State governments; and
- until funding for the hospital care of veterans is rationalised in July 1998, there is insufficient knowledge to allow the development of a performance indicator for cost effectiveness.

4.23 Overall, however, DVA needs to improve the performance indicators it uses to assess its performance in purchasing hospital services

[12] *DVA Annual Report 1996-97*, Commonwealth of Australia, Australian Government Publishing Service, Canberra,1997, p. 138.

from the States so as to be better able to demonstrate its success in implementing Government policies.

Evaluations and audits

4.24 DVA has conducted one review (the RPPS Review) and three internal audits of its purchase of hospital services from the States in the last five years. DVA has also hired consultants to undertake a review of its hospital contracting process. During this period, the ANAO conducted an audit of DVA's purchase of services from private hospitals and a follow-up to that audit, as well as this audit. When planning its evaluation and audit program, DVA takes account of work undertaken by the ANAO.

4.25 A report (or in some cases a summary of the report) on each DVA evaluation has been made public. Evaluation reports have been supplied to known stakeholders, who are often involved in the evaluations. Other interested parties can obtain them on request.

4.26 Internal audit reports are not generally available to the public. The reports (or in some cases a summary of the reports) would be available under the Freedom of Information Act.

Other data

4.27 DVA spent $811m on the maintenance of patients in non-departmental institutions in 1996-97 (see Table 2, Chapter 2). Of this $766m was for the purchase of hospital services, with $418m relating to the purchase of hospital services from State governments. No details of the expenditure on the purchase of hospital services from State governments were published in DVA's annual report or in Portfolio Budget Statements. That was because:

(i) the Department of Finance and Administration's Guidelines[13] for preparation of departmental financial statements are designed for general purpose financial reports and do not require DVA to reveal how much it paid the States for hospital services;

(ii) the Department of Finance and Administration's 'Estimates Memorandum'[14] advising departments and agencies of the procedural instructions for the preparation of the Portfolio Budget Statements on Federal financial relations do not require publication of the $418m DVA pays for hospital services; and

[13] DoFA, *Financial Statements of Commonwealth Departments*, Guidelines issued by the Minister for Finance, revised June 1997.

[14] DoFA, Estimates Memorandum 1997/50, *Preparation of Portfolio Budget Submissions for the 1998-99 Budget.*

(iii) the $418m payment was not a specific purpose payment to the States. Therefore, it did not have to be reported in Budget Paper No.3, Federal Financial Relations 1997-98.

4.28 Overall, there is no official requirement on DVA to reveal how much it spends on purchasing hospital services from State governments.

4.29 Commonwealth agencies moving into purchaser-provider relationships with State and Territory governments need to consider the information needs of stakeholders, including clients, service providers and Parliament. Agencies also need to consider the most appropriate avenues for communicating with various categories of stakeholders.

4.30 DVA publishes statistics internally which include:

- expenditure by State and type of hospital;
- separations by State and type of hospital;
- occupied bed days and type of hospital; and
- average length of stay by State and type of hospital.

4.31 This information is supplied upon request to researchers and the public. The ANAO was not presented with any evidence of unmet information needs.

Summary

4.32 DVA has performance indicators in place to allow it to assess its performance in purchasing hospital services from the States. The ANAO has made recommendations to improve these performance indicators. DVA undertakes regular reviews and audits of its purchases of hospital services. DVA publishes information on its purchases of hospital services from the States internally, but not externally, but this information is available to external users on request. DVA's decision not to publish externally complies with reporting guidelines.

5. Other Management Issues

This chapter discusses other management issues identified by the audit including the management of risk, change, quality and benchmarking for better performance.

Risk

Current Procedures

5.1 In 1996 DVA instituted the DVA National Risk Management Project. This is a comprehensive risk management program which addresses all identified areas of risk faced by DVA.

5.2 Initially this project identified perceived risk for approximately 88 program components and activities across the Department. The second stage of this project, which is currently under way, assesses the controls in place in each program / sub-program and estimates the residual risk. During this process the effectiveness of each control is assessed and ineffective controls are either dropped or replaced (depending on the consequences of no control). The result is an estimate of residual risk and an action plan if the residual risk is significant.

5.3 A draft risk assessment has been prepared for the purchase of services from private hospitals. At the completion of this audit no risk assessment had been completed for the purchase of services from public hospitals. An initial perceived risk assessment, which did not consider controls and hence did not reflect residual risk, ranked the perceived risk for public hospitals as the second highest amongst DVA's programs. This ranking reflects the large expenditure involved.

5.4 During 1997 DVA prepared a draft risk management objective '…to create an environment where all staff will participate in the identification and treatment of risk, and where managers will take responsibility for managing risk …'.[15] To achieve this objective DVA is proposing to take steps to 'develop and provide risk management awareness and training throughout the organisation'.[16] The ANAO noted that at the time of the audit field work awareness of DVA's approach to risk management amongst managers in national office and state offices was uneven.

[15] DVA, *Risk Management Policy*, August 1997, p. 4.

[16] *ibid*, p. 6.

Initial Arrangements with the States

5.5 At the time the Arrangements with the States were being negotiated, DVA did not have a formal risk management strategy in place. However, through a variety of activities, including widespread consultation with stakeholders, a range of risks was identified and countermeasures developed. Examples, which are reflected in the Arrangements, are shown in Table 11.

Table 11

DVA Arrangement with State governments - risks and countermeasures

Risk	Countermeasure
• that transfer of hospitals to States and private sector would not be accepted by the veteran community	• formal commitment to veterans • extensive consultation • ongoing involvement of veterans' organisations • development of RPPS
• that the quality of services provided and access to these services would deteriorate	• treatment monitoring committees
• that veterans would be unable to access sites of significance within hospitals	• access provisions in Arrangements
• that DVA would be unable to access clinical records	• provisions for access to clinical records in Arrangements
• that a RGH may cease to exist	• provision for the continuing provision of services at the site for a minimum period of 5 years • ongoing involvement of Deputy Commissioners in DVA State offices in consultation committees on planning/ redevelopment

Conclusion

5.6 Although there was no formalised risk management strategy in place in DVA when the Arrangements with the States for the provision of hospital services were signed, risks were identified and counter measures put in place. In late 1996 a more systematic and effective approach to risk management was introduced by DVA. This methodology has yet to be applied to the purchase of hospital care services from State governments.

Change

5.7 There are major changes occurring in the way veterans' health services are funded, purchased and delivered in Australia. These changes include:

- developments in IT systems for managing health care, particularly in managing hospitals;
- the development of treatment classification systems such as Casemix; and
- the development of funding systems based on outcomes rather than inputs.

5.8 The audit examined DVA's strategies for managing change in the purchase of health care services from public hospitals for veterans and their dependants.

5.9 The ANAO found that DVA has strategies in place to anticipate and manage change. An example is the Veterans' Service Delivery (VSD) project. The aim of the VSD Project was:

> *to develop a framework for the delivery of services to the veteran community into the next century. The project focused on understanding thoroughly the needs of the veteran community and on the changes required to meet those needs effectively, to the satisfaction of all who have a stake in this: the veteran community, the broader community, the Government and DVA staff*.[17]

5.10 Another example stems from the recent trend towards early discharge from hospital, which has led to more emphasis on the need for continuity of care. DVA has responded to this need by developing discharge planning kits to improve the level and extent of discharge planning in public and private hospitals. These kits have been warmly received by hospitals.

5.11 In future, DVA will rely much more on Casemix data for its purchase of hospital services. Casemix data are discussed later in this chapter.

Quality

5.12 The Repatriation Private Patient Principles (RPPPs) set out the circumstances in which veterans may be treated as private patients. The RPPPs are prepared under section 90A of the *Veterans' Entitlements Act 1986* and as disallowable instruments have the status of regulations. The RPPPs state that 'The Commission will monitor the access to and quality of hospital care arranged for entitled persons. As part of the process, the Commission

[17] DVA, Veterans Service Delivery, Exposure draft, *Improving the quality of services to the veteran community*, Canberra, March 1997, p. 4.

will establish and support a National Treatment Monitoring Committee and a Treatment Monitoring Committee in each State, the Australian Capital Territory and the Northern Territory'. As a consequence, as well as quality being a sub-program objective, there is a formal requirement for DVA to monitor quality.

5.13 Monitoring of healthcare quality is not a well developed process. A 1996 research project for the Department of Health and Family Service's (DH&FS) National Hospital Outcomes Program commented that nationally healthcare quality indicators were in an early stage of development. To quote from the report:

> *an appropriate growth and development analogy would place quality indicators in early childhood, rather than infancy, with several quality and outcome indicator programs having passed significant developmental milestones. Most existing quality and outcome indicators are imperfect.*[18]

5.14 In practice this means that the indicators available to DVA to monitor the quality of hospital care services provided to veterans are limited.

Treatment Monitoring Committees

5.15 DVA has established a Treatment Monitoring Committee in each State and Territory. These are overseen by the National Treatment Monitoring Committee (NATMOC). Treatment Monitoring Committees play an important role in monitoring the quality of health care provided in both public and private hospitals. As indicated earlier, the Committees are established under the Repatriation Private Patient Principles, which are in turn determined under Section 90A of the *Veterans' Entitlements Act 1986*.

5.16 Terms of reference are in place for NATMOC and the State and Territory Committees. The key section of the terms of reference reads:

> *Consistent with the Repatriation Private Patient Principles, the Committee will monitor:*
>
> *a) the quality of health care available to entitled persons;*
>
> *b) the range of health care services available to entitled persons; and*
>
> *c) the access to health facilities by entitled persons.*[19]

5.17 An annual report is published covering the work of the State and National Treatment Monitoring Committees. The report for 1996-97 was combined with the DVA annual report. The report gives details of the

[18] Department of Health and Family Services, *Quality and Outcomes Indicators for Acute Healthcare Services*, 97.01, Australian Government Publishing Service, Canberra, 1997.

[19] DVA, *National Treatment Monitoring Committee Terms of Reference*, Revised July 1996, p. 6, 29.

composition of each of the monitoring committees, the background to the committees and the activities undertaken by each committee.

5.18 State Treatment Monitoring Committees are chaired by the Deputy Commissioner (DVA State Manager) for the State. DVA officers with responsibility for health care functions in the State are ex-officio members. However most committee members are representatives of ex-service organisations. Representatives of State health departments and the former Repatriation General Hospitals also attend meetings of Treatment Monitoring Committees.

5.19 NATMOC is chaired by the President of the Repatriation Commission and is composed of representatives of the major national ex-service organisations and a senior DVA manager.

5.20 As mentioned in Chapter 4, complaints and compliments from veterans and their families about services provided by public hospitals are a useful source of information for Treatment Monitoring Committees. However, if a complaint is made directly to a public hospital neither DVA or the relevant committee may be aware of the complaint. To the extent that this occurs, the number of complaints received by committees may understate the extent of any problems in the quality of hospital service. The information available to committees may be improved if Arrangements could be made for public hospitals to inform DVA of complaints received from veterans or their families. Alternatively, DVA could conduct periodic customer satisfaction surveys of veterans treated in public hospitals.

5.21 Perusal of the minutes of State Monitoring Committees makes it clear that, when public hospital health care services are monitored, emphasis is on areas such as discharge planning, access to hospitals, and standards of accommodation. The committees appear to be an effective means of monitoring these aspects of health care services provided by hospitals. The ANAO also noted that the committees serve as an important liaison channel between the Repatriation Commission, DVA, the former Repatriation General Hospitals and the veteran community. However, the unavailability of aggregate data on the complaints they receive and address ensures that only a tentative conclusion is possible on their efficacy.

Clinical standards

5.22 An aspect of the quality of the health care available to veterans that DVA needs to monitor is the quality of the clinical care provided by hospitals. Treatment Monitoring Committees have a role to play in monitoring clinical standards, particularly through investigating complaints where there appears to have been a lapse in clinical standards.

However, there are other mechanisms available to DVA to allow it to monitor clinical standards.

5.23 When purchasing services from private hospitals, DVA requires contracted private hospitals to have, or obtain accreditation from, the Australian Council of Healthcare Standards (ACHS). As part of the accreditation process hospitals are required to maintain a minimum set of clinical performance indicators.

5.24 In assessing the quality of clinical care services provided by public hospitals, DVA has two alternatives. DVA can assume that the quality is by default acceptable, because the service provider is a public hospital which is already subject to external monitoring. Alternatively, DVA can attempt to monitor the quality of clinical care provided by public hospitals. Information presented to the audit team indicated that the quality of clinical care provided by public hospitals can vary, which suggests that there is a need to monitor quality. In practice DVA relies on State health departments to monitor and maintain clinical standards. However, there is a need for DVA to gain assurance that State Health Departments are in fact fulfilling this role.

5.25 In New South Wales and Victoria, which have the largest populations of veterans, services to veterans are only about three to five per cent of total services provided by public hospitals. In other words, DVA does not have much leverage. This, and administrative simplicity, indicate that it is appropriate for DVA to continue to rely on State health departments to monitor and maintain clinical standards rather than for DVA to directly monitor clinical standards in hospitals. However, there is a need for DVA to gain assurance that State health departments are in fact fulfilling this role.

5.26 DVA staff were able to articulate clearly the methods used to monitor clinical care quality in private hospitals. Staff were less able to articulate the position with respect to public hospitals. The ANAO considers that DVA should ensure that its staff have a clear knowledge of DVA's strategy for monitoring the quality of clinical care in public hospitals.

Recommendation No.9

5.27 The ANAO recommends that DVA ensure that staff have a sound knowledge and understanding of DVA's strategy for monitoring clinical standards in public hospitals.

DVA response

5.28 **Agreed.**

Benchmarking

5.29 Benchmarking, as defined by MAB-MIAC, is where you 'systematically measure and compare the products, services and processes of your organisation - internally and against other relevant organisations - and take the best practices into your organisation'.[20] Benchmarking can be a useful tool for improving performance where it is relevant and applicable.

Casemix[21]

5.30 An essential element of DVA's ability to benchmark hospitals is Casemix. In the second phase of the Arrangements with the States, DVA is anticipating a move towards Casemix funding and is working with public hospital systems to obtain data on the treatment of veterans classified on a Casemix basis. This information is already supplied by contracted private hospitals. As Casemix data is at the core of DVA's plans for benchmarking hospital services, a brief description of Casemix follows.

5.31 All Australian State and Territory health authorities are moving towards a Casemix-output based funding model for distributing fixed budgets between public hospitals. Under Casemix, hospital payments are paid based on hospital activity levels up to a pre-determined (or capped) level.[22] Hospital activity is categorised to numerous individual treatment classifications, which attract differing payment amounts.

5.32 The individual treatment classifications used are Diagnosis Related Groups (DRGs). Each DRG is intended to contain patient care episodes which are similar in terms of the health problem or method of care, and which also have similar costs. An example of a DRG is DRG number 405, 'hip replacement without complications'. When benchmarking, DVA compares the prices hospitals charge (and other data such as average length of stay) for particular DRGs between various suppliers. The classification currently used in Australia is AN-DRG 3, which has 667 classes. Hospital services for veterans tend to be concentrated in a relatively small number of classes and DVA concentrates on these classes when benchmarking.

[20] MAB-MIAC, *Raising the Standard: Benchmaking for Better Government,* Report No. 21, AGPS, Canberra, June 1996, p. 10.

[21] For further details refer to Hindle, Don, *Fundamentals of Casemix*, The Private Sector Casemix Unit, Canberra, 17 December 1996.

[22] For an example of Casemix funding in action see *Victoria - Public Hospitals, Policy and Funding Guidelines 1997-98*, Human Services Victoria, June 1997.

Benchmarking in DVA

5.33 Benchmarking is an established tool in DVA, and MAB/MIAC has acknowledged the Department's benchmarking activities in a best practice guide.[23] DVA's strategy for introducing benchmarking to the purchase of hospital services from both the public and private sectors is contained in DVA's Casemix Strategic Plan.[24] DVA has begun to use benchmarking for services provided by private hospitals, and intends to benchmark services provided by the public hospital sector. The relevant computer systems to process the considerable volumes of public hospital data and generate benchmarking reports were about to be tested at the time of audit fieldwork.

5.34 An example of successful benchmarking in DVA is cataract surgery. Advances in techniques enabled hospitals in one State to carry out this procedure as a day surgery procedure. The average length of stay for cataract surgery in another State was more than two days, with a much higher cost. This difference was identified by DVA as a result of a benchmarking exercise. After discussion, the hospital in the second State offered a price more consistent with the national average. The resultant saving to the Commonwealth was in the vicinity of $600□000 per year

Data requirements

5.35 Benchmarking hospital services requires timely and accurate data in a common format. The common standard used is known as the Hospital Casemix Protocol (HCP).[25] This identifies individual veterans, and includes information at different levels on both the reason for the hospitalisation and the particular procedure performed.[26]

5.36 The Repatriation Commission approved the establishment of a data repository for the collection and analysis of hospital Casemix and payment data in December 1996. DVA has already implemented an interim database

[23] MAB/MIAC, *Raising the Standard: Benchmarking for Better Government*, Report No 21, AGPS, Canberra, June 1996, pp. 54, 58.

[24] DVA Annual Report 1996-97, Commonwealth of Australia, Australian Government Publishing Service, 1997, Canberra, p. 76.

[25] The Hospital Casemix Protocol (HCP) is a format for the provision of data used by private hospitals to supply information to DH&FS. This format comprises 80 fields of data including:

- patient and provider details;
- diagnosis and procedures performed;
- length of stay;
- hospital charges for accommodation, theatre, prostheses, intensive care, pharmaceuticals; and
- Diagnostic Related Groups (DRG).

As this protocol meets DVA's needs they have adopted it.

[26] A broad indication of the reason for hospitalisation can be obtained at an aggregate level through the use of DRG (Diagnosis Related Group) codes. International Classification of Diseases (ICD) codes reveal particular diagnoses and medical procedures.

and is building a more sophisticated Casemix data repository. Initially this will comprise verified HCP data from private hospitals, which later will be supplemented by similar data from the public sector.

5.37 DVA has also obtained initial public hospital data from a number of States, each of which has a different data system. This data does not currently identify individual veterans. DVA's ability to proceed with benchmarking the public sector in all States depends on the capacity of each State to provide complete datasets.

5.38 The data needed for reconciliations and for benchmarking currently use different sets of data. The ANAO noted that there appeared to be scope for modifying the data requested for reconciliations under block payment reconciliation processes and using the same dataset for benchmarking purposes.

Benchmarking with related agencies

5.39 Agencies handling similar functions can compare benchmarking data. At the time of the audit, DVA did not undertake such comparisons with the major private health funds because of the requirement to avoid the appearance of collusive pricing. This requirement inhibits organisations from exchanging benchmarking data which includes prices or costs. However, there is scope for exchanging non-costs data. DVA is considering this possibility.

Benchmarking administrative processes

5.40 DVA has benchmarked aspects of its administrative processes relating to the provision of health services to veterans. It compared the cost-effectiveness of its claim processing on the Treatment Accounts System (TAS) with that of the Health Insurance Commission (HIC). The HIC option proved more cost effective. As a result the processing of bills from the various health provider groups paid through TAS was progressively outsourced to the HIC during 1997.

5.41 The ANAO considers that DVA should seek further opportunities to benchmark its administrative processes.

Canberra ACT
17 April 1998

P.J. Barrett
Auditor-General

Part Three

Appendices

Appendix A

List of former Repatriation Commission facilities

	RGHs AND RAHs 1 JANUARY 1990	DATES ON WHICH SOLD, CLOSED AT DOWN 0R TRANSFERRED TO THE STATE
NSW	Repatriation General Hospital Concord.	Transferred to State government 1 July 1993. Now known as Concord RGH.
	Lady Davidson Hospital	Sold to Australian Hospital Care (AHX) 1 October 1997.
	Repatriation Wards, Rozelle Psychiatric Hospital	Wards transferred to State on 1 July 1994.
	Queen Victoria Memorial Hospital, Picton	Wards transferred to State on 1 July 1994.
VIC	Repatriation General Hospital Heidelberg	Transferred to the State government 1 January 1995. Now known as the Austin and Repatriation Medical Centre.
	Macleod Repatriation Auxiliary Hospital	Closed 27 January 1993.
	Bundoora Repatriation Auxiliary Hospital	Closed 29 October 1993.
	Anzac Hostel	Closed end of June 1995. Transferred to City of Bayside 26 March 1996.
QLD	Repatriation General Hospital Greenslopes	Sold to the Ramsay Health Care Group. Began operating as a private hospital on 6 January 1995. Now known as Greenslopes Private Hospital.
	Kenmore Repatriation Auxiliary Hospital	Closed 29 April 1994. Sold to Queensland War Veterans Homes Trust on 11 February 1997.
	Repatriation Pavilion, Wacol Psychiatric Hospital	Wards transferred to State on l July 1995.
TAS	Repatriation General Hospital Hobart	Transferred to State government 1 July 1992.
SA	Repatriation General Hospital Daw Park	Transferred to State government on 9 March 1995.
WA	Repatriation General Hospital Hollywood	Sold 24 February 1994 to the Ramsay Health Care Group. Now known as Hollywood Private Hospital.
	Repatriation Wards, Lemnos Psychiatric Hospital	State operated hospital but DVA has 50 per cent interest in the buildings. Current agreement with State is being renegotiated.

Appendix B

Lessons for other Federal agencies purchasing services from State governments

There are a number of lessons other Federal agencies purchasing services from State governments that flow from this audit. These lessons include:

1. There should be a formal agreement or contract with the State government agency. The contract should contain a comprehensive penalty regime to cover non-performance by all parties to the contract. The contract should also contain incentives to encourage superior performance where this possible and desirable.
2. The Federal agency should conduct a full risk assessment before agreeing to purchase services, and the contract should contain countermeasures to the risks identified.
3. If there are alternate suppliers (e.g. the private sector) the contract should require sufficient information to be available to allow the purchasing agency to compare cost, quality and outcomes between suppliers.
4. Cost effective service provision is easier to identify where there are other suppliers.
5. Sufficient information should be available to the Federal agency in a timely fashion to allow acquittal of the services purchased.
6. There should be appropriate IT systems in place on both sides to ensure that accounting and management information can be readily supplied and easily processed.
7. The purchasing agency should be benchmarking suppliers against each other.
8. The purchasing agency needs to consider the information needs of stakeholders, including its clients, service providers and Parliament. It also needs to consider the most appropriate avenues for communicating with various categories of stakeholders.

Appendix C

Separations by State - States with which DVA has Arrangements

This Table provides more detail on individual State expenditures shown in Table 6 in Chapter 2.

Public hospital (including RGH) Separations by State - New South Wales, Victoria, South Australia and Tasmania - in current and constant[1] prices

Year	Separations (preliminary estimates)	Expenditure (current prices)	Cost per separation	
		$ 000	(current prices) $	(1996-97 prices) $
New South Wales				
1992-93	49 077	205 089	4 179	4 669
1993-94	43 524	217 239	4 991	5 475
1994-95	39 700	196 327	4 945	5 258
1995-96	43 000	173 823	4 042	4 124
1996-97	41 000	164 881	4 021	4 021
Victoria				
1992-93	31 133	146 533	4 707	5 258
1993-94	33 815	147 866	4 373	4 797
1994-95	38 928	173 808	4 465	4 747
1995-96	31 500	156 919	4 982	5 082
1996-97	31 000	153 730	4 959	4 959
South Australia				
1992-93	11 328	61 384	5 419	6 054
1993-94	11 644	67 480	5 795	6 357
1994-95	12 498	74 224	5 939	6 314
1995-96	13 574	65 926	4 857	4 955
1996-97	14 272	64 950	4 551	4 551
Tasmania				
1992-93	5 392	23 618	4 380	4 893
1993-94	4 823	19 950	4 136	4 537
1994-95	4 729	23 001	4 864	5 171
1995-96	4 663	17 519	3 757	3 833
1996-97	4 636	16 203	3 495	3 495
Total				
1992-93	96 930	436 624	4 505	5 032
1993-94	93 806	452 535	4 824	5 292
1994-95	95 855	467 360	4 876	5 184
1995-96	92 737	414 187	4 466	4 557
1996-97	90 908	399 764	4 397	4 397

(1) Deflated using the CPI All Groups index number.

Points of interest in this Table include:

- in 1996-97 the average cost per separation varied from $3□495 in Tasmania to $4□959 in Victoria;
- the average cost per separation in Victoria in current prices has risen from $4□707 in 1992-93 to $4□959 in 1996-97. However, in 1996-97 prices the average cost has fallen from $5□258 in 1992-93 to $4□959 in 1996-97; and
- In New South Wales, South Australia and Tasmania the average cost per separation, in both current and constant prices, has fallen over the period 1992-93 to 1996-97.

Appendix D

Repatriation Private Patient Principles

REPATRIATION COMMISSION

Section 90A Veterans' Entitlements Act 1986

Repatriation Private Patient Principles

INTRODUCTION

The *Repatriation Private Patient Principles* are prepared under section 90A of the *Veterans' Entitlements Act 1986* (the Act) and set out the circumstances in which private patient care may be rendered under Part V of the Act.

2. The *Repatriation Private Patient Principles* reflect the long term commitment of the Repatriation Commission, on behalf of the Commonwealth, to the care and welfare of veterans and their dependants.

3. The Principles set out the circumstances in which, and conditions subject to which, private patient care may be rendered to eligible persons under Part V of the Act and should be read subject to the Act.

4. The Principles apply only in States or Territories where there is an Arrangement under paragraph 89(1)(b) of the Act, between the Commission and the appropriate authority of the State or Territory for the provision of hospital care for eligible persons in public hospitals including the former Repatriation General Hospitals.

5. Persons coming within sections 85 and 86 of the Act are eligible for treatment arranged by, or provided at the expense of, the Repatriation Commission. In general terms these persons include:

- Australian veterans (section 85 of the Act) including:
  - a veteran with a war or Defence-caused injury or disease;
  - a veteran with a malignant neoplasm or pulmonary tuberculosis;
  - a veteran who receives a disability pension at or above the 100 per cent general rate;
  - a veteran who receives a disability pension at or above 50 per cent of the general rate and who also receives a service pension;
  - a veteran who receives a service pension and is permanently blinded in both eyes or meets an income or assets test;
  - a veteran who served in World War I;

  - a veteran (including any person who during World War 2 was an eligible civilian) who was detained by the enemy;
  - a Vietnam veteran in need of urgent treatment;
  - a female veteran who rendered qualifying service in World War 2;
- dependants of Australian veterans (section 86 of the Act) including:
  - a war or a defence widow or widower and her or his dependant children;
  - the child of a deceased veteran who had operational service, if the child is not being cared for by a remaining parent;
  - a dependant of a Vietnam veteran in need of urgent treatment;

6. Treatment for eligible persons may be provided:

(a) at a hospital or other institution operated by the Commonwealth, a State or Territory, or any other body with which the Commission has entered into arrangements for the care and welfare of persons eligible to be provided with treatment in accordance with paragraph 84(1)(b) of the Act; or

(b) otherwise, in accordance with Part V of the Act.

7. Consistent with the private patient status described in these Principles, the Commission will ensure continuity of the provision of aids, appliances and other non in-patient hospital services to entitled persons, notwithstanding the integration of the former Repatriation General Hospitals into the State health care systems.

8. The Commission will monitor the access to and quality of hospital care arranged for entitled persons in accordance with these Principles through a National Treatment Monitoring Committee and a Treatment Monitoring Committee in each State, the Australian Capital Territory and the Northern Territory.

9. The *Repatriation Private Patient Principles* form an instrument which is a disallowable instrument for the purposes of section 46A of the *Acts Interpretation Act 1901.*

Part A

Definitions

1. The words below, where used in these Principles, have the following meaning:

"Act" means the Veterans' Entitlements Act 1986 (Commonwealth) as amended;

"Commission" means the Repatriation Commission;

"Contracted private hospital" means a private hospital with which the Commission has entered into arrangements for the care and welfare of persons eligible to be provided with treatment under the Act;

"Country area" means the part of the State outside the metropolitan area of the capital city of that State, determined by the Commission to be a country area under paragraph 80(2)(b) of the Act;

"Department" means the Department of Veterans' Affairs;

"Doctor" means a medical practitioner appointed under the Department's Local Medical Officer (LMO) Scheme, or any medical specialist;

"Emergency" means a situation where a person requires immediate treatment in circumstances where there is a serious threat to life or health;

"Entitled person" means a person who is:

(a) an entitled veteran;
(b) an entitled widow or widower; or
(c) a child eligible for treatment under section 86, except for a child eligible only under sub-section 86(5) of the Act;

"Entitled veteran" means a person who is eligible for treatment under section 85, except for a person eligible only under sub-section 85(9) of the Act;

"Entitled widow(er)" means a person who is eligible for treatment under sub-section 86(1) or 86(2) of the Act;

"Medical specialist" means a medical practitioner who is recognised as a consultant physician or specialist, in the appropriate specialty, for the purposes of the *Health Insurance Act 1973;*

"Medicare Benefits Schedule" means Schedule 1 and Schedule lA of the *Health Insurance Act 1973;*

"Private hospital" means premises which have been specifically declared as private hospitals for the purposes of the *Health Insurance Act 1973*; and

"Private patient" means an entitled person who has the status which gives doctor of choice and shared hospital accommodation, in accordance with these Principles.

Part B

Repatriation Private Patient Principles

1. Hospital care for entitled persons will be arranged on a private patient basis.

2. With a primary objective of ensuring that entitled persons obtain access to the nearest suitable facility, the Commission has identified the following order of preference for admission to a hospital:

(i) public hospitals;

(ii) contracted private hospitals; and

(iii) other private hospitals.

The accommodation level upon admission will be consistent with private patient (shared accommodation) status.

3. Under these Principles, entitled persons will have direct referral, for treatment as a private patient, to a public hospital of choice. That choice will include access to services available at former Repatriation General Hospitals.

4. Entitled persons may obtain direct referral, from their Local Medical Officer or a specialist, for treatment as a private patient, to medical specialists operating at either hospital or rooms facilities, subject to the fees being no greater than those prescribed in the Medicare Benefits Schedule.

5. Further to paragraph 4, where hospital treatment is required, the choice of doctor under these arrangements is also subject to the doctor having visiting rights to the public or private hospital in which the treatment will occur.

6. Where, after taking into account the factors outlined in paragraph 8, the Commission is satisfied that a suitable public hospital bed is not available, entitled persons may be admitted to a contracted private hospital at the expense of the Commission where financial authorisation for the admission is obtained (other than in the circumstances detailed in paragraphs 10 and 11).

7. Where, after taking into account the factors outlined in paragraph 8, the Commission is satisfied that a suitable bed is not available, either in a public hospital or a contracted private hospital, entitled persons may be admitted to an non-contracted private hospital at the expense of the Commission, where financial authorisation for the admission is obtained.

8. In determining whether financial authorisation will be given for admission to, or continuing treatment in, a private hospital, the Commission will consider where the medical need can most appropriately be met within a reasonable time, by seeking advice from the treating doctor on:

- the condition(s) being treated;
- the clinical necessity of the proposed treatment;
- the degree of pain or discomfort; and
- the effect on quality of life;

and, in the light of the reported severity of the clinical condition, giving due consideration to:

- relative waiting times in the public and private sectors;
- distance for entitled persons to travel;
- reasonable control over expenditure; and
- any specific requirements contained in these Principles or under the Act.

9. Where admission of an entitled person to a contracted private hospital has received financial authorisation, he or she may instead elect to obtain access to a non-contracted private hospital of his or her own choice. In this case the Commission will meet accommodation, pharmaceutical and theatre fees and certain other incidental expenses to a level determined by the Commission. Any expenses above this level will be the responsibility of the entitled person.

10. The Commission's financial authorisation is not required for in-patient treatment of entitled persons in a contracted private hospital in those circumstances where the agreement between the Commission and the hospital specifically excludes the need for financial authorisation.

11. The Commission will provide retrospective financial authorisation for the emergency admission of entitled persons to any private hospital, where the immediacy of the treatment which was required made normal referral arrangements to a public hospital emergency accident centre inappropriate, provided that an office of the Department is notified on the first working day after admission, or as soon thereafter as is reasonably possible.

12. The Commission will accord private patient status to Vietnam veterans, not otherwise entitled, and their not otherwise entitled dependants for medically urgent in-patient treatment at former Repatriation General Hospitals and country or Territory public hospitals.

13.[27] The Commission will monitor the access to and quality of hospital care arranged for entitled persons. As part of this process, the Commission will establish and support a National Treatment Monitoring Committee and a Treatment Monitoring Committee in each State, the Australian Capital Territory and the Northern Territory. The National Treatment Monitoring Committee will consist of nine people including:

(a) two representing the Commonwealth, being a member of the Commission, who is the chair, and the National Program Director (Health) of the Department; and

(b) representing veterans, a representative of each of:

- the Returned and Services League of Australia;
- the War Widows' Guild of Australia;
- the Australian Veterans' and Defence Services Council;
- the Australian Federation of Totally and Permanently Incapacitated Ex-servicemen and Women;
- the Legacy Co-ordinating Council;
- the Regular Defence Force Welfare Association; and
- the Vietnam Veterans' Association of Australia.

14.[28] Membership of State and Territory Monitoring Committees will be drawn from at least the ex-service organisations listed above (or associated State or Territory organisations where the relevant ex-service organisations are only national organisations), together with representation from the Department of Veterans' Affairs, including the Deputy Commissioner, who is the chair, and the State or Territory Health authority.

15. The National Treatment Monitoring Committee must consider the reports of the State and Territory Treatment Monitoring Committees.

16. The National Treatment Monitoring Committee must report at least annually to the Repatriation Commission. The Commission must within seven days of receipt furnish the report to the Minister for Veterans' Affairs. The Minister must cause a copy of the report to be laid before each House of the Parliament within 15 sitting days of that House after the Minister receives the report.

[27] Amended by Instrument No. 1 of 1994, commencement 14 January 1994.

[28] *ibid.*

Appendix E

DVA expenditure on hospital services by State

DVA Expenditure on Hospital Services by State - Public and Private - 1996-97

	Public $ 000	% of total hospital expenditure	Private $ 000	% of total hospital expenditure	Total $ 000
Arrangements					
NSW	164 881	63.5	94 718	36.5	259 599
Vic	153 730	71.0	62 826	29.0	216 556
SA	64 950	88.5	8 446	11.5	73 396
Tasmania	16 203	65.4	8 572	34.6	24 775
No Arrangements					
Qld	7 502	5.6	126 686	94.4	134 188
WA	8 393	16.4	42 916	83.6	51 309
NT	21	2.8	736	97.2	757
ACT	2 085	36.3	3 666	63.7	5 751
Total	417 765	54.5%	348 566	45.5%	766 331

This Table demonstrates that DVA expenditure on hospital services by State can be divided into two broad groups - States where there are Arrangements in place and States and Territories where there are no Arrangements. The Table illustrates the following points:

- in the States with which DVA has Arrangements (NSW, Vic, SA and Tasmania) around two-thirds or more of expenditure on services provided by hospitals is on services provided by public hospitals;
- in the States and Territories where there are no Arrangements in place the picture is reversed. In WA, Qld and the NT expenditure on services provided by private hospitals exceeds 80 per cent of total expenditure, while in the ACT private hospitals provide over 63 per cent of total expenditure.

Appendix F

Performance audits in the Veterans' Affairs Portfolio

Set out below are the titles of the reports of the main performance audits by the ANAO tabled in the Parliament in the last three years.

Audit Report No.7 1995-96
Financial Management
Department of Veterans' Affairs

Audit Report No.3 1996-97 - Follow-up Audit
Compensation Pensions to Veterans and War Widows
Department of Veterans' Affairs

Audit Report No.6 1996-97
Commonwealth Guaranties, Indemnities and Letters of Comfort
Department of Veterans' Affairs

Audit Report No.16 1996-97 -Financial Control and Administration Audit
Payment of Accounts
Department of Veterans' Affairs

Audit Report No.20 1996-97
Selected Commonwealth Property Sales
Department of Veterans' Affairs

Audit Report No.21 1996-97
Management of IT Outsourcing
Department of Veterans' Affairs

Audit Report No.28 1996-97 - Follow-up Audit
Use of Private Hospitals
Department of Veterans' Affairs

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Audit Activity Report: Jan-Jun 1997
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Audit Report No.2 Performance Audit
Government Business Enterprise Monitoring Practices
Selected Agencies

Audit Report No.3 Performance Audit
Program Evaluation in the Australian Public Service

Audit Report No.4 Performance Audit
Service Delivery in Radio and Telecommunications
Australian Telecommunications Authority and Spectrum Management Agency

Audit Report No.5 Performance Audit
Performance Management of Defence Inventory
Defence Quality Assurance (preliminary study)

Audit Report No.6 Performance Audit
Risk Management in Commercial Compliance
Australian Customs Service

Audit Report No.7 Performance Audit
Immigration Compliance Function
Department of Immigration and Multicultural Affairs

Audit Report No.8 Performance Audit
The Management of Occupational Stress in Commonwealth Employment

Audit Report No.9 Performance Audit
Management of Telecommunications Services in Selected Agencies

Audit Report No.10 Performance Audit
Aspects of Corporate Governance
The Australian Tourist Commission

Audit Report No.11 Performance Audit
AUSTUDY
Department of Employment, Education, Training and Youth Affairs

Audit Report No. 12 Performance Audit
The Pharmaceutical Benefits Scheme
Department of Health and Family Services

Audit Report No.13 Performance Audit
Third Tranche Sale of the Commonwealth Bank of Australia

Audit Report No.14 Financial Control and Administration Audit
Official Travel by Public Sector Employees

Audit Report No.15 Financial Control and Administration Audit
Internet Security Management

Audit Report No.16 Performance Audit
Equity in Employment in the Australian Public Service
PSMPC and other agencies

Audit Report No.17 Performance Audit
Sydney Airport Noise Amelioration Program
Department of Transport and Regional Development

Audit Report No.18 Performance Audit
Management of the Implementation of the New Commonwealth Services Delivery Arrangements
Centrelink

Audit Report No.19 Performance Audit
Risk Management in ATO Small Business Income
Australian Taxation Office

Audit Report No.20 Performance Audit
Sales Tax
Australian Taxation Office

Audit Report No.21 Financial Control and Administration Audit
Protective Security

Audit Report No.22 Financial Control and Administration Audit
Audits of the Financial Statements of Commonwealth Entities for 1996-97
Summary of Results and Outcomes

Audit Report No.23 Performance Audit
Ministerial Travel Claims

Audit Report No.24 Performance Audit
Matters Relevant to a Contract with South Pacific Cruise Lines Ltd
Department of Employment, Education, Training and Youth Affairs

Audit Report No.25 Performance Audit
Gun Buy-Back Scheme
Attorney-General's Department

Audit Report No.26 Performance Audit
Strategic and Operational Management
National Registration Authority for Agricultural and Veterinary Chemicals

Audit Report No.27 Performance Audit
Managing the Year 2000 Problem
Risk Assessment and Management in Commonwealth Agencies

Audit Report No.28 Performance Audit
Contracting Arrangements for Agencies Air Travel

Audit Report No.29 Financial Control and Administration Audit
Management of Accounts Receivable

Audit Report No.30 Performance Audit
Evaluation Processes for the Selection of
– Records Management Systems
– Internet Access Services
for the Commonwealth
Office of Government Information Technology

Audit Report No.31 Financial Statement Audit
Aggregate Financial Statement prepared by the Minister for Finance and Administration
Year ended 30 June 1997

Audit Report No.32 Performance Audit
The Management of Boat People
Department of Immigration and Multicultural Affairs
Australian Protective Service
Australian Customs Service Coastwatch

Audit Report No.33 Performance Audit
Commonwealth Management of the Great Barrier Reef
Great Barrier Reef Marine Park Authority

Audit Report No.34 Performance Audit
New Submarine Project
Department of Defence

Audit Report No.35 Performance Audit
DEETYA International Services
Department of Employment, Education, Training and Youth Affairs

Audit Report No.36 Performance Audit
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July to December 1997
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Audit Report No.37 Performance Audit
Protection of Confidential Client Data from Unauthorised Disclosure
Department of Social Security
Centrelink

Audit Report No.38 Performance Audit
Sale of Brisbane Melbourne and Perth Airports

The Auditor-General

Purchase of Hospital Services from State Governments

Department of Veterans' Affairs

Australian National Audit Office

ISSN 1036-7632

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Australian National
Audit Office

Canberra ACT
17 April 1998

Dear Madam President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit of the Department of Veterans' Affairs in accordance with the authority contained in the *Auditor-General Act 1997*. I present this report of this audit, and the accompanying brochure, to the Parliament. The report is titled *Purchase of Hospital Services from State Governments*.

Yours sincerely

P. J. Barrett
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

AUDITING FOR AUSTRALIA

The Auditor-General is head of the Australian National Audit Office. The ANAO assists the Auditor-General to carry out his duties under the *Auditor-General Act 1997* to undertake performance audits and financial statement audits of Commonwealth public sector bodies and to provide independent reports and advice for the Parliament, the Government and the community. The aim is to improve Commonwealth public sector administration and accountability.

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Part Three

Abbreviations and Glossary

Abbreviations

Act	*Veterans' Entitlements Act 1986*
ACHS	Australian Council of Healthcare Standards
ANAO	Australian National Audit Office
AN-DRG 3	Australian National Diagnosis Related Groups, version 3
Commission	Repatriation Commission
CPI	Consumer Price Index
DoFA	Department of Finance and Administration
DRGs	Diagnosis Related Groups
DH&FS	Department of Health and Family Services
DVA	Department of Veterans' Affairs
HCP	Hospital Casemix Protocol
HIC	Health Insurance Commission
ICD	International Classification of Diseases
IT	Information technology
LMO	Local Medical Officer
MAB/MIAC	Management Advisory Board/Management Improvement Advisory Committee
NATMOC	National Treatment Monitoring Committee
PFA	Prior Financial Authorisation
RAH	Repatriation Auxiliary Hospital
RGH	Repatriation General Hospital
RPPPs	Repatriation Private Patient Principles
RPPS	Repatriation Private Patient Scheme
TAS	Treatment Accounts System

Definitions

Accreditation	Accreditation with the Australian Council on Healthcare Standards as evidenced by a certificate of accreditation issued by the Council.
Arrangement	The Commonwealth (Repatriation Commission) has entered into detailed formal agreements of a contractual nature with certain State governments concerning the provision of treatment, care and welfare of eligible persons.
Block funding	Block funding refers to a fixed amount of funding given by DVA to State governments for an agreed volume of separations. The degree of complexity of the hospital treatment performed on the veteran is not taken into account. For example, an ingrown toe nail operation would count as one separation, as would a triple bypass cardiac operation.
Casemix	An information tool involving the use of scientific methods to build and make use of classifications of patient care episodes. In popular usage, the mix of types of patients treated by a hospital or other health care facility.
Department of Veterans' Affairs	DVA provides administrative support to the Repatriation Commission in discharging its responsibilities to veterans and other entitled persons.
Discharge planning	The planning of post hospitalisation treatment, care and welfare of a hospital patient.
Gold Treatment Card (Gold Card)	The Repatriation Health Card - For All Conditions (gold). Provides eligibility for all conditions. It is granted if a person: • receives a Disability Pension at 100 per cent of the General Rate or higher; or • receives a Disability Pension at 50 per cent of the General Rate or higher and any amount of Service Pension; or • is an ex Australian Prisoner of War; or • is a First World War veteran; or • receives of a War Widow/er's Pension; or • is a female Second World War veteran with qualifying service; or • is an Australian veteran on a Service Pension with income and assets which satisfy the treatment benefits limits.
Prior Financial Authorisation	Prior financial authorisation from DVA is required before a 'White Card' veteran gains admission to public hospitals.
Private patient	An eligible veteran who has shared-ward hospital accommodation and the choice of attending specialist.

Repatriation Commission	Responsible under the *Veterans' Entitlements Act 1986* for granting pensions, allowances and other benefits, providing treatment and other services through hospital and community facilities, providing advice to the Minister on matters relating to the Act's operation and, subject to the Minister's control, generally administering the Act.
Repatriation General Hospitals	Major tertiary teaching hospitals providing a full range of acute surgical and medical care to veterans, their dependants; and, in latter years, community patients. Formerly owned and operated by the Repatriation Commission.
Repatriation Auxiliary Hospitals	Supporting hospitals formerly owned and operated by the Repatriation Commission for patients not requiring acute surgical or medical care.
Repatriation Private Patient Principles	The Repatriation Private Patient Principles are prepared under section 90A of the *Veterans' Entitlements Act 1986* (VEA). They set out the circumstances in which, and conditions subject to which, private patient care may be rendered to eligible veterans under Part V of the VEA (see Appendix D).
Separation	As defined in the Arrangements, a separation is a complete episode of care and may involve stays in more than one hospital. Readmission to hospital within 24 hours of discharge counts as only one separation.
Tertiary hospitals	Teaching and research hospitals which offer a full range of acute surgical and medical care.
White Treatment Card (White Card)	Provided to Australian and other veterans who are ineligible to receive treatment for all conditions. It is issued where particular disabilities have been accepted as war-caused.

Part One

Summary and Recommendations

Audit Summary

Background

For over seventy years hospital services for eligible veterans[1] and their dependants were primarily provided by institutions owned by the Repatriation Commission. In 1989 the Commonwealth Government decided that Repatriation hospitals should be integrated into State public hospital systems. Hospital services for veterans would be provided by public hospitals under Arrangements with each State and by private hospitals under contracts.

Since then, the Repatriation Commission has handed over to the States, sold to the private sector, or closed and disposed of all six Repatriation General Hospitals (RGHs) and nine other Repatriation Commission facilities (see Appendix A). Three hospitals have been sold to the private sector. The purchase of hospital care services from State governments and from the private sector for eligible veterans and their dependants is managed by the Department of Veterans' Affairs (DVA) on behalf of the Repatriation Commission.

DVA has entered into Arrangements with four States for the provision of hospital services by public hospitals to eligible veterans and their dependants. The Arrangements provide for the admission of eligible veterans as private patients. This status gives a veteran the choice of attending specialist, and hospital accommodation in a shared ward. In the other two States DVA has entered into contracts with the owners of the privatised former Repatriation General Hospitals for the provision of services to veterans and their dependants. The Repatriation Commission also effected an exchange of letters with Western Australia concerning the provision of all public hospital services in that State. DVA has no formal Arrangements with the governments of Queensland, the Northern Territory or the Australian Capital Territory, other than those embodied in the Medicare agreements. In these jurisdictions veterans are treated in public hospitals on a fee for service basis. The audit concentrates on those States where there are contract Arrangements in place.

Purchases of hospital services for veterans and their dependants totalled $766m in 1996-97, with $418m of services being provided by public hospitals

[1] Except where otherwise specified, references to veterans relate to those who are eligible for treatment through the Repatriation Commission. The term is also used to include eligible war widows and widowers, as well as their eligible dependants.

and $349m of services provided by private hospitals. For 1997-98, DVA anticipates that expenditure on services provided by public hospitals will be in the order of $399m, while expenditure on private hospital services is expected to be about $443m.

Audit objectives and criteria

Veterans may receive hospital care at Repatriation Commission expense where they satisfy certain eligibility requirements. This audit focuses on arrangements for veterans who satisfy these requirements. The ANAO notes that, in common with the general community, veterans and their dependants can also receive public hospital care under Medicare.

The objectives for the audit were to assess the:

- economy, administrative effectiveness, and accountability of DVA's management of the purchase of hospital services from State and Territory governments; and
- strategies adopted by DVA to manage change associated with its purchase of hospital care services from State and Territory governments.

Criteria for the audit were developed from DAS Purchasing Guidelines and DoFA documentation on the purchaser-provider model, from examination of previous external and internal audit coverage in DVA, and from experience in other ANAO audits. The twin aims were to provide assurance to stakeholders and to identify any area in which improvements could be made to achieve better results.

Audit conclusion

Economy

Subsequent to the decision to integrate the RGHs into public hospital systems, DVA identified possible savings of $1bn over 10 years. This was based primarily on the divestment of the RGHs, the integration of the majority into public hospital systems, reductions in expenditure achieved through the sale of RGH Greenslopes and RGH Hollywood, and the introduction of the Repatriation Private Patient Principles. DVA has not attempted to quantify the savings achieved but, given that outcomes are consistent with the savings projections, DVA is satisfied that significant savings have been made as a result of moving towards a broad purchaser/provider model for hospital services.

The ANAO agrees that significant savings have been achieved but is unable to verify the full extent due to the limited supporting documentation available.

Administrative effectiveness

The ANAO found that the administrative effectiveness of DVA's management of the purchase of hospital services from State and Territory governments generally was sound. However, the ANAO found scope for progressive improvement in the following areas:

- a more comprehensive penalty regime and additional incentives for superior performance as part of the Arrangements with the States; and
- processes to complete reconciliations of services claimed by the States within the time frames specified in the Arrangements.

Accountability

The ANAO concluded that DVA is meeting its reporting obligations on its purchase of hospital services from State and Territory governments. However, the ANAO found that DVA is experiencing difficulties in developing performance indicators that reflect its performance in ensuring the quality of hospital services provided to eligible veterans and their dependants by public hospitals. The information available for some existing performance indicators published in DVA's annual report is not comprehensive enough to allow a reasonably informed assessment of DVA's performance by stakeholders. The ANAO has consequently recommended improvements to DVA's performance indicators.

DVA is not required by any reporting guidelines to make public that it is spending in the order of $400m annually on the purchase of hospital services from State governments. Details of this expenditure are not published but are available on request. To improve transparency in public expenditure, there would be value in the Department publishing more detail about these outlays.

Strategies for change

There are major changes occurring in Australia in the way health services are funded, purchased and delivered. The ANAO noted that DVA is both anticipating and initiating change in service delivery. It has a number of strategies in place to manage such change in its purchase of hospital care services from State and Territory governments.

Key Findings

Cost of services provided by public hospitals has fallen

The ANAO noted that DVA expenditure on public hospitals and Repatriation General Hospitals, in 1996-97 prices, peaked at $658m in 1993-94 and declined by 36 per cent to $418m in 1996-97. Costs per service provided, in 1996-97 prices, peaked at $5 292 in 1993-94 and declined by 17 per cent to $4 397 in 1996-97. The number of services provided in public hospitals has fallen by 17 per cent from 127 412 in 1992-93 to 105 655 in 1996-97.

Factors influencing the fall in public sector expenditure and the level of services provided include:

- the sale of two RGHs to the private sector;
- the gradual shift of veterans away from the former RGHs, to benefit from access to public and private hospital services closer to their place of residence and support; and
- efficiency gains resulting from the integration of the former RGHs into State hospital systems.

Increased purchases from private sector

Purchase of hospital services for eligible veterans and their dependants totalled $766m in 1996-97, with $418m provided for public hospitals and $349m for private hospitals. The ANAO noted that there was a large decrease in percentage terms in DVA's purchase of services from the public sector and a corresponding increase in expenditure in the private sector. In 1992-93, 83.3 per cent of DVA's total hospital expenditure related to public hospitals (including the RGHs) and 16.7 per cent related to private hospitals. By 1996-97, the divestment of the RGHs and other factors led to 54.5 per cent of DVA's total hospital expenditure being related to public hospitals and 45.5 per cent related to private hospitals.

The value of services provided by private hospitals rose from $118m in 1992-93 to $349m in 1996-97. Over the same period, the number of services provided in private hospitals has more than doubled, from 52 263 in 1992-93 to 123 730 in 1996-97.

Arrangements with States need better penalties and incentives

The Arrangements with the States are agreements that require performance by both parties. The Arrangements, like any comprehensive agreement, require clearly defined penalties for non-performance and incentives to encourage superior performance. There are penalties and incentives in the

current Arrangements. However, the ANAO noted examples of non-compliance where penalties would have been useful, but did not exist. The ANAO considers there is scope for the Commonwealth's interests to be better protected by the inclusion of a more comprehensive penalty regime, and additional incentives to encourage superior performance in service delivery.

Reconciliations not completed in a timely fashion

DVA's Arrangements with New South Wales, South Australia and Victoria involve block payments based on the number of veteran separations in any one year. Establishing the number of separations that should be counted for payment purposes involves a reconciliation process between the separations claimed by each State and departmental eligibility and approval records, as well as the exclusion of any episodes that are outside the scope of the Arrangements.

The ANAO noted that at the time of the audit field work (third quarter 1997) these reconciliations had not been completed. Part of the problem was due to the late supply of the required data by the States, but part was due to delays in the development of the required IT systems by DVA. DVA anticipates that the difficulties identified will be overcome in 1998.

The mechanisms in place to ensure value for money could be made more effective

The ANAO concluded that there have been adequate mechanisms in place to provide assurance that DVA is getting value for money. Moreover, DVA's previously incomplete knowledge of the full cost of treating eligible veterans in public hospitals will be overcome when the Department assumes the full funding of the cost of veterans' hospital care in July 1998. DVA will then have scope to ensure that these mechanisms operate more effectively and provide greater accountability for performance value. The ANAO noted that the cessation of block funding could also provide opportunities to the Commonwealth to seek more cost-effective and efficient Arrangements.

Risks are being managed

Although there was no formalised risk management strategy in place in DVA when the Arrangements with the States for the provision of hospital services were signed, all major risks were identified and counter measures put in place. In late 1996 a more systematic and effective approach to risk management was introduced by DVA. This methodology has yet to be applied to the purchase of hospital care services from State governments.

Quality of care is monitored

The quality of care provided to eligible veterans and their dependants is important to DVA. The ANAO noted that DVA monitors the access to and quality of hospital care arranged for entitled persons. Primary tools in this process are the National and State Treatment Monitoring Committees which meets two to three times a year. DVA relies on State health departments to monitor and maintain clinical standards in public hospitals.

Benchmarking of suppliers of hospital services is in progress

The ability to compare hospital services between suppliers will have important benefits for DVA. It will give the Department the tools to monitor the standard and quality of public hospital care provided to veterans, facilitate possible moves towards Casemix payments, and make informed judgements about the relative cost-effectiveness of the public and private sectors. The ANAO noted that DVA has begun benchmarking services provided by private hospitals and has plans to benchmark hospital services purchased from State public hospital systems. DVA has initiated the development of a sophisticated data repository to assist in benchmarking hospital services.

Performance indicators can be improved

DVA has three performance indicators in place covering the purchase of hospital services from State governments. However, two of these indicators are limited by incomplete data while the third is only indirectly relevant to the purchase of services from public hospitals. There is no performance indicator for cost effectiveness. The report recommends ways in which the performance indicators could be improved. The ANAO recognises that DVA faced difficulties in developing satisfactory performance indicators in that:

- quality is an outcome of the performance of hospitals rather than being directly related to the performance of the Department; and
- there was insufficient knowledge to allow the development of performance indicator(s) for cost effectiveness.

Change is anticipated and managed

There are major changes occurring in Australia in the way health services are funded, purchased and delivered. The ANAO noted that DVA is both anticipating and initiating change in service delivery. It has a number of strategies in place to manage such change in its purchase of hospital care services from State and Territory governments.

There are lessons for other Commonwealth agencies purchasing services from State governments

The audit attempted to identify such lessons for other agencies purchasing services from State and Territory governments.

Recommendations

The audit makes nine recommendations for improvement. DVA has accepted all recommendations.

DVA's comments

The broad directions reflected in the report are consistent with the objectives of the Repatriation Commission and the Department of Veterans' Affairs, and the audit team noted the significant developments under way at the time of their work on the audit.

Recommendations

Recommendation No. 1 Para. 3.24

The ANAO recommends that the Department seek the introduction of a more comprehensive penalty regime, and additional incentives to encourage superior performance in all future DVA Arrangements with the States, to strengthen the Commonwealth's capacity to achieve its objectives.

DVA response: Agreed.

Recommendation No. 2 Para. 3.30

The ANAO recommends that where possible, in instances where Commonwealth money is paid to a State for particular purposes, such as for capital programs, the Arrangement and/or the supporting documentation should include details of:

- the purpose for which the payment is made;
- the time frame in which the money is expected to be spent; and
- the consequences if the purpose or time frame is not met.

DVA response: Agreed.

Recommendation No. 3 Para. 3.43

The ANAO recommends that, where accurate and timely data is received, DVA complete reconciliations of public hospital separations data within the time frames specified by the Arrangements with the States, to ensure that the Commonwealth pays the correct amounts to State governments for the provision of their services.

DVA response: Agreed.

Recommendation No. 4 Para. 3.49

The ANAO recommends that DVA, to facilitate reconciliations, ensure that appropriate IT systems are in place at the latest shortly after the commencement of new Arrangements with the States.

DVA response: Agreed.

Recommendation No. 5 Para. 3.53

The ANAO recommends that DVA review its current allocation of responsibilities for the reconciliation of Commonwealth and State data.

DVA response: Agreed.

Recommendation No. 6 Para. 3.60

The ANAO recommends that future Arrangements with the States should include provisions to ensure the supply of the public hospital data required by DVA to make informed judgements on the cost and quality of alternate suppliers of hospital services.

DVA response: Agreed.

Recommendation No.7 Para. 4.9

The ANAO recommends that DVA include in its annual report the number of complaints received by Treatment Monitoring Committees, to allow readers to more fully understand DVA's performance indicator on the investigation of these complaints.

DVA response: Agreed.

Recommendation No. 8 Para. 4.17

The ANAO recommends that DVA ensure that it has adequate systems in place to monitor progress in data reconciliation, and develop a performance indicator to allow an assessment of the timeliness of its performance in reconciling claims submitted by the States.

DVA response: Agreed.

Recommendation No. 9 Para. 5.27

The ANAO recommends that DVA ensure that staff have a sound knowledge and understanding of DVA's strategy for monitoring clinical standards in public hospitals.

DVA response: Agreed.