The Auditor-General
Audit Report No.43 2004–05
Performance Audit

Veterans' Home Care

Department of Veterans' Affairs

Australian National Audit Office

ISSN 1036–7632

ISBN 0 642 80840 6

Australian National
Audit Office

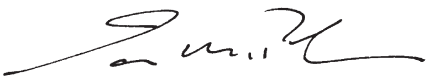
Canberra ACT
17 May 2005

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in the Department of Veterans' Affairs in accordance with the authority contained in the *Auditor-General Act 1997*. Pursuant to Senate Standing Order 166 relating to the presentation of documents when the Senate is not sitting, I present the report of this audit and the accompanying brochure. The report is titled Veterans' Home Care.

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely



Ian McPhee
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

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Contents

Abbreviations

Agency	Regional Assessment and Coordination Agency
ANAO	Australian National Audit Office
CACP	Community Aged Care Package
DVA	Department of Veterans' Affairs
ESO	ex-service organisation
HACC	Home and Community Care
Health	Department of Health and Ageing
IT	Information Technology
LMO	local medical officer
RSL	Returned and Services League of Australia
UNSW Evaluation	University of New South Wales, September 2003, *Veterans' Home Care Evaluation Final Report*, UNSW, Sydney
veteran	For the purposes of this paper, 'veteran' includes Australian defence force veterans and mariners, and war widows/widowers of Australian defence force veterans and mariners.
VHC	Veterans' Home Care
VHC Guidelines	Department of Veterans' Affairs, December 2003, *Veterans' Home Care Guidelines*

Summary and Recommendations

Summary

1. War veterans are valued and important members of our society. At 30 June 2004, there were almost half a million Australian veterans. The second of the Department of Veterans' Affairs' (DVA) five outcomes is related to health of veterans, and states that:

> Eligible veterans, serving and former defence force members, their war widows and widowers and dependants have access to health and other care services that promote and maintain self sufficiency, well-being and quality of life.[1]

2. Under this outcome, DVA works with providers, the veteran and service communities to ensure that programs meet the needs of veterans and serving and former members of the Australian Defence Force.[2] DVA provides a range of health and community care services for eligible veterans, including community nursing, in-home and residential respite, allied health services, home modifications and transport for health care.

Veterans' Home Care

3. One of the programs administered by DVA, which contributes to the health outcome mentioned above, is Veterans' Home Care (VHC). VHC was announced in the 2000-01 Federal Budget and commenced in January 2001. In 2004–05, the program's budget is $85 million.[3]

4. The aim of VHC, which is consistent with the Australian Government's general principle of supporting people to remain longer in their own homes, is:

> to enhance the independence and health outcomes of veterans by reducing the risk of avoidable illness and injury and assisting them to remain independent in their own homes as long as possible.[4]

5. The objectives of the program are to:

- provide a comprehensive, coordinated and integrated range of basic maintenance and support services to eligible veterans;

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1 Department of Veterans' Affairs, 2005, *Portfolio Additional Estimates Statements 2004-05*, *Department of Veterans' Affairs (Defence Portfolio),* DVA, Canberra, p.33.

2 Department of Veterans' Affairs, 2004, *Portfolio Budget Statements 2004-05*, *Department of Veterans' Affairs (Defence Portfolio),* DVA, Canberra, p.57.

3 This amount excludes funding for respite care. Respite care is administered through VHC, but is funded separately. In 2003-04, $14 million was expensed on respite services through VHC.

4 Department of Veterans' Affairs, December 2003, *Veterans' Home Care Guidelines*, DVA, Section 1.2.1. Note: hereafter these Guidelines will be referred to as the 'VHC Guidelines'.

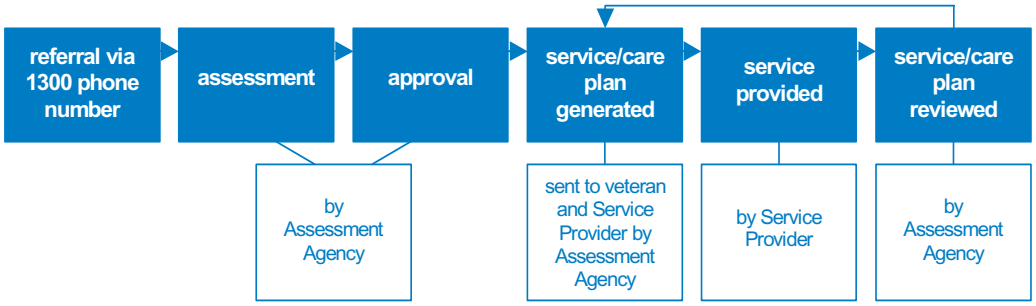
- provide flexible, timely services that respond to the health care needs of eligible veterans;
- target eligible veterans not using services who are experiencing some difficulties with acts of daily living; and
- close the loop in DVA's provision of holistic health care and support to the veteran community.[5]

6. Access to VHC is not automatic. To be assessed for VHC services a person must have a Gold or White Repatriation Health Card and be an Australian defence force veteran or mariner, or a war widow/widower of an Australian defence force veteran or mariner.

7. To deliver VHC, DVA has contracted with 29 Agencies and over 250 Service Provider organisations across the 54 VHC regions. DVA pays Agencies on the basis of a standard fee for assessment and coordination for each veteran, and pays Service Providers a standard fee for each hour of service provided to veterans. In addition, veterans pay the Service Provider a co-payment for each hour of service received.[6] The main steps in the VHC process, from assessment to service provision, are shown in Figure 1.

Figure 1

The VHC process (simplified)–from assessment to service provision



Source: ANAO.

8. The services available through VHC are domestic assistance, personal care, home and garden maintenance, and respite care.[7] In 2003–04 almost 70 000 veterans were approved for VHC services. The majority of veterans are approved for domestic assistance (85 per cent in 2003–04), while the majority of the almost four million hours in services approved were for domestic

[5] VHC Guidelines, Section 1.2.2.

[6] The copayment is subject to certain limits and depends on the type of service received.

[7] The services are defined in Appendix 1.

assistance (52 per cent) and respite (43 per cent). On average, veterans were approved for around 58 hours of services in 2003–04 at a cost of $1 235.[8]

Audit objective and methodology

9. The objective of the audit was to form an opinion about DVA's management of the current and future demand for VHC services. To form an opinion, the Australian National Audit Office (ANAO) examined whether DVA:

- effectively planned the distribution of VHC resources;
- distributed VHC resources according to its planning; and
- monitored and evaluated how effectively it managed the demand for VHC services.

10. To form an opinion against the audit objective, the ANAO interviewed DVA personnel, examined DVA documents, interviewed personnel at a selection of Agencies, Service Providers and stakeholders, and reviewed relevant literature.

[8] Includes respite care.

Key Findings

Planning and coordinating Veterans' Home Care (Chapter 2)

11. In 2000, DVA developed a reasonable approach to estimate the number of veterans it expected to receive VHC services, and developed budgets for services based on this estimate. However, the ANAO found that there is scope for DVA to develop a comprehensive profile of the eligible VHC veteran population. By doing so, DVA would be in a better position to refine the budgetary model. In addition, a profile would assist DVA to identify eligible veterans and provide these veterans with information about VHC. Profiling would also assist DVA's planning for VHC and ensure that those veterans most in need are receiving VHC services.

12. Since VHC is a budget-capped program and veterans are not automatically entitled to receive services, DVA managed information about the program to ensure that it did not raise expectations which it could not meet. The ANAO found that while DVA has provided information to veterans, it has not evaluated whether this communication has been effective in reaching all eligible veterans or whether the information distributed was clear, accurate and appropriate.

13. One of DVA's main sources of data about VHC and veterans receiving services is the information entered online onto the standard veteran assessment form. DVA does not require contracted Agencies to ask veterans all questions on the form, which affects the consistency of data produced by the VHC systems. In addition, the ANAO found that DVA does not aggregate the information. Therefore, DVA does not maximise use of information gathered through the assessment form. This inhibits its ability to describe the characteristics of veterans in the program, evaluate VHC service levels, and plan for the delivery of VHC in the future. As part of its current review of the assessment form, DVA is considering these issues, including the number of mandatory questions on the form.

14. VHC is one of a range of community care programs available to veterans. The ANAO found that there were a number of factors that hampered effective coordination and integration of VHC and other community services. These included limited data about how veterans enter VHC and why they leave; the lack of strategies to move veterans to other programs when appropriate; and the absence of strong links with other relevant programs. Program coordination and integration are recognised as challenging issues across the community care sector. However, improved coordination between

VHC and other services would assist DVA to achieve an integrated response to caring for veterans.

Veterans' Home Care budgets and fees (Chapter 3)

15. The ANAO found that DVA's method of distributing funds to Agencies to provide services was reasonable. For the first two financial years, regional budget allocations for service provision were based on the estimated number of VHC recipients in each region and an estimate of the cost of services. From 2002–03, regional budget allocations have been based on the actual number of veterans receiving services in the previous financial year and the actual cost of providing those services.

16. In the latter part of 2002, VHC service provision budgets came under heavy pressure. The ANAO found that the reasons for this pressure include the higher than estimated cost of providing services to veterans who transferred from Home and Community Care (HACC)[9] compared to other veterans, and the difficulty of referring veterans to other programs, when appropriate. In response, DVA implemented a number of strategies to relieve the pressure on the budget and improve budget management. These strategies included: the introduction of a recommended benchmark of 1.5 hours of domestic assistance a fortnight; ceasing the grandfathering arrangements for veterans transferring from HACC; the ability to recredit unused hours of service; and the introduction of a notional budget buffer that allowed Agencies to approve services above their nominal budgets. The effect of these budget management strategies was a decrease in the hours of service approved nationally.

17. The ANAO found that DVA's primary financial control over payments to contractors relied on the Agency and Service Provider reporting to DVA when inaccurate payments had been made. Other financial controls were limited and did not prevent inaccuracies occurring in claims submitted by contractors.

18. DVA revised the fees paid to Agencies and Service Providers in 2003, increasing the fee amount and introducing an annual increment. DVA has not evaluated the effect of the fees model on the distribution and quality of services provided to veterans.

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[9] A veteran transferring from HACC is a veteran who was receiving services under Health's HACC program before transferring to VHC. When these veterans transferred to VHC, they retained their existing level of service. This is referred to as 'grandfathering'.

Assessing and approving Veterans' Home Care services (Chapter 4)

19. The ANAO found that the standard assessment form was adequate for straightforward assessments, but was not as effective for more complex cases, such as when the veteran had higher-level care needs, or hearing or cognitive problems. The VHC Guidelines, which were distributed to all Agencies, were clear and understandable and allowed flexibility to adapt to local initiatives. However, this flexibility meant that the VHC Guidelines did not contain details about how prescribed service levels should be applied, which caused uncertainty for some Agencies. Consequently, the ANAO found that some Agencies had developed their own service approval guidelines to supplement the VHC Guidelines, often without advice from, or in consultation with, DVA.

20. The ANAO found that there have been significant variations in service levels across regions. Possible reasons for these variations include, *inter alia*, regional differences such as locality and availability of other care programs and providers, and inconsistent application of the VHC Guidelines. The ANAO found that DVA has not analysed the available VHC data to identify why these variations are occurring, nor has it set boundaries within which it considers variations to be acceptable or valid.

21. The ANAO ascertained that veterans were assessed and received services in a timely manner, with the majority of veterans assessed within one week of referral and receiving services within three weeks of approval for services. However, DVA only collected waiting list data on veterans who were involved in some stage of the VHC process. It did not actively promote the program. Therefore, the ANAO considers that the number of veterans applying for assessment or services was limited This, in turn, limits the number of people waiting for assessment or services.

Monitoring and evaluating Veterans' Home Care (Chapter 5)

22. The ANAO found that DVA uses a number of mechanisms to monitor the quality of services, including contract management visits, reporting from Agencies and Service Providers, complaints and client surveys. Overall, the ANAO found that DVA's quality assurance mechanisms do not set parameters for controlling or monitoring variations in the program. When reviewing these mechanisms, the ANAO found that DVA's contract management visits to Agencies and Service Providers have been infrequent and that reporting from Agencies and Service Providers has been irregular. Complaints about VHC were, generally, relatively minor and were resolved quickly. However, the ANAO found that DVA did not collect and effectively use stakeholders' comments about the program.

23. DVA has not evaluated whether VHC is meeting its aim of enhancing the independence and health outcomes of veterans by reducing the risk of avoidable illness and injury and assisting veterans to remain independent in their own homes as long as possible. However, DVA has reviewed various aspects of VHC since its inception in 2001. The reviews reported that VHC had made a significant contribution to community-based aged care services in Australia. Importantly, DVA's Veterans' Satisfaction Survey reported high levels of satisfaction with the program.

Overall audit conclusion

24. DVA has taken some positive steps in developing a new approach to delivering services to veterans. VHC includes a standard assessment process, automated claiming for payment, and a standard fees model. Under VHC, veterans are assessed and, if approved, receive services in a timely manner.

25. At the start of the program, DVA estimated the number of veterans to whom it planned to provide VHC services. However, it did not estimate the likely initial demand for such services. During the first 21 months of the program the VHC budget was sufficient to meet demand for services. By late 2002, the demand was such that the VHC budget was under pressure. The main reasons for this were that:

- the information provided to veterans, Agencies, Service Providers and other stakeholders did not effectively communicate that VHC was not an entitlement-based program—veterans needed to meet the eligibility criteria and be assessed as needing services;
- the cost of providing services to veterans who transferred from HACC was higher than expected; and
- it was difficult to transfer veterans to other programs when appropriate.

26. DVA responded to the rising demand and resulting budget pressures by introducing a number of budget management strategies. As a result of these strategies, the hours approved for VHC services decreased nationally.

27. DVA does not effectively collect and use data to assist it to manage the demand for VHC services. The limited reliability and accuracy of the available VHC data restricts DVA's ability to describe the eligible VHC population and to identify or explain variations in service levels between regions, and to assess and manage demand. DVA has not evaluated the effectiveness of its communication to stakeholders or whether it is meeting the program's aims.

28. This report makes seven recommendations aimed at improving DVA's management of the current and future demand for VHC services.

Recommendations

The most important recommendations are two, three and four.

Recommendation No.1
Para. 2.24

The ANAO recommends that DVA identify and profile the veterans eligible for VHC, and use this profile to ensure that those veterans are provided with appropriate information about VHC.

DVA's response: Agreed.

Recommendation No.2
Para. 2.59

The ANAO recommends that DVA develop and implement exit strategies to support the transition of veterans from VHC to other, more appropriate, care when necessary.

DVA's response: Agreed.

Recommendation No.3
Para. 2.61

The ANAO recommends that DVA collect and use data, for example, entry and exit data, to improve integration and coordination and to further assist DVA to manage the current and future demand for VHC services.

DVA's response: Agreed.

Recommendation No.4
Para. 2.63

Recognising DVA's prime Commonwealth responsibility for veterans, the ANAO recommends that DVA adopt the lead role for veterans in developing links between community care providers, with a view to promoting better service delivery to veterans, including exploring common approaches to assessment, regional boundaries and data sharing.

DVA's response: Agreed.

Recommendation No.5
Para. 3.30

The ANAO recommends that DVA implement adequate controls over payments to VHC contractors that provide it with assurance that those payments are accurate.

DVA's response: Agreed.

Recommendation No.6
Para. 5.16

The ANAO recommends that DVA ensure that its contract management procedures satisfy the VHC Guidelines and its contractual agreements with Agencies and Service Providers, particularly in the areas of:

- reporting from Agencies and Service Providers;
- monitoring the quality of VHC services; and
- monitoring regional budgets and Agency budget management.

DVA's response: Agreed.

Recommendation No.7
Para. 5.21

The ANAO recommends that DVA periodically evaluate whether VHC is meeting is stated aims and objectives.

DVA's response: Agreed.

Department of Veterans' Affairs' Response

29. DVA agrees with the overall findings and recommendations of the ANAO report, in particular that DVA has taken positive steps in developing a new approach to delivering services to veterans. This conclusion highlights the Department's ongoing commitment to ensuring that eligible veterans, serving and former defence force members, their war widows and widowers and dependants have access to health and other care services that promote and maintain self-sufficiency, well-being and quality of life.

Audit Findings and Conclusions

1. Introduction

This Chapter describes some of the main features of the VHC program, and provides a background to the audit, including the audit objective, approach and methodology.

Background

1.1 War veterans are valued and important members of our society. At 30 June 2004, there were almost half a million Australian veterans.

1.2 The Repatriation Commission is responsible for the general administration of the *Veterans' Entitlements Act 1986*. The functions of the Repatriation Commission include the granting of pensions, allowances and other benefits, arranging for the provision of treatment and other services, and providing advice to the responsible Minister on matters relating to the operation of the *Veterans' Entitlements Act 1986*. DVA provides administrative support to the Repatriation Commission in discharging its responsibilities to veterans and other entitled people.

1.3 The second of DVA's five outcomes is related to health, and states that:

> Eligible veterans, serving and former defence force members, their war widows and widowers and dependants have access to health and other care services that promote and maintain self sufficiency, well-being and quality of life.[10]

1.4 Under this outcome, DVA works with providers, the veteran and service communities to ensure that programs meet the needs of veterans and serving and former members of the Australian Defence Force.[11] DVA provides a range of health and community care services for eligible veterans, including community nursing, in-home and residential respite, allied health services, home modifications and transport for health care.

Veterans' Home Care

1.5 One of the programs administered by DVA, which contributes to Outcome 2, is VHC. VHC was announced in the 2000–01 Federal Budget and commenced in January 2001. In 2004–05, the program's budget is $85 million.[12]

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[10] Department of Veterans' Affairs, 2005, *Portfolio Additional Estimates Statements 2004-05*, *Department of Veterans' Affairs (Defence Portfolio)*, DVA, Canberra, p.33.

[11] Department of Veterans' Affairs, 2004, *Portfolio Budget Statements 2004-05*, *Department of Veterans' Affairs (Defence Portfolio)*, DVA, Canberra, p.57.

[12] Excludes respite care.

The aim of VHC, which is consistent with the Australian Government's general principle of supporting people to remain longer in their own homes, is:

> to enhance the independence and health outcomes of veterans by reducing the risk of avoidable illness and injury and assisting them to remain independent in their own homes as long as possible.[13]

1.6 The objectives of the program are to:

- provide a comprehensive, coordinated and integrated range of basic maintenance and support services to eligible veterans;
- provide flexible, timely services that respond to the health care needs of eligible veterans;
- target eligible veterans not using services who are experiencing some difficulties with acts of daily living; and
- close the loop in DVA's provision of holistic health care and support to the veteran community.[14]

Eligibility

1.7 Access to VHC is not automatic; that is, not all veterans are eligible to receive VHC services. In June 2004, 345 082 of the 499 900 veterans held Repatriation Health Cards.

Figure 1.1

VHC eligibility criteria

To be assessed for VHC services, a person:	
must be: • a veteran of the Australian defence forces; or • an Australian mariner; or • a war widow/widower of a veteran of the Australian defence forces or an Australian mariner;	and have: • a Gold Repatriation Health Card; or • a White Repatriation Health Card.

Source: VHC Guidelines, Section 2.1.

Agencies and Service Providers

1.8 DVA has contracted with 29 Regional Assessment and Coordination Agencies (Agencies) and over 250 Service Provider organisations across the 54 VHC regions. Each region has one Agency and several Service Providers. Agencies assess veterans for VHC services and develop appropriate

[13] VHC Guidelines, Section 1.2.1.

[14] VHC Guidelines, Section 1.2.2.

coordinated packages of care for veterans assessed as needing VHC. The Agencies are mainly large private and not-for-profit organisations, and local governments.[15] Service Providers provide the VHC services approved by the Agencies. The majority of the Service Providers are medium to large organisations (88 per cent in October 2003) and are also a mix of private, not-for-profit, and local government organisations.

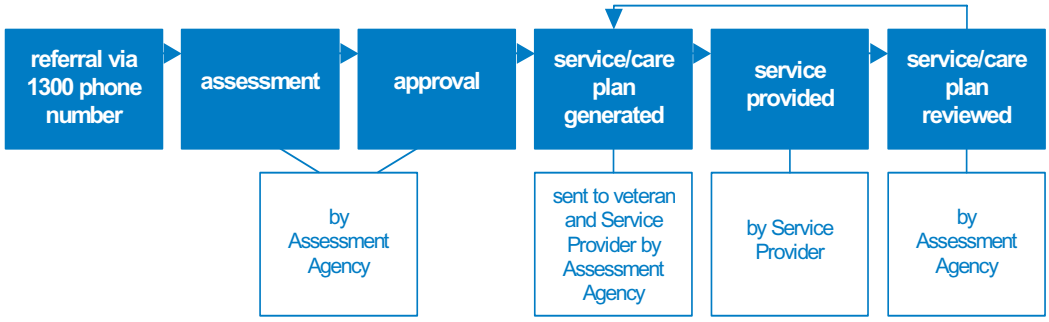
The VHC process

1.9 Since 1985 the HACC program has provided a range of personal, health and domestic services to the frail aged, people with disabilities, and their carers. The Australian Government, through the Department of Health and Ageing (Health), and State and Territory Governments jointly fund the program. When developing the business model for VHC, DVA adopted a different approach to that used in HACC. This included greater use of information technology (IT) and a separation of assessment and service delivery.

1.10 The main steps in the VHC process, from assessment to service provision, are outlined in Figure 1.2.

Figure 1.2

The VHC process (simplified) - from assessment to service provision



Source: ANAO.

1.11 Assessment begins with a veteran being referred to VHC. Referral sources include self-referral, local medical officers (LMOs) and other health professionals, other community services, and family members. Referral is made via a 1300 telephone number at the cost of a local telephone call. The call is automatically routed to the Agency in the veteran's region.

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[15] Organisation size based on the Australian Bureau of Statistics definitions, as follows:

- small business - fewer than 20 employees:
- medium business – between 20 and 200 employees; and
- large business - 200 or more employees.

1.12 A telephone assessment is conducted by Agency staff on-line. That is, the Agency has direct access to the VHC IT system, entering the information directly into the fields on the electronic assessment form (an on-line form). Should a telephone assessment be deemed unsuitable, there is provision for an in-home assessment.

1.13 The Agency then reviews the assessment and recommendation for service type and level, and approves or declines services. The Agency enters the approved service type and level into the VHC system, and selects a Service Provider from the contracted providers in the region.

1.14 The Agency develops a care plan for the veteran, and a service plan for the Service Provider. The care plan lists the services and hours that the Agency has approved for the veteran, and the details of the contracted Service Provider. The service plan lists the veteran's details, the services and the hours approved. The plans are sent to the Service Provider and veteran. On receipt of the service plan, the Service Provider contacts the veteran to arrange for service delivery.

1.15 Agencies are required, by their contracts with DVA, to reassess veterans every six months. During the six-month period, the Agency may conduct additional reassessments if necessary (for example, if the veteran's circumstances change due to hospitalisation or moving house). Following reassessment, care and service plans are revised if necessary, and the process resumes.

Service types

1.16 The services available through VHC are domestic assistance, personal care, home and garden maintenance, and respite care.[16] Agencies approved 69 164 veterans for services in 2003–04. Of these approvals:

- 85 per cent were for domestic assistance;
- 4 per cent were for personal care;
- 19 per cent were for home and garden maintenance; and
- 21 per cent were for respite care services.[17,18]

1.17 Just under four million hours of service were approved in 2003–04. The majority of these hours were for domestic assistance and respite, as illustrated in Figure 1.3. Veterans were approved for an average of 58 hours of services in 2003–04, at an average cost of $1 235 per veteran (including respite).

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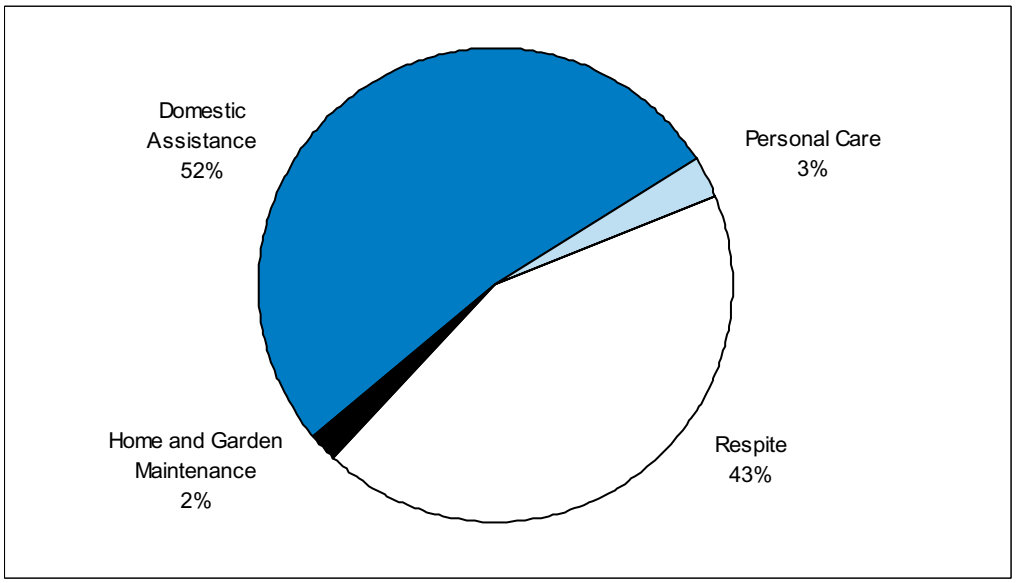
16 The services are defined in Appendix 1 and appear in this order throughout the report.

17 As veterans may receive more than one service type, these percentages add to greater than 100 per cent.

18 Respite care is administered through VHC, but is funded separately. Throughout this report, respite care has been excluded from calculations of budgets or hours of service, unless stated otherwise.

Figure 1.3

VHC hours approved, 2003–04



Source: ANAO analysis of DVA data.

Previous audit coverage

1.18 The ANAO audits the financial statements of DVA annually. Other ANAO performance audits relevant to the health of Australia's veterans include[19]:

- *Management of Repatriation Health Cards*, Department of Veterans' Affairs, No.41, 2003–04;
- *Purchase of Hospital Services from State Governments Follow-up Audit*, Department of Veterans' Affairs, No.37, 2001–02;
- *Home and Community Care Follow-up Audit*, Department of Health and Ageing, No.33, 2001–02;
- *Home and Community Care*, Department of Health and Aged Care, No.36, 1999–2000;
- *Administration of Veterans' Health Care*, Department of Veterans' Affairs, No.29, 1999–2000;
- *Planning of Aged Care*, Department of Health and Aged Care, No.19, 1998–99; and

[19] Audits completed since 1998.

- *Purchase of Hospital Services from State Governments*, Department of Veterans' Affairs, No.40, 1997–98.

1.19 The ANAO is currently conducting an audit of the effectiveness of Health's administration of the National Respite for Carers Program. The ANAO expects to publish the report in mid-2005.

The audit

Audit methodology

1.20 The objective of the audit was to form an opinion about DVA's management of the current and future demand for VHC services. To form an opinion, the ANAO examined whether DVA:

- effectively planned the distribution of VHC resources;
- distributed VHC resources according to its planning; and
- monitored and evaluated how effectively it managed the demand for VHC services.

1.21 To form an opinion against the audit objective, the ANAO:

- interviewed DVA's personnel in DVA's National Office (National Office) and three State Offices (State Offices);
- examined DVA's documents, including files on a selection of Agencies and Service Providers;
- analysed DVA's financial and performance data;
- interviewed personnel at a selection of Agencies and Service Providers;
- interviewed representatives of a selection of stakeholders, including ex-service organisations; and
- reviewed relevant literature, including *A New Strategy for Community Care, The Way Forward*.[20]

1.22 The audit fieldwork was conducted between July and September 2004, in accordance with ANAO Auditing Standards at a cost of $360 000.

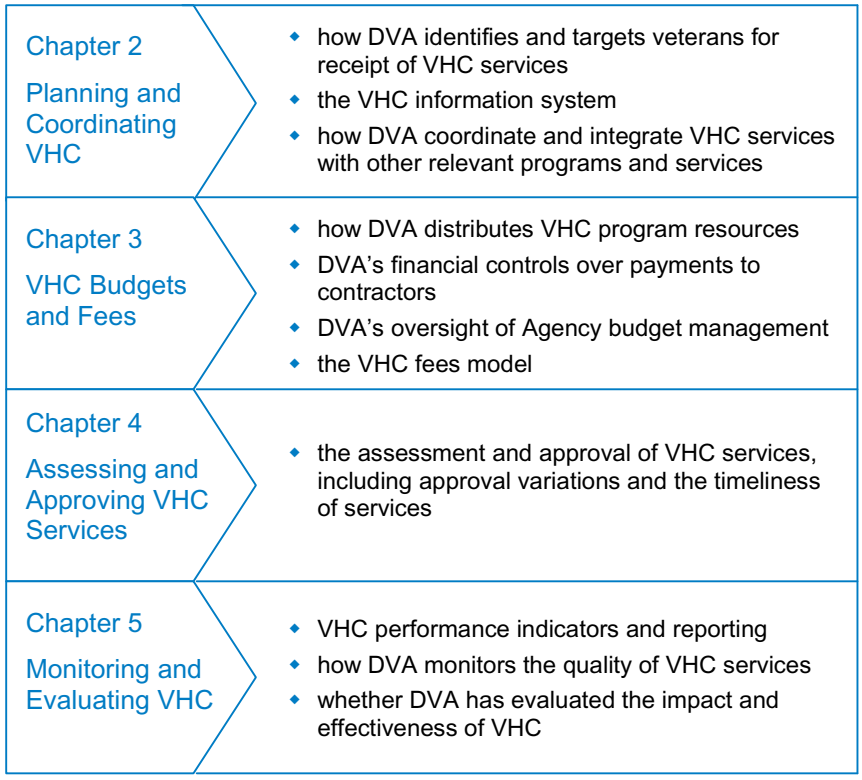
[20] Department of Health and Ageing, 2004, *A New Strategy for Community Care, The Way Forward,* Health, Canberra.

Report structure

1.23 This report is divided into five Chapters, as illustrated in Figure 1.4.

Figure 1.4

Report structure



2. Planning and Coordinating Veterans' Home Care

This Chapter discusses how DVA identifies and targets veterans for VHC services, the VHC information system, and how DVA coordinates and integrates VHC services with other relevant programs and services.

Identifying and targeting

2.1 As a preventative health measure, one of the broad objectives of VHC is to provide basic maintenance and support services for eligible veterans. This includes targeting eligible veterans not using services and who are experiencing some difficulties with acts of daily living: for example, veterans who need assistance with aspects of personal care like showering, or with domestic tasks, like preparation of meals.

2.2 As outlined in Chapter 1, eligibility for VHC is related to the type of Repatriation Health Card held by the veteran. In 2000, immediately before the program commenced, DVA estimated that the number of veterans it expected to receive VHC services would be around 50 000. Figure 2.1 illustrates how this number was derived.

Figure 2.1

DVA's estimates of VHC recipients

Formula	Year 1	Year 2	Year 3
Number of DVA health card holders aged 70 years and older	282 600	279 500	273 000
less veterans in residential care facilities	18 643	19 516	21 368
	263 957	259 984	251 632
multiplied by number of veterans receiving home and community care services from DVA[21] plus an allowance for new veterans who previously had not received any services (expressed as a percentage)	12.5%	12.5%	12.5%
	32 995	32 498	31 454
plus estimate of veterans receiving HACC services	19 500	18 525	17 599
Estimated number of veterans approved for VHC services	52 495	51 023	49 053

Source: ANAO analysis of DVA data.

[21] Before VHC was developed, DVA provided some home and community care services through other programs.

2.3 This formula was used to estimate the number of VHC recipients in each of the 54 VHC regions. Budget projections for 2000–01 and 2001–02 were then developed for the regions based on this estimate and on an estimate of the cost of services. The estimate of the service cost was based on the cost of providing HACC services to the HACC client population aged 70 years and older. DVA's development of the VHC regions was based on the HACC regions as they were at that time. DVA then planned and distributed funds according to this structure, that is, distributing funds directly to regions. In 2000–01 the budget for VHC services was $23.7 million[22], and in 2001–02 it was $47 million. At a regional level in 2004–05, regional budgets for service provision varied from as little as $10 000 to greater than $4 million.

2.4 DVA's estimate of around 50 000 VHC recipients was accurate for the first full year of the program, when 50 028 veterans received VHC services. On a state basis there were variations between the estimated and actual number of VHC recipients. For example, the smallest variation was 51 per cent less than the expected number of veterans in the Northern Territory, and the largest was 131 per cent more than the expected number of veterans in Tasmania for 2001–02. Subsequently the number of veterans receiving services nationally rose to 63 229 in 2003–04. These variations had implications for regional budgets, as discussed in Chapter 3.

2.5 In general, the ANAO considers that the approach used by DVA to estimate the number of VHC recipients and develop regional budgets was reasonable. DVA has not reviewed the original total and state VHC projections of numbers of veterans. Reviewing these projections against actual data would assist DVA to test the validity of its approach to estimating the number of veterans it expects to receive VHC services in the future. Following verification of its approach, the ANAO suggests that DVA develop projections of the expected number of VHC recipients in the medium and longer term at regional and national levels. Given the budget-capped nature of the program, projections would assist DVA to plan for future resource requirements with respect to budgets and delivery capability. This would assist DVA to develop a strategy to manage the current and future demand for VHC services and plan, and budget for, the delivery of those services.

Profiling VHC veterans

2.6 DVA has general information on veterans, such as contact details, the type of Repatriation Health Card held, and some medical history. However, DVA has not developed a comprehensive profile of the VHC target population, although it is considering doing so. The ANAO considers that a

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[22] The VHC program commenced in January 2001, therefore the budget for 2000–01 was for half a year.

veteran profile would include information that is specific to VHC, such as what services eligible veterans received prior to VHC, the services eligible veterans are currently receiving, and how eligible veterans find out about VHC.

2.7 Describing the veteran population in this way would assist DVA to identify eligible veterans, and provide these veterans with information about the program. It would also improve DVA's planning for VHC, enable it to estimate veterans' needs for services, including their average levels of need, and ensure that those veterans most in need are receiving VHC services. This information would enhance DVA's ability to accurately identify and target those veterans who would benefit from VHC, and to further develop plans for program delivery.

2.8 In 2003, a DVA review of the impact of VHC on other DVA programs recommended further analysis of the characteristics of the eligible VHC veteran population in different regions. Additionally, DVA engaged a consultant in October 2004 to develop a method of estimating and projecting the veteran population with more accuracy. The ANAO expect that these reports will assist DVA to determine the characteristics of those veterans receiving VHC services.

Communicating with veterans and stakeholders

2.9 The VHC Guidelines list a number of outcomes for the VHC program. The outcome relating to communication states:

> To ensure that each member of the veteran community is informed about VHC and relevant DVA health services, policies and procedures by developing and implementing effective communication strategies.[23]

2.10 In August 2000, DVA developed a communication strategy for the implementation of VHC. In the communication strategy, DVA stated that the issues of restricted veteran eligibility and the limited budget of the program would be unfamiliar concepts to veterans and stakeholders, and would require careful management.

2.11 As a new program with a new approach to the delivery of community care, there were some concepts about VHC that DVA determined would be unfamiliar to veterans and stakeholders, and would require explanation. For example, unlike other DVA programs, not all veterans would be automatically entitled to receive VHC services. Veterans had to meet eligibility criteria, be assessed, and be approved to receive services. As a means of addressing these

[23] VHC Guidelines, Section 1.3.

matters, the communication strategy stated that DVA would only target VHC eligible veterans with VHC information.

2.12 As demand for VHC services can exceed supply, it was important for DVA to ensure that the information provided to veterans appropriately shaped expectations within the veteran community. This information included veteran eligibility, the process of applying for VHC, and the bases upon which assessment was made and services were approved.

2.13 DVA stated that, during the program's initial implementation, it provided information about VHC to veterans and stakeholders, as opposed to advertising or publicising the program to the wider population. The communication strategy identified several groups to whom it wished to provide information about VHC. These included Australian Gold and White Card holders, and veterans using HACC. DVA also provided VHC information to veterans through other means, including existing HACC and DVA providers, LMOs, ex-service organisations (ESOs), and state and local government. The communication strategy stated that DVA designed specific messages to suit each group. For example, DVA should communicate directly with eligible veterans, and provide them with basic information about the program: and DVA should communicate to LMOs through written correspondence and conferences, informing them about VHC, veteran eligibility, and their referral role.

2.14 Following implementation, DVA used a range of mechanisms to provide information about VHC to veterans and stakeholders. These included articles in selected publications, (for example *Vetaffairs, Veterans' Health, RSL Newsletter),* relevant Health publications, and VHC Fact Sheets. A VHC information kit was also developed and distributed to existing HACC service providers.

2.15 DVA also developed a VHC brochure to provide information to a wide audience. This brochure was withdrawn in early 2003 pending changes to its contents. Since then, many Agencies and Service Providers have expressed a need for a brochure. DVA advised the ANAO that the brochure was being redesigned.

2.16 DVA produced an information video early in the program to inform potential tenderers about the VHC program and the tender process.[24] This video was then edited for circulation as a source of general VHC information. DVA VHC staff have also provided information at various conferences for health professionals and community service providers.

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[24] At the beginning of the program, DVA invited interested organisations to tender for the Agency and Service Provider contracts.

2.17 In ANAO interviews, Service Providers stated some veterans were confused about various aspects of VHC. This confusion related to issues such as veterans' point of contact for the program (whether they should contact DVA, the Agency or their Service Provider); and the difference between HACC and VHC. The ANAO also found evidence of confusing and inconsistent information relating to what tasks might be included within types of VHC services. For example, with home and garden maintenance there was an expectation from veterans and some Agencies that lawn mowing was acceptable. However, the Guidelines state that the focus of home and garden maintenance is to minimise environmental health and safety hazards that impact on the veteran and does not include regular lawn mowing. Initial information did not clearly make this distinction.

2.18 The ANAO found that while DVA has provided information to veterans, it has not evaluated, either specifically or as part of its veteran surveys, whether this communication about VHC has been effective in reaching all eligible veterans. Without this evaluation, DVA does not know if all eligible veterans have received information about the program, whether the information was accurate, appropriate or useful, or whether it achieved one of its broad objectives, which is to successfully target eligible veterans not using services and who are experiencing some difficulties with maintaining themselves in their homes. The ANAO suggest that DVA evaluate the effectiveness of its communication with veterans.

Communicating with Agencies and Service Providers

2.19 When administrative issues arise, DVA communicates with Agencies and Service Providers in a number of ways. One way is through bulletins, which contain details of recent program changes and other relevant information, and which are produced as required. In addition, State Offices communicate with Agencies and Service Providers through their own bulletins and newsletters, through email, over the telephone, and through teleconferences.

2.20 In November 2000, DVA commissioned the University of New South Wales to evaluate VHC (hereafter referred to as the UNSW Evaluation).[25] The UNSW Evaluation identified gaps and inconsistencies in the information DVA provided to Agencies and inadequate communication between DVA and VHC referral sources, such as hospital discharge planners, LMOs, and other health professionals. The UNSW Evaluation concluded that these issues had a negative impact on Agency and Service Provider efficiency, and adversely affected veterans.

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[25] University of New South Wales, September 2003, *Veterans' Home Care Evaluation Final Report*, UNSW, Sydney, page 54.

2.21 For example, when there were issues with the VHC service budget in late 2002, DVA developed a new communication strategy.[26] The strategy stated that DVA expected questions about the program from veterans, ESOs, Agencies, Service Providers and other stakeholders**.** This strategy was a guide for DVA personnel to use when answering questions about changes to the program's budget. The strategy did not require DVA to communicate directly with Service Providers. As budget changes had implications for service provision which would affect veterans, Service Providers informed the ANAO that DVA's approach to communication was frustrating.

2.22 The UNSW Evaluation concluded that VHC required a comprehensive communication strategy to address the issues discussed above. In response, in April 2004, DVA began work on a new strategy to address current communication needs. The new strategy is currently still in draft form. DVA advised that this strategy would clarify any inconsistent DVA messages to Agencies and Service Providers and address the recommendations of the UNSW Evaluation. However, the ANAO considers that implementation of this new strategy is much needed, and encourages DVA to finalise and implement it as a matter of priority.

2.23 DVA has also established a VHC Reference Group to meet three times a year. The VHC Reference Group includes representatives from four Agencies, eight Service Providers, and Health. A function of the group is to advise on improvements to the delivery and management of VHC, including communication between DVA, veterans, Agencies and Service Providers. DVA is also planning an Agency forum in 2005 to assist it to identify communication needs.

Recommendation No.1

2.24 The ANAO recommends that DVA identify and profile the veterans eligible for VHC, and use this profile to ensure that those veterans are provided with appropriate information about VHC.

DVA's response

2.25 Agreed. The Department has a range of processes in place to ensure that veterans eligible for VHC are identified and provided with information about the program. The Department has ongoing arrangements, through a range of forums and committees, with care providers, general practitioners, ex-service organisations, etc, where details on DVA's programs, including VHC, are made available. In addition, the Department has written to every eligible veteran providing information on the VHC program, through its

[26] These issues are discussed in greater detail in Chapter 3.

Vetaffairs publication, on several occasions (*Vetaffairs* is mailed to every veteran who receives a benefit from DVA, including gold and white card holders and recipients of DVA pensions and allowances).

Information Technology and data

DVA's information system

2.26 DVA's administration of VHC relies significantly on IT, including the Internet. The program is a part of DVA's overall IT strategy, which is to make greater use of the Internet in service delivery.[27] DVA refers to its existing client database for VHC. Agencies and Service Providers access VHC systems through the Internet.[28] Agencies use an Agency specific system with links to the client database to check veterans' eligibility and conduct veterans' assessments. DVA then uses this assessment information to calculate payments to Agencies. Service Providers access a separate web-based application to submit payment claims for VHC services they provided. To help Agencies and Service Provider use the VHC systems, at the beginning of the program DVA provided them with IT training and manuals.

VHC data from assessment

2.27 As all VHC transactions take place within the VHC systems, these are the main source of VHC data and reporting. Veteran details from the assessment process, Agency and Service Provider contract details, and program administration details are stored within these systems.

2.28 During assessment an Agency assessor completes an online assessment form for each eligible veteran, using information supplied by that person. The online assessment form is a standard form used for each VHC assessment. The assessor works through a series of questions with the veteran, and records the answers. DVA does not require Agency assessors to ask all questions in the assessment form. DVA informed the ANAO that as a result of this, some assessors do not complete the form, asking only those questions necessary to assess the veteran's needs.

2.29 The mandatory and non-mandatory fields on the assessment form affect the consistency of data produced the VHC systems. For example, it is possible that veterans who are in similar circumstances and who are being assessed for the same services will be asked different questions. While all

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[27] Department of Veterans' Affairs, 2003-04, *IT Strategic Plan 2003-04,* DVA, Canberra.

[28] Each VHC System user requires their own individual logon identification and passwords. To gain these, Agency and Service Provider staff are required to complete a VHC System Access Request Form and Confidentiality Deed, and provide these forms to DVA.

veterans will be asked the series of mandatory questions, any other questions asked are at the discretion of each Assessor. This inconsistency and the fact that DVA does not aggregate the data provided by Agencies via the VHC systems means that DVA cannot effectively use all information gathered through the online assessment form. Notwithstanding, the systems are a valuable information source for VHC. Information received during veterans' assessments could assist DVA to create a VHC veteran profile. This would assist DVA to accurately target veterans, evaluate VHC service levels, and evaluate the program. DVA is currently reviewing the assessment form, including the issue of mandatory fields.

Reports produced by DVA

2.30 Through the VHC systems, National Office produces reports for State Offices, which then provide information to Agencies and Service Providers. These reports include:

- Agency budgets;
- status of approvals, assessments and reviews;
- service levels and service standards;
- service plan details;
- client numbers; and
- monthly reports showing the percentages of services approved and those pending.

2.31 In ANAO interviews, State Offices said that their capacity to produce reports from the VHC system was limited, and because they had to request reports as required this led to inefficiencies. National Office informed the ANAO that reports are produced in this way to ensure consistency of interpretation and to reduce demand on the system. The ANAO found that the reports provided by National Office for State Offices required detailed manipulation by State Offices in order to be useful to contract managers and to Agencies. This data manipulation included changing the format of a report so it is relevant to a particular region. Some State Offices invest five to six hours per month formatting reports in this way, and stated to the ANAO that this amount of time was problematic, and it would be more efficient if they could access and provide the exact information that they required. DVA has enhanced its data management system and informed the ANAO that this new system will be available to State Offices in early 2005. The new system should improve reporting at National and State Office level.

Agency and Service Provider reporting to DVA

2.32 Agencies and Service Providers are required by their service agreements to report to DVA every six months. Under the VHC Guidelines, this reporting should include documentation that shows compliance with the VHC standards, and data that contributes to evaluating the VHC program.

2.33 The current VHC Guidelines[29] state that the reporting process and forms are under review. DVA issued an interim guide for reporting on quality and contract management in September 2002. This interim guide will be used pending the results of DVA's review of its contract management, which was completed in February 2005. Some States Offices have introduced their own reporting requirements, in addition to those required by DVA's National Office, in order to obtain additional and necessary information. For example, the NSW State Office's reporting requirements include regular contact with Agencies via fortnightly teleconferences, and contract management processes that identify high and low risk contractors.

2.34 The ANAO found limited reporting from Agencies and Service Providers. Of the seven Agency files reviewed, only one contained a report produced for DVA. This report covered the period January to September 2001. Of the 18 Service Provider files reviewed, none contained reports for DVA.

IT issues

2.35 In the UNSW Evaluation, 49 per cent of assessors stated that the VHC IT system did not function well most of the time. DVA informed the ANAO that, as VHC was the first DVA program to rely significantly on the Internet for administration, the IT aspects of the program presented challenges and issues.

2.36 Agencies stated that DVA's IT system is often unreliable, although this has improved since the beginning of the program. This system instability affects Agencies as they rely entirely on the system to undertake and approve individual veteran assessments. Agencies stated that when the VHC system is not operational, assessments and reviews must be conducted manually, and the information must be entered into the system at a later time, which is time consuming and increases costs. This also causes delays for Service Providers in their provision of service to veterans. For example, when the system is not functioning, it can create a backlog of assessments, meaning that Agencies take longer to produce service and care plans, resulting in services to veterans being delayed. In response, DVA has developed a process for Agencies to record and report operational difficulties with the systems. This process will provide DVA

[29] DVA issued the VHC Guidelines in November 2002.

with information on the frequency of technical problems, and their impact on Agencies.

2.37 Agencies also raised as an issue inadequate reporting from the system. For example, Agencies reported that they do not have access to data such as average cost per veteran, eligible veteran population projections and the number of HACC transfers for the region. This limits their ability to effectively manage their budgets. DVA is addressing IT issues in a number of ways. One way is through an IT teleconference between National and State Offices. These teleconferences, held when needed, give National and State Offices the opportunity to raise systems issues.

2.38 The VHC system uses a shared public network (the Internet) to function, as well as the networks of other organisations. As such, some of the above operational issues experienced are due to factors beyond DVA's control. While DVA has taken responsibility for those system problems within its control, the ANAO considers that these problems should have been addressed earlier in the program.

2.39 A review of the VHC system reported in January 2005. DVA is currently considering this report and its recommendations.

Coordination and integration

2.40 DVA aims to provide holistic health care and support to the veteran community through integrating services, expanding the range of services available to the veteran community, and through partnerships with key stakeholders. VHC is one of a range of services available to veterans.[30]

2.41 The VHC Guidelines state that the VHC assessment should assist in development of coordinated care for veterans. During assessment, the Agency may determine that referral to other services is appropriate in addition to, or instead of, arranging for VHC service delivery. In this, DVA encourages links between VHC and the wider community care industry.

Care coordination and case management

2.42 DVA makes a distinction between VHC care coordination and case management. While the Agencies' role is that of care coordination, in interviews with the ANAO, Service Providers raised the lack of case management as a problem for them. Possible reasons for this include:

- an unclear distinction in the VHC Guidelines between care coordination and case management;

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[30] For a list of DVA services and other related community care services, see Appendix 2.

- an incomplete service/care plan as a result of incomplete data from the assessment form; and
- veterans not supplying information during assessment.

2.43 DVA states that the Guideline distinction between care coordination and case management is clear. However, in interviews Service Providers stated that as the first face-to-face contact with the veteran, they have found that further services may be required and, consequently, they act as an advocate for the veteran, adopting a referral and support role. Service Providers told the ANAO that to address this, DVA should more clearly define case management and coordination, which would also assist when veterans become confused about eligibility and specific services offered by different programs.

How veterans enter and leave VHC

2.44 DVA does not have reliable and accurate data on how veterans enter the VHC program. The assessment form contains a question about the veteran's source of referral. However, DVA does not require assessors to ask this question, resulting in DVA having incomplete data about entry to the program.

2.45 DVA stated that the majority of veterans self-refer to the VHC program; that is, the veteran has information about VHC, and telephones to request an assessment. Other veterans are referred to the program by other sources, such as a family member, carer or friend, LMOs, hospital discharge planners, community nurses, other health professionals, and ESOs. DVA assists by providing information to some of these referral sources. Examples include a VHC information brochure for LMOs, and the DVA Discharge Planning Resource Kit for use by hospital discharge planners. If DVA collected data from these referral sources, it would assist them in making a profile of the VHC veteran population.

2.46 The ANAO found that DVA does not have reliable and accurate data on how veterans leave VHC. In addition, DVA does not have processes to move veterans to more appropriate programs when needed, that is, exit strategies. Veterans generally leave VHC when their needs exceed the services available under the program, although there may be other reasons. Veterans may leave VHC for any of the following reasons:

- to move to programs that provide a higher level of care such as Community Aged Care packages (CACPs);
- to move to residential care;
- to apply for or return to HACC, although DVA does not have accurate data on the numbers of veterans who move between VHC and HACC;

- the veterans' family circumstances may change and they may no longer require external assistance; and
- the death of the veteran.

2.47 As with entry to VHC, DVA does not collect data on why veterans leave VHC. This exit data could be recorded during the assessment review process (which Agencies are required to do every six months), when DVA are informed a veteran has left the program, or when service plans lapse. Accurate veteran information that includes VHC entry and exit data is necessary to create an accurate veteran profile, to enable effective planning and targeting, and for financial control. Effective planning and targeting will assist DVA to measure the effectiveness of VHC's links, and its coordination and integration with other programs. The ANAO suggests that Agencies be required to ask and record entry data during the initial VHC assessment, and capture exit information during the review process.

Links between VHC and other community care programs

2.48 The VHC assessment form has a blank space for comments at the end of the assessment form where Agencies can record data about services and support veterans are receiving from other programs. However, like entry and exit details, Agencies are not required to collect this data. As a result, DVA does not have reliable and accurate data about the full range of government and community services individual veterans are accessing.

2.49 As VHC is part of a broad strategy to ensure the well–being of veterans, strong links with other DVA and non-DVA programs are important parts of coordinating and integrating services. Without strong links between VHC and other programs, and knowledge of services veterans are receiving, a number of issues arise that affect Agencies, Service Providers, veterans and DVA.

2.50 For Agencies, ineffective links between veterans' programs can result in a duplication of work, as a separate assessment must be conducted for each program, regardless of the programs' similarities. For example, a veteran may be assessed by an occupational therapist for the Rehabilitation Appliance Program, by an Agency for VHC, and by a general practitioner for medication. Additionally, there must be clear working links between VHC and other programs so that Agencies can effectively fulfil their role as care coordinators for veterans.

2.51 Service Providers stated to the ANAO that they try to use a minimum number of carers per veteran. For example, when a Service Provider is servicing a veteran under a number of programs, the Service Provider will try to use the same carer. For this reason, uncoordinated care during assessment for VHC services can result in staffing issues for Service Providers.

2.52 Service Providers informed the ANAO that multiple services from multiple providers can have a negative impact on veterans, who have been confused as a result. For example, veterans have been confused about which programs deliver specific services, and which programs they are receiving services from. Service Providers also stated that participating in a separate assessment for each program, and having more than one carer scheduled to visit their home, can increase veteran confusion and be difficult for the veteran to manage.

2.53 DVA is the lead Commonwealth department serving Australian veterans. As such, insufficient coordination between VHC and other related services inhibits DVA's ability to achieve an integrated response to the provision of care for veterans. DVA's achievement of holistic care and co-ordination with other programs for veterans is difficult to measure due to the inconsistency of data collected; the use of different assessment forms by different programs; and the fact that different programs and services are planned and delivered in different regions. VHC's 54 regions are different from the regions that are used to plan and deliver other programs. For example, VHC's 54 regions are different from HACC's 52 regions, although there is overlap.

2.54 Service coordination and integration is particularly important in the relationship between VHC and HACC, which is the largest of all community care programs. VHC and HACC executives regularly meet, and DVA is a member of HACC Officials.[31] These meetings facilitate communication and better understanding between these two programs, while also creating a forum to resolve specific issues, for example, issues associated with veterans who transferred from HACC. DVA and Health have agreed that while receiving VHC, a veteran may also receive HACC services if the services are different from, or not included in, VHC. For example, a veteran may receive domestic assistance through VHC, and regular garden maintenance through HACC. While DVA knows the number of veterans moving from HACC to VHC, it does not have accurate data on the number of veterans receiving both VHC and HACC services. DVA has discussed this issue with Health, with privacy and access issues still to be negotiated.

2.55 Agencies and Service Providers informed the ANAO that veterans receiving VHC have, at times, had difficulties accessing services from other programs. Reasons for this include waiting lists for other services, higher costs to veterans than VHC costs, and the perception within the community care industry that veterans' needs are fully met by VHC.

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[31] The HACC Officials oversee the general direction of the HACC program. Membership of HACC Officials comprises officers from Health, each government department responsible for HACC, and representatives from DVA.

2.56 In 2003, DVA commissioned a study of veterans' use of aged care services. DVA stated that the purpose of this study was to enhance its understanding of veterans' use of aged care services, and the relationships between these and other related services. This study is due to report in 2007. In addition, the VHC Reference Group (as discussed in paragraph 2.23) will consider improvements in communication with other community care programs.

DVA's role in the Community Care Review

2.57 During 2003, DVA was represented on the Government's Strategic Directions in Community Care review, including a Review of the Home and Community Care Specific Purpose Payment (to States and Territories).[32] The Government established the Committee to give Australian Government agencies the opportunity to comment on the strengths and weaknesses of community care. The Committee focussed on Health's programs and did not specifically include DVA programs. The Federal Minister for Ageing released *A New Strategy for Community Care, The Way Forward* in August 2004.[33] The Minister's paper provides a focus for Health to develop a coordinated community care system able to meet the needs of older people and people who require assistance. The review emphasised the importance of common Health and DVA arrangements for assessment, data and quality monitoring. The second phase of this review will continue discussions on these matters.

2.58 DVA expects to remain involved in Health's continuing review of community care programs. This involvement will be a foundation for strong coordination and integration links between DVA and Health.

Recommendation No.2

2.59 The ANAO recommends that DVA develop and implement exit strategies to support the transition of veterans from VHC to other, more appropriate, care when necessary.

DVA's response

2.60 Agreed. DVA supports the transition of veterans from VHC to more appropriate, higher level care where necessary. DVA notes that there is already a well-established framework in place for veterans, and other Australians, to access higher levels of care through a range of programs, and is already working within that framework.

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[32] This was an Interdepartmental Committee consisting of representatives from Health, Prime Minister and Cabinet, Finance and Administration, Treasury, Transport and Regional Services, Immigration and Multicultural and Indigenous Affairs, Veterans' Affairs, and Family and Community Services.

[33] Department of Health and Ageing, 2004, *A New Strategy for Community Care, The Way Forward,* Health, Canberra.

Recommendation No.3

2.61 The ANAO recommends that DVA collect and use data, for example, entry and exit data, to improve integration and coordination and to further assist DVA to manage the current and future demand for VHC services.

DVA's response

2.62 Agreed. DVA has already taken a number of steps in this area, including:

- the development of the Veterans' Home Care 'datamart' (which allows detailed analyses of VHC recipients to be undertaken);
- the commissioning of a report in late 2004 that provided statistical projections of future VHC populations, to assist in planning for future demand; and
- the implementation of an enhanced VHC assessment instrument in 2005–06, which will include the collection of entry and exit data.

Recommendation No.4

2.63 Recognising DVA's prime Commonwealth responsibility for veterans, the ANAO recommends that DVA adopt the lead role for veterans in developing links between community care providers, with a view to promoting better service delivery to veterans, including exploring common approaches to assessment, regional boundaries and data sharing.

DVA's response

2.64 Agreed. DVA notes that it is only a relatively small player in the aged and community care sector in Australia. For example, around 55,000 veterans receive VHC services each year, compared to over 700,000 Australians receiving similar services through the Home and Community Care (HACC) program. Further, DVA's budget for providing VHC services is approximately $85 million per year, compared to approximately $1.3 billion expended by the Department of Health and Ageing and State/Territory governments in providing community care services through the HACC program. Therefore, while DVA does takes a lead role in promoting aged and community care services for veterans, its role needs to been seen in this context.

2.65 However, DVA is active in developing links between community care providers through its relationships with other agencies in the aged and community service sector, such as the Department of Health and Ageing, State/Territory governments, local councils and community service organisations. In particular, DVA works with the Department of Health and Ageing on common issues of policy and service delivery, assessment and data sharing, through its representation on the HACC Officials Committee (which

comprises representatives from State and Territory governments and the Department of Health and Ageing) and on the newly formed national Community Care Review Officials Committee (and the associated reference groups of that Committee).

Chapter summary

2.66 DVA has not reviewed the formula it developed to estimate the number of VHC recipients. While DVA does not have a comprehensive profile of the VHC target population, it has engaged a consultant to develop an approach to estimating the veteran population with more accuracy.

2.67 In 2000, DVA developed a communication strategy to manage information about VHC during implementation. The ANAO found that DVA used various means to provide information to VHC to veterans, Agencies, Service Providers, and other stakeholders. DVA has not evaluated whether this information has reached all eligible veterans or whether the information received by veterans was accurate or useful. The UNSW Evaluation, commissioned by DVA, identified inadequacies in DVA's communication with Agencies and Services Providers, and concluded that DVA required a comprehensive communication strategy for VHC to address these inadequacies.

2.68 The on-line VHC assessment form is one of DVA's main sources of VHC data. As the assessment form has many questions that Agencies are not required to ask the veteran, the data DVA collects from this process is variable by design. DVA does not aggregate this information and, therefore, it is not maximising its use of the assessment data. DVA is currently reviewing this issue. DVA has enhanced its data management system, and State Offices will be able to use a new reporting system in early 2005. DVA states that the new system will improve efficiency for State Offices.

2.69 As VHC is one of a number of community care programs available to veterans, it is important that DVA co-ordinates and integrates VHC with other relevant programs. This coordination and integration is difficult as DVA does not have reliable data about how veterans enter VHC, why they leave the program, or what services they receive when they leave. Also, DVA does not have reliable data about services VHC veterans are receiving from other programs. DVA has not established strong links with other providers; links that are an important part of coordinating and integrating services.

3. Veterans' Home Care Budgets and Fees

This Chapter reviews how DVA distributes VHC resources, its controls over payments to contractors, and its oversight of Agency budget management. The Chapter also discusses the VHC fees model.

Regional budgets for Veterans' Home Care services

3.1 Agencies manage the budgets for regions in which they provide assessment and coordination services. DVA refers to these regional budgets as notional budgets because they are notionally distributed to Agencies. Agencies are not given actual funds to pay Service Providers; Service Providers claim payment directly from DVA. Each Agency may approve services to the limit of its regional budget.

3.2 As discussed in Chapter 2, the budgets for 2000–01 and 2001–02 were based on estimates of the number of VHC recipients and the cost of providing those services. DVA based the notional regional budget allocations for the past three financial years on actual data from the previous year plus an amount for program growth. For example, the 2004–05 regional budgets were based on the actual number of veterans receiving services in each region in 2003–04 and an actual unit cost to provide those services. The unit cost of providing services was calculated on two bases—the cost of providing services to standard veterans and the higher cost of providing services to veterans who transferred from HACC.[34] Essentially, this means that budget figures were based on expenditure in the previous year plus a growth factor.

3.3 The original method used to calculate VHC budgets incorporated cost data based on similar services provided to a comparable client base, and it estimated client numbers using appropriate variables that included the numbers of DVA Health Card holders and an estimate of the numbers of veterans receiving similar services. The later method was based on actual data. Therefore, the ANAO considers that these methods of distributing funds to Agencies for VHC services are reasonable.

Regional budget matters

3.4 During 2001–02 the demand for the program grew substantially and regional budgets were sufficient to meet this demand. However, in the latter

[34] Veterans transferring from HACC, and the cost of providing VHC services to this group of veterans, are discussed in greater detail later in this Chapter.

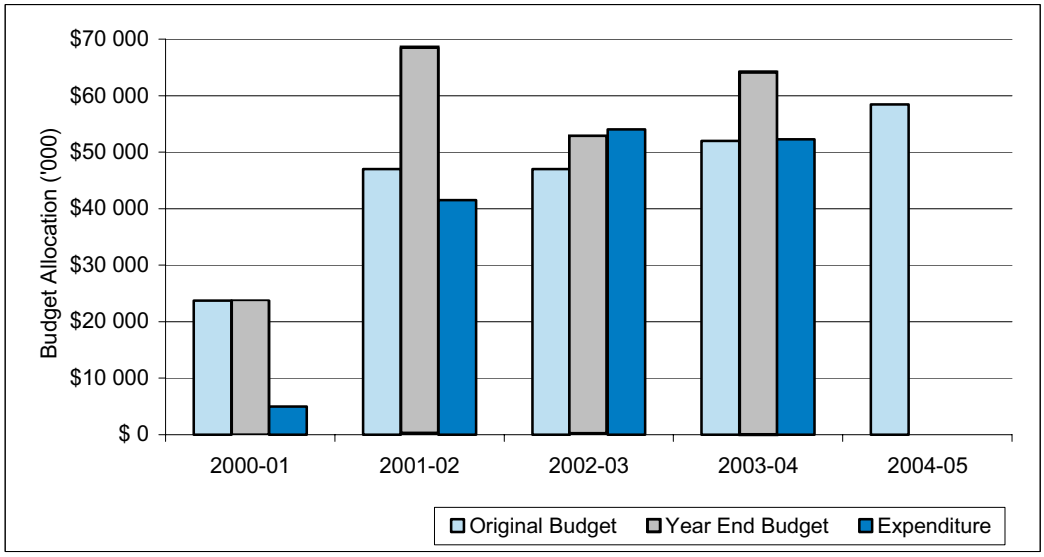
part of 2002, the VHC budget for service provision came under heavy pressure. The main reasons for this are discussed below.

3.5 The ANAO noted that DVA has made a number of adjustments to the regional budget allocations. The change to the way the regional budgets were calculated (from estimates to actual numbers) resulted in adjustments to individual regional budgets. In 2002–03, and as a result of this methodology, the notional budget allocations of 36 of the 54 VHC regions were reduced and 18 regional budgets were increased. The ANAO found that the majority of regions experienced changes of less than 30 per cent. Eight regions experienced substantial changes of greater than 50 per cent. For the Agencies in these regions, this change impacted on their ability to manage budgets and services.

3.6 The ANAO also noted that DVA changed the total budget for service provision on a number of occasions. In 2001–02 there was one major adjustment to the regional budget allocation, three adjustments in 2002–03, and three adjustments in 2003–04 (including one adjustment resulting from a fee increase). The total original and year-end budget allocations are demonstrated in Figure 3.1.

Figure 3.1

Original and year-end regional budget allocations and expenditure



Source: ANAO analysis of DVA data.

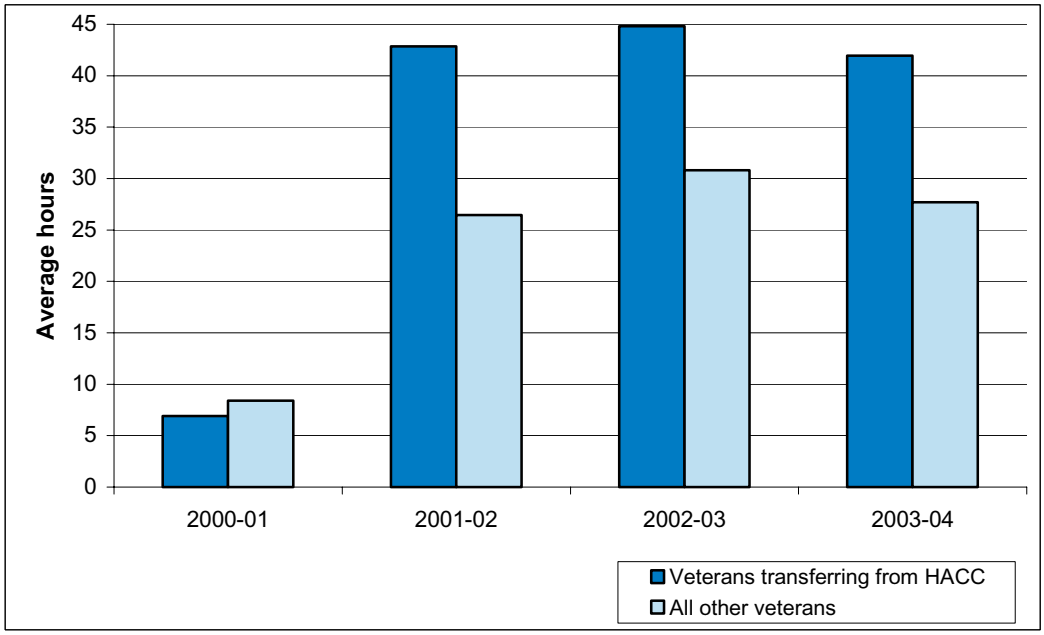
3.7 In addition to these major budget adjustments, there have been numerous minor redistributions between regions, with DVA topping-up regional budgets when necessary. During January 2002, for example, the ANAO noted that 15 regions received 40 budget increases totalling over $2 million. One region alone received eight budget increases totalling $400 000,

while another region received the same amount in five increases. Agency requests for frequent budget top-ups decreased in 2003 as a result of new budget management strategies (discussed later in this Chapter).

3.8 Another significant pressure on the service provision budget was that the cost of providing services to veterans who transferred from HACC was higher than DVA had anticipated. This was because the levels of service HACC transitions were receiving when moved into VHC was, on average, higher than for other veterans receiving VHC services, as shown in Figure 3.2.

Figure 3.2

Average hours of service provided to veterans who transferred from HACC and other veterans[35]



Source: ANAO analysis of DVA data.

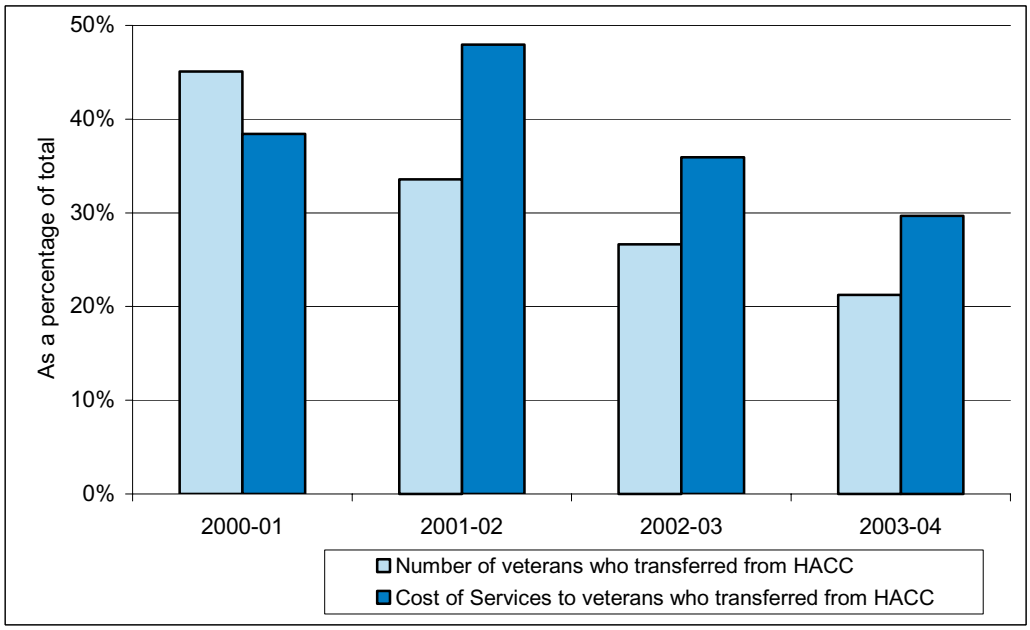
3.9 As a result of the higher level of services veterans who transferred from HACC receive, the unit cost of providing these services is higher than for other veterans receiving the same VHC services. The ANAO found that, in 2003–04, 13 168 of the 50 061 veterans approved for services (excluding respite care) were veterans who transferred from HACC. The average cost of providing these services to veterans who transferred from HACC was $1 215, compared with $777 for other veterans ($1 365 and $984 respectively including respite care), the average cost of providing services to all veterans was $870 per veteran ($1 062 including respite).

[35] Excludes respite.

3.10 The majority of veterans who wished to transfer to VHC did so during the first 18 months of the program. Consequently, the number of veterans transferring from HACC has decreased since 2001–02.[36] Also, the grandfathering arrangements ended on 1 November 2002. From this date all new veterans, regardless of whether they receive HACC services, are assessed in the same way. Therefore, the proportionate cost of providing services to veterans who transferred from HACC compared to other veterans is decreasing. This will relieve the pressure on the budget for providing services to all veterans.

Figure 3.3

Number and cost of veterans who transferred from HACC as a percentage of total veterans receiving VHC services (excluding respite)



Source: ANAO analysis of DVA data.

3.11 A further, ongoing, reason for budgetary pressure is the difficulty of referring veterans to other programs where this is appropriate. The focus of VHC is on providing low-level support to veterans. As veterans age, frailty often increases, resulting in a need for higher levels of care. Since VHC provides services to veterans assessed as requiring low level care, in these circumstances it is more appropriate for veterans to receive care under other programs such as DVA's Community Nursing, Health's CACPs, or through

[36] The number of veterans who transferred from HACC receiving VHC services (excluding respite) has decreased from a peak of 16 543 in 2001–02 to 13 168 in 2003–04.

other services provided by government, not-for-profit or commercial organisations.[37] However, as Agencies and Service Providers reported to the ANAO, often there are waiting lists for these programs. Consequently, these veterans must be maintained on VHC at higher levels of care than other veterans. In addition, veterans who pay only a nominal co-payment for VHC services would be expected to pay more for care under some other programs. As a result, Agencies and Service Providers relayed to the ANAO veterans' reluctance to transfer to these programs.

DVA's response to regional budget matters

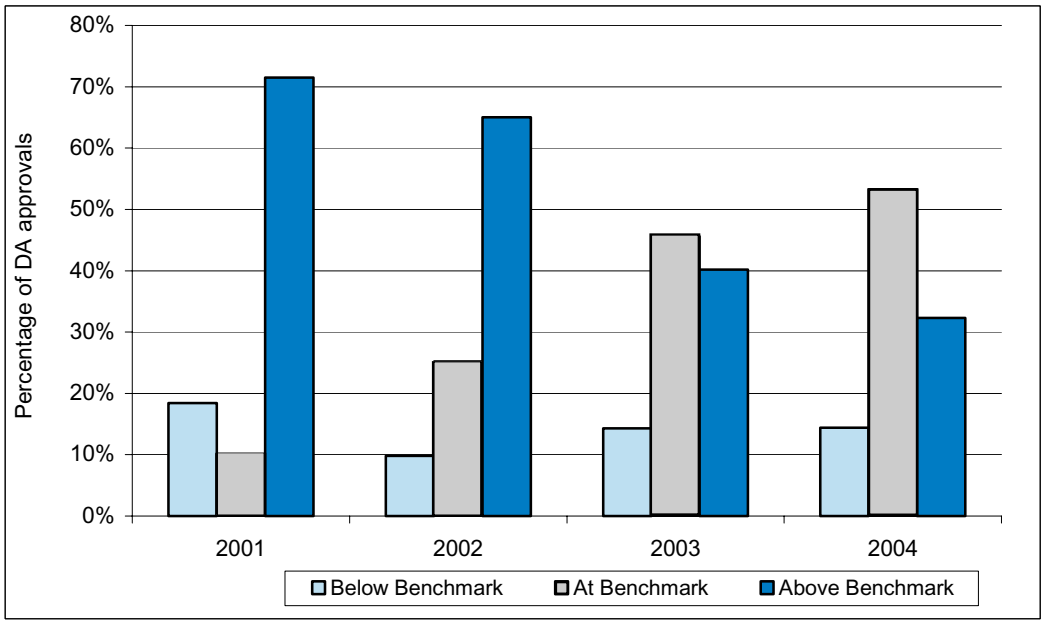
3.12 Budget issues culminated in October/November 2002 when demand for VHC services was such that the budget limit was reached. As a result, a number of Agencies limited the approval of services, while some Agencies did not approve services for any new entrants. In response, DVA implemented strategies to improve budget management, advising Agencies that they should manage regional budgets closely and carefully. Also, since the budget management issues that arose in late 2002, DVA's Secretary has approved regional budgets.

3.13 One of the measures introduced was a benchmark of 1.5 hours of domestic assistance a fortnight. This was based on the average level of domestic assistance provided to persons 70 years and older in the HACC program. The introduction of the benchmark was prompted by DVA's view that some veterans were being overserviced and that levels of care being approved could not always be justified. Agencies were encouraged to heed the benchmark when reviewing the level of services veterans received and when approving services for new entrants to the program. Assessments for hours greater than 1.5 a fortnight were to be considered carefully before approval by Agencies. DVA estimated that the introduction of the benchmark would result in reduced service levels for about half the veterans receiving services. Figure 3.4 shows the percentage of veterans receiving domestic assistance below, at and above the 1.5 hour benchmark. As the Figure demonstrates, the percentage of veterans receiving more than 1.5 hours of domestic assistance has decreased over the four year period, while the percentage receiving 1.5 hours has increased.

[37] Appendix 2 contains a list of other community care programs available to veterans.

Figure 3.4

Percentage of veterans receiving domestic assistance below, at and above the 1.5 hour benchmark



Source: ANAO analysis of DVA data.

3.14 A further measure was the cessation of grandfathering arrangements for veterans transferring from HACC. As discussed above, the ANAO found that the average unit cost of providing VHC services is increased by the higher cost of servicing veterans transferring from HACC in comparison with other veterans. Consequently, ceasing the grandfathering arrangements had the effect of decreasing the average and total cost of providing VHC services.

3.15 DVA also encouraged Agencies to review the level of services provided to existing veterans who transferred from HACC to ensure that it was in line with needs. While doing this, DVA reminded Agencies to take account of the grandfathering arrangements for veterans transferred before November 2002. These arrangements stated that changes to service level or type can be made only with the agreement of the veteran.

3.16 DVA introduced further measures to assist Agencies to better manage unused hours of service. Between January 2001 and June 2004, 24.2 per cent of approved services were not provided, meaning that the approved service hours were not used. In interviews, Agencies and Service Providers informed the ANAO that this was due to a variety of reasons, including the veterans being absent from home at the time the service was scheduled, and the veteran or Service Provider cancelling services and not rescheduling for another time.

3.17 One of the measures introduced in June 2002 to assist Agencies to manage unused service hours was the ability to recredit these hours. When Agencies approve services that are not provided, DVA recredits the value of those services to the region's notional budget 60 days after the scheduled date of the service.

3.18 Another measure DVA introduced, in December 2002, was a notional budget buffer of 30 per cent.[38] The buffer allows Agencies to approve services to the value of 30 per cent above their nominal budgets, balanced by subsequent recredits of unused services. For example, a region with a notional budget of $1 000 would have a buffer of $300, and therefore is able to commit $1 300 to services. The balancing effect of a percentage of approved services not being provided would mean that only the notional budget amount of $1 000 would be expended at the end of the financial year.[39] However, when monitoring regional budgets, DVA and Agencies must ensure that costs are contained within agreed allocations.

3.19 Agencies reported to the ANAO that the notional buffer and the recredit function has improved their ability to monitor approvals, projected cashflows and expenditure patterns.

Outcomes of budget management strategies

3.20 While the demand for VHC services did not change following the introduction of these budget management strategies, the effect was a decrease in the hours of service approved. The ANAO analysed VHC approval data and found that, in the three months to October 2003, hours of service approved for new and existing VHC recipients were 18.3 per cent less than in the three months to October 2002. In addition, the number of veterans assessed as requiring no services increased. In the months before the culmination of the budget issues in October 2002, an average of three per cent of veterans were assessed as requiring no services. This number increased to 11 per cent in October and November 2002. The effect of these changes can be seen in Figure 3.5.

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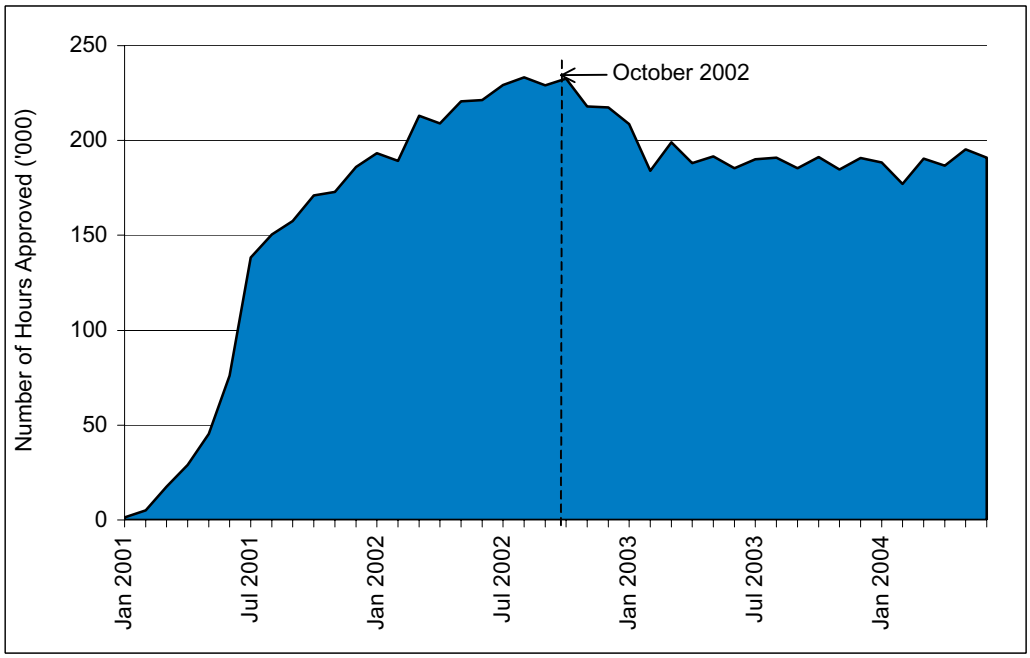
[38] This buffer may be increased to 35 per cent if required.

[39] The amounts have been simplified to assist explanation. In 2004-05, regional budgets vary from less than $10 000 to greater than $4 million.

Figure 3.5

Hours of VHC service approved



Source: ANAO analysis of DVA data.

3.21 One effect of the pressure on regional budgets was an increased awareness by Agencies of budget levels and availability when they approve services. ANAO analysis of budget and approval data suggests that, prior to October 2002, Agencies approved services largely on the basis of veterans' needs with little regard to regional budgets. Following the budget difficulties in 2002, DVA advised Agencies to assess and approve services for new entrants to the program only as their budgets allowed, stating that veterans assessed as having low or no real needs should be advised to re-contact the Agency if their needs or circumstances changed. DVA advised the ANAO that this direction to Agencies was rescinded in 2004.

3.22 In 2004, DVA analysed the gap between assessed need and the level of services actually approved.[40] Quantitative analysis found that seven per cent of assessments in the sample of 210 had a gap between need and approved services; three per cent were approved for services for *less* than their assessed need, while four per cent were approved for services for *more* than their assessed need. DVA advised the ANAO that the main reason for a veteran

[40] The results of this analysis were not statistically robust. There were a number of reasons for this, including that: Agencies' participation in this analysis was voluntary; the sample of assessments was small; the period of collection was short. Therefore, the results cannot be relied on as definitive, but they may be used as an indication of the gap between VHC approval and need for services.

receiving more than their assessed need was that they transferred from HACC prior to November 2002 and, therefore, benefited from the HACC grandfathering arrangements.

Agency budget management

3.23 Each Agency has a contractual responsibility to DVA to manage the budget for its region. DVA's State Offices are responsible for day-to-day contract management. This role includes monitoring regional budgets and helping Agencies to resolve issues that adversely impact their budgets. State Office contract managers maintain close contact with Agencies, primarily by telephone, teleconference and email, and provide Agencies with various data and reports. These reports include approval, budget and recredit data. Issues with Agency reporting to DVA are discussed in Chapter 2.

3.24 Another part of DVA's contract management role is to visit contractors. These visits are DVA's primary means of discussing regional budget issues with Agencies. DVA informed the ANAO that, ideally, its contract managers visit each Agency at least once a year. In practice, the ANAO found that contract management visits have been less frequent. Of the seven Agency files examined by the ANAO, all had received at least one visit since the start of the program in January 2001. Only one Agency had received more than one formal contract management visit, although three other Agencies had met with DVA on one occasion each. The ANAO suggests that DVA implement a program of regular contract management visits, which include discussion of any issues affecting regional budgets. Further, DVA should monitor the program of visits to ensure they are carried out as scheduled and that budget matters are effectively dealt with. Such a program would assist DVA to effectively monitor regional budgets and Agency budget management.[41]

3.25 As discussed above, the budget buffer and recredit function will assist Agencies to manage regional budgets. However, there are a number of issues, also discussed above, that inhibit Agencies' ability to manage regional budgets. These include the high level of clients transferring from HACC, the HACC grandfathering arrangements, and the difficulty of transferring veterans from VHC to other programs when appropriate.

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[41] Recommendation No.6 is relevant to this issue.

3.26 The timeliness of regional budget announcements has been an issue for Agencies. Each year of the program, DVA has not advised Agencies of their notional regional budgets until after the start of the financial year. For example, Agencies were not advised of their 2004–05 notional regional budgets until August 2004. As Agencies approve services and commit funds six months into the future, by August 2004 Agencies were committing funds for February/March 2005. This means that Agencies are committing funds without having adequate knowledge of their budgets, inhibiting their ability to plan cashflows and approval patterns, recruit and maintain staff, and effectively manage budgets.

Financial controls

3.27 There are a number of financial controls built into the VHC claiming system. For Service Provider claims, the controls include specific formats for certain data (for example, dates and number of hours), the inability to claim in advance for services not yet provided, and the inability to claim for a greater number of hours than approved. However, these controls do not prevent inaccurate data being entered into the system by Agencies or Service Providers. In addition, the controls do not provide DVA with assurance that payments to contractors are accurate. DVA's primary control relies on Agencies and Service Providers reporting when an inaccurate payment has been made, and the amount of the adjustment required. The number and amount of over- and under-payments reported to DVA varies from month to month.

3.28 As part of DVA's assurance procedures, State Offices review a sample of Service Provider records as part of their contract management. The ANAO reviewed 18 Service Provider files, and found that only five included evidence of a reconciliation of payments with provider timesheets. In each of the five cases, only one reconciliation had been carried out since the start of the program. The results of these reconciliations were recorded in only two cases. In both cases, timesheets were missing and discrepancies were found between the numbers of service hours claimed and the numbers of hours provided.

3.29 In May 2004, DVA contracted a consultant to review its contract management procedures, including its financial and fraud controls, in the VHC and Community Nursing programs, and make recommendations for improvements. DVA is considering the consultant's draft report, received in February 2005. As a result of the consultancy, DVA expects improved controls over payments to contractors.

Recommendation No.5

3.30 The ANAO recommends that DVA implement adequate controls over payments to VHC contractors that provide it with assurance that those payments are accurate.

DVA's response

3.31 Agreed. DVA undertook an independent review of the VHC program in 2004–05 and, as a result, will be implementing an enhanced contract management framework for VHC in 2005–06, which will address:

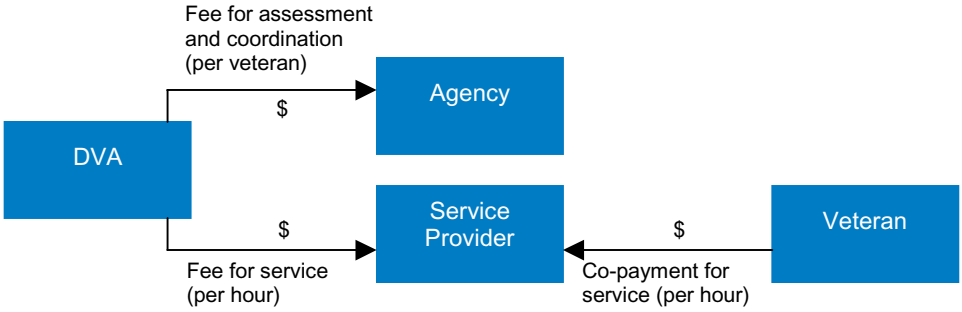
- contract management processes;
- quality assurance processes;
- financial audit processes; and
- records management processes to support the above.

Veterans' Home Care fees model

3.32 DVA pays Agencies on the basis of a standard fee for assessment and coordination functions for each veteran. DVA pays Service Providers a standard fee for each hour of service provided to a veteran. DVA included the fees policy in its contracts with Agencies and Service Providers. In addition to the fees paid by DVA, veterans pay the Service Provider $5 for each hour of service received. This is called a co-payment and is subject to certain limits.

Figure 3.6

VHC fees and co-payment



Source: ANAO analysis.

3.33 Total expenditure on VHC is the sum of the amount paid by DVA in fees to Agencies and Service Providers and the amount paid by veterans as a co-payment to Service Providers. While DVA encourages Service Providers to collect the co-payment, it does not require Service Providers to report on the amount of co-payments received from veterans.

3.34 A veteran may apply to DVA to have the co-payment waived. If DVA grants a waiver, it pays the $5 co-payment to the Service Provider on behalf of the veteran. Applications for co-payment waivers are rare; since inception of the VHC program, DVA has received 50 applications for co-payment waivers. Of these, 19 (38 per cent) were granted.

Issues with fees paid by DVA

Fees to Service Providers

3.35 In interviews with DVA and Service Providers, the ANAO were informed that many Service Providers considered the fees they received for providing VHC services were less than the costs of some services. These included when Service Providers:

- worked on weekends and public holidays, when staff were paid at higher rates;
- travelled considerable distances to reach veterans, for example, in rural areas;
- needed to use the skills of a qualified tradesperson or more than one person because of health and safety requirements; and
- assumed the role of care co-ordinator.

Fees to Agencies

3.36 Veterans require varying levels of coordinated care. For example, the time devoted to veterans recently released from hospital and those receiving high levels of care is usually greater than for other veterans. These veterans may require a combination of service types (for example, personal care to assist with bandages, bathing and dressing, and domestic assistance for help to wash clothes and clean their homes), and the level and type of services they receive may need to be reviewed more frequently. Other veterans require almost no coordination beyond the initial assessment and subsequent six-monthly review.

3.37 DVA pays Agencies an annual payment, called an anniversary payment, for each veteran for the 12-month period following that veteran's initial assessment. Annual fee increments are effective on a specific date. DVA pays the anniversary payment at the rate applicable on the anniversary date. Some Agencies claim that this is unfair as initial assessments completed prior to the date the fee changes attract a lower fee than those completed after the increment. As such, Agencies can defer new assessments until after the increment date in order to attract the higher fee. The ANAO does not consider this to be a significant issue as the number of new assessments potentially

affected is only a small proportion of total assessments.[42] Nevertheless, DVA should monitor the effect of anniversary payments on new assessments to ensure that assessments are not unnecessarily delayed.

Review of the fees model

3.38 In 2003, DVA reviewed the fees structure. The main focus of the review was the impact of the fees on Agencies and Service Providers; it did not evaluate the impact of the fees model on the quality and distribution of VHC services or the type of VHC service available to veterans in different areas. However, the review made some observations about the amount of work in rural areas and the increased costs of providing services in rural areas with low veteran numbers. The review also found that the assessment fee did not adequately cover the costs of performing assessments. Similarly, the review found that the fee for domestic assistance, personal care and respite did not adequately cover the costs of providing those services.

3.39 In response to the recommendations of the review, DVA revised the fees structure in 2003, increasing the amount of the fees paid, and introducing an annual increment based on the Health and Community Care Sector Wage Cost Index. The new fees were effective from 1 January 2004. Under the new fees structure, in 2004 Agencies received $116.20 per year, per veteran, for assessment and coordination functions. The fee received by Service Providers varies depending on the type of service provided, as shown in Figure 3.7.

Figure 3.7

Fees paid to Service Providers[43]

Service type	*Fee paid by DVA*	*Co-payment paid by veteran*
Domestic Assistance	$28.30 per hour	$5.00 per hour to a maximum of $10.00 per week
Personal Care	$28.30 per hour	$5.00 per hour to a maximum of $5.00 per week
Home and Garden Maintenance	$30.00 per hour	$5.00 per hour
In-home or Emergency Respite	$25.80 per hour	nil
Overnight Respite	$15.40 per hour	nil

Source: Service Provider contracts with DVA.

[42] The ANAO calculated that new assessments conducted in the two months prior to the fee increase in January 2004 represented around 2 per cent of total assessments for 2003–04.

[43] Effective 1 January 2004 to 31 December 2004.

3.40 The ANAO notes that while some Agencies and Service Providers continue to be concerned about the fees they receive, the majority (around 94 per cent) recently recontracted with DVA. DVA has informed the ANAO that it considers the current fees structure to be appropriate and adequate and, as such, it will not be reconsidering the structure for the duration of current contracts.

3.41 The ANAO suggests that, prior to the end of the current contracts, DVA evaluate the effect of the VHC fees model on the type, distribution and quality of services provided to veterans. The evaluation should consider, for example, whether the fees model disadvantages any particular group of veterans and whether the fees paid by DVA affects the supply of VHC services.

Chapter summary

3.42 DVA's approaches to distributing funds to Agencies for VHC services were reasonable and each approach was appropriate at the time it was used. However, there have been problems with VHC budgets. These included the higher cost of providing services to veterans who transferred from HACC and the difficulty of referring veterans to other programs when appropriate. In the latter half of 2002, growing demand for VHC services meant that DVA's budget limit was reached. In response, DVA implemented a number of budget management measures. The ANAO regards these strategies as reasonable approaches to managing VHC budgets. Following the introduction of the budget management strategies, the number of hours of approved VHC services decreased and the number of veterans assessed as not needing services increased.

3.43 The ANAO found that DVA's primary control over payments to VHC contractors relied on the contractor notifying DVA when an inaccurate payment had been made. The ANAO concludes that financial controls over payments to VHC contractors do not prevent inaccurate data being entered into the VHC claiming system and do not systematically identify inaccurate payments.

3.44 DVA reviewed the fees it paid to Agencies and Service Providers in 2003, increasing the fees and introducing an annual increment. While some Agencies and Service Providers continue to raise issues regarding the fees, the ANAO noted that around 94 per cent recently recontracted with DVA. DVA has not evaluated the effect of the fees model on the type, distribution and quality of services provided to veterans. The ANAO suggests that DVA complete an evaluation prior to the end of the current contracts.

4. Assessing and Approving Veterans' Home Care Services

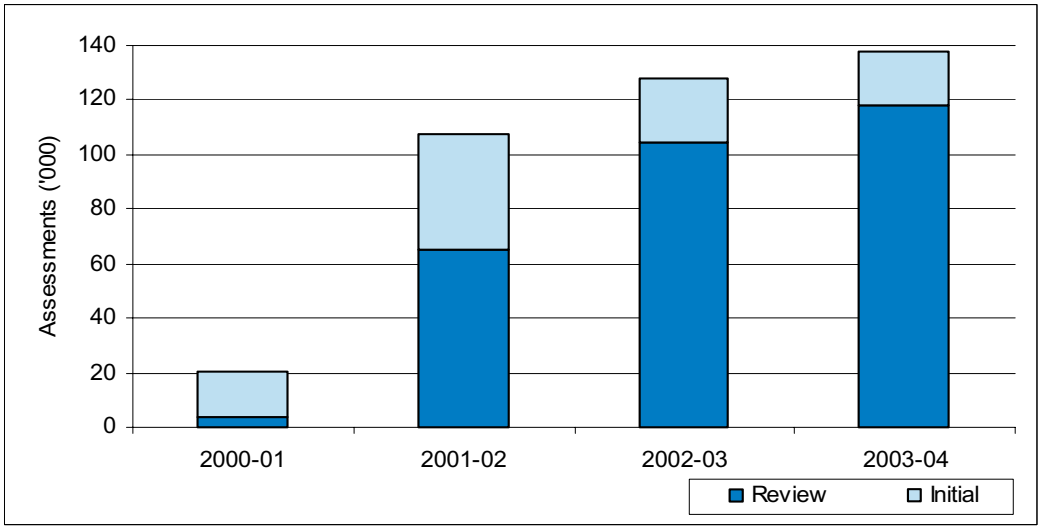
This Chapter reviews the assessment and approval of VHC services, including variations in VHC services approved and the timeliness of services.

Assessment and approval

4.1 DVA developed a standard assessment form to assess veterans for VHC. The form is used by Agencies when conducting an initial assessment or a review. After the first year of the program, the majority of assessments have been reviews of veterans already receiving VHC services, as illustrated by Figure 4.1.

Figure 4.1

VHC assessments



Source: ANAO analysis of DVA data.

4.2 The assessment form directs the assessor to ask a variety of questions regarding living arrangements, type of assistance currently receiving (for example: delivered meals, personal care, housekeeper, social support), health status, mobility, Activities of Daily Living and Instrumental Activities of Daily Living.[44,45] The vast majority of assessments are conducted by telephone.

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[44] Activities of Daily Living is an index of the veteran's ability to perform personal care tasks such as showering, dressing and grooming. Instrumental Activities of Daily Living is an index of the veteran's ability to perform tasks such as shopping, cooking, banking and doing chores around the home.

4.3 The assessment form was developed in consultation with a team of community assessment experts, including health professionals and academics. The assessment form was validated in December 2000 and reviewed as part of the UNSW Evaluation. The validation and later review found that the assessment process worked well when assessing veterans with basic home care needs. DVA commenced a review of the assessment form in February/March 2004. DVA has informed the ANAO that this review is on hold pending the outcome of the separate review of the VHC system discussed in Chapter 2 (paragraph 2.39). DVA is considering the draft report of the review of the VHC system, which it received in January 2005. The ANAO expects that the review of the assessment form will improve its application in complex cases, and that DVA will revise the Guidelines to reflect these improvements.

4.4 All Agencies and Service Providers interviewed by the ANAO agreed that telephone assessment using the standard assessment form is adequate for straightforward cases. However, Agencies and Service Providers reported that telephone assessment is not as effective for more complex cases, such as when the veteran has higher-level care needs, or hearing or cognitive problems (for example, dementia). If a problem is identified during the telephone assessment, Agencies reported difficulty in accurately assessing a veteran's needs. But often the problem is not identified during the assessment, only coming to light when the Service Provider contacts the veteran or during provision of the approved service. In these cases, telephone assessments often resulted in approval of inappropriate or inadequate services types and levels, and the veteran needed to be reassessed.

4.5 The VHC Guidelines contain guidance on assessments and criteria for approving types and levels of services. Section 3.2, for example, describes the following tasks that may be approved under the category 'Domestic Assistance':

- household cleaning;
- clothes washing and ironing;
- shopping for the veteran;
- assistance with meal preparation but not total preparation of meals.
- dishwashing;
- cleaning internal windows;
- bed making; and

4.6 The Guidelines also include, where applicable, benchmarks and service limits.

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[45] These are not mandatory questions on the assessment form.

Figure 4.2

VHC service limits and benchmarks[46]

Service Type	Service Limit / Benchmark
Domestic Assistance	benchmark of 1.5 hours per fortnight[47]
Personal Care	limit of 1.5 hours per week – refer to Community Nursing program if need is above this amount
Home and Garden Maintenance	limit of 15 hours per financial year
Respite Care	limit of 196 hours (28 days) per financial year

Source: VHC Guidelines, Section 3.

4.7 The ANAO found that DVA distributed the Guidelines to all Agencies. Assessors must have skills in comprehensive assessment and care planning and have a minimum of two years experience in the aged or community care sector. As such, DVA expects that assessors would have the skills and experience to apply the Guidelines appropriately. The Guidelines are not intended to be overly prescriptive or restrict appropriate local initiatives. In ANAO interviews, Agency personnel agreed that the Guidelines were clear, understandable and useful.

4.8 To assist Agencies when assessing veterans, VHC has adopted the concept of different levels of service, described in Figure 4.3.

Figure 4.3

VHC service levels

Service Level	Hours of Service	Proportion of Veterans
VHC Standard	< 15 hours during a 4 week period	approximately 83 per cent of eligible veterans
VHC Plus	15 – 40 hours during a 4 week period	approximately 15 per cent of eligible veterans
VHC Extended	> 40 hours during a 4 week period	approximately 2 per cent of eligible veterans

Source: VHC Guidelines, Section 5.

[46] These limits/benchmarks do not apply to veterans transferring from HACC who continue to receive the same level of services when they transfer from HACC to VHC, unless otherwise agreed.

[47] This is not a service limit; it is a benchmark. The Guidelines state that approval for an amount of time above the benchmark will require careful consideration by the Agency.

4.9 These categories are used by Agencies as a guide to the proportion of veterans who should receive average and high levels of VHC services. However, the Guidelines do not contain details about how the service levels should be applied. The ANAO found that, as a result, some Agencies were uncertain about approving care, particularly when veterans were assessed as requiring higher levels of care. To address this uncertainty, these Agencies have developed their own service approval guidelines to supplement the VHC Guidelines. For example, one Agency uses a benchmark of one hour a fortnight of domestic assistance if the veteran lives in a small unit and two hours a fortnight if the residence is large. With Agencies developing guidance in addition to the VHC Guidelines and without advice from, or consultation with, DVA, the ANAO believes that the probability of inappropriate interpretation and approval is heightened and will lead to increased variations across regions.

4.10 Recognising that the approval of veterans with high care needs is difficult for Agencies, the Queensland State Office, in conjunction with Agencies and Community Nursing Advisors and with the agreement of the National Office, has developed a model to improve understanding of the approval criteria for veterans requiring high levels of service. The model extends the assessment form when higher than average levels of care are indicated during assessments, and it includes budget forecasts based on the numbers of veterans receiving certain levels of service projected over the financial year. The model was piloted in three Agencies in Queensland over a three month period to August 2004. The ANAO found that the Agencies involved in the pilot were very supportive of the model, which allowed them to better target services for higher needs clients and assisted with budget management. DVA's National Office is currently considering the model, following piloting in a further three States between October 2004 and January 2005.

Veterans' Home Care service variations

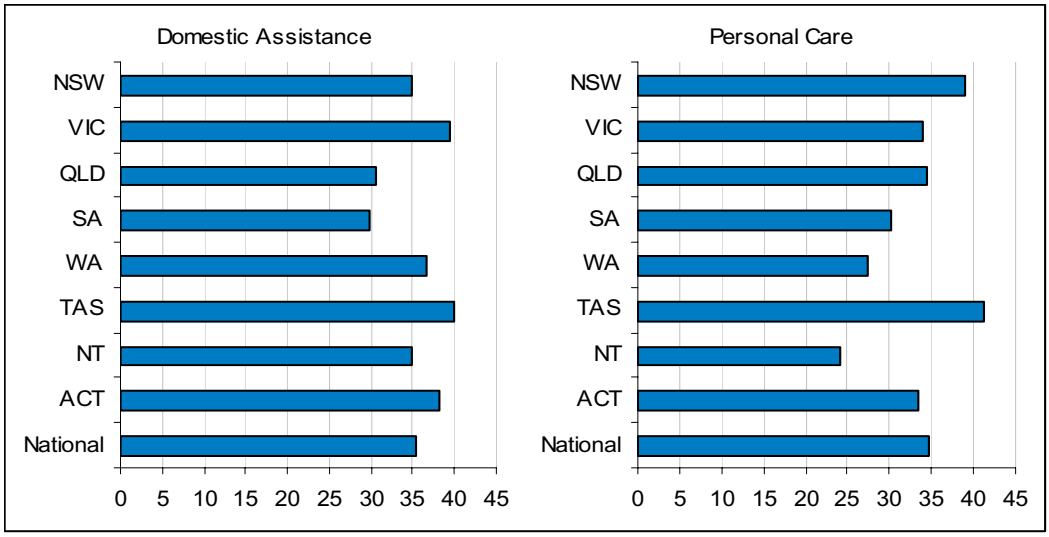
4.11 DVA recognises that there have been significant variations in service levels across regions. There are a number of possible reasons for these variations including differences in the amount of travel required in rural areas, the prevalence and availability of other programs and providers, and the application of the VHC Guidelines. However, the ANAO found that DVA has not analysed the available VHC data to identify why these variations are occurring. DVA has acknowledged that some Agencies have had more success in applying the Guidelines than others, and that variations suggest that there has been some confusion regarding service definitions and criteria.

4.12 Early in the program there was some confusion among Agencies, Service Providers and veterans regarding what types of tasks might be included within the individual service types, especially home and garden maintenance. As mentioned in Chapter 3, the HACC grandfathering arrangements also resulted in inequities. The end of these arrangements in November 2002 has restored equity between veterans who transferred from HACC moving to VHC after November 2002 and other veterans. During ANAO interviews, Service Providers referred to a number of cases that suggested inconsistencies in approved service levels. Most of the cases involved veterans with similar needs receiving different levels of service, or veterans with different needs receiving the same level of service. Variations also become apparent when veterans move between regions, and particularly when moves are made to another State.

4.13 Figure 4.4 demonstrates the variation between States in approvals for domestic assistance and personal care. These graphs show, in some cases, substantial variations, in average hours of service approved for veterans.

Figure 4.4

Average hours approved, 2003–04

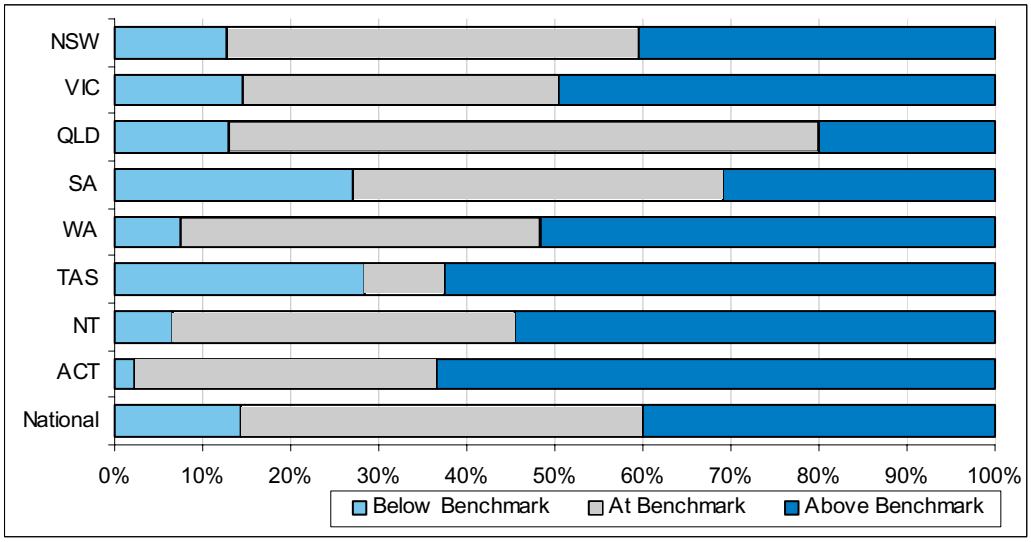


Source: ANAO analysis of DVA data.

4.14 Figure 4.5 shows the variation in the percentage of veterans receiving domestic assistance below, at and above the 1.5 hour benchmark.

Figure 4.5

Percentage of veterans receiving domestic assistance below, at and above the 1.5 hour benchmark, 2003

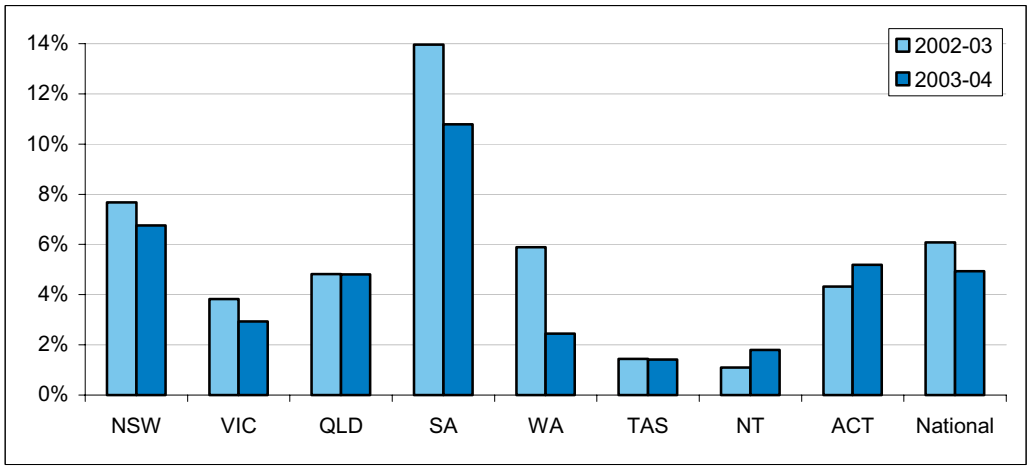


Source: ANAO analysis of DVA data.

4.15 As shown in Figure 4.6, the percentage of veterans assessed but not approved (that is, the percentage of veterans who were assessed as not requiring VHC services) also varied significantly between States. A comparison of the two years shows that these variations have not substantially decreased in the past financial year. At the regional level, the variation was even more pronounced, ranging from zero (that is, all veterans assessed were approved for services) to 17.3 per cent of veterans not approved for services.

Figure 4.6

Percentage of veterans assessed and not approved for services



Source: ANAO analysis of DVA data.

4.16 The extent of these variations is not explained by regional differences alone, and they point towards inequities in service levels across Australia. The ANAO suggests that DVA analyse the VHC data to determine, to the extent possible, why variations are occurring, identify and set appropriate boundaries for acceptable variations, and clarify the VHC Guidelines where necessary.

Timely assessment, approval and service provision

4.17 The Guidelines do not specify times within which the various stages of the VHC process must be completed. The Guidelines state only that veterans must be assessed and provided with services in a timely way. DVA informed the ANAO that it does not consider timeliness of assessment, approval or service provision to be an issue in the VHC program. The ANAO concurs with this view, noting that the majority of veterans were assessed within one week of referral, as shown in Figure 4.7.

Figure 4.7

VHC waiting list data, as at 30 June 2004

	≤ 7 days	8 – 21 days	≥ 22 days	Not specified	Total
Veterans waiting for assessment	230	45	10	45	330
Veterans approved, waiting for services	0	10	0	0	10

Source: ANAO analysis of DVA data.

4.18 Agencies are required by their contracts to provide waiting lists data monthly to DVA. However, waiting lists only collect data on veterans who are involved in some stage of the VHC process. As DVA does not actively promote the program, the number of people applying for assessment or services is limited, thereby limiting the number of people waiting for assessment or services.

4.19 There have been periods when waiting lists for assessment have considerably exceeded the times in Figure 4.7. These periods usually coincided with times when the Agency in a particular region changed or when a large number of reviews were required at the one time.

4.20 When veterans are waiting for assessments or there are delays in approvals, Agencies need to give priority to some types of assessments and approvals. Priorities are largely determined by the Agencies, but DVA emphasises the need to ensure certain services, such as post-hospital personal care, are provided immediately. Agencies interviewed by the ANAO agreed that certain requests always elicited an immediate response. For example, one Agency informed the ANAO that it gives priority to hospital discharges, in-

home respite and emergency one-off services (for example, changing a light bulb or urgent plumbing repairs).

Chapter summary

4.21 DVA uses a standard assessment form to assess veterans, which was developed in consultation with a team of experts. While the assessment form appears to work well for basic assessments, the form was not as effective for veterans with complex needs. Similarly, the ANAO found that, on the whole, the VHC Guidelines were clear and understandable, and allowed for appropriate local initiatives. However, when veterans required higher levels of care, some Agencies had developed their own service approval guidelines to supplement the VHC Guidelines. DVA has developed a model to improve understanding of the approval criteria for veterans requiring high levels of service. It is considering the model, following piloting in 2004–05.

4.22 The ANAO found significant variations in service levels across the 54 VHC regions and between States and Territories. One reason for these variations is Agencies not applying the VHC Guidelines consistently, suggesting that there are inequities in service levels across Australia. DVA has not analysed the available VHC data to determine to what extent variations are acceptable, or why these variations are occurring. Further, DVA has not set boundaries within which it considers variations to be acceptable.

4.23 The ANAO agrees with DVA that timeliness of assessment and service provision is not an issue in the VHC program. The majority of veterans are assessed within one week of referral and, if approved, services are usually in place within a few weeks.

5. Monitoring and Evaluating Veterans' Home Care

This Chapter discusses DVA's external reporting of VHC matters, how DVA monitors the quality of VHC services and whether it has evaluated VHC's impact and effectiveness.

Performance indicators and reporting

5.1 VHC is administered through DVA's portfolio outcome 2, as illustrated by Figure 5.1.

Figure 5.1

Departmental and program objectives

DVA's mission

The Department of Veterans' Affairs exists to serve members of Australia's veteran and defence force communities, war widows and widowers, widows and dependants, through programs of care, compensation, commemoration and defence support services.

Outcome 2: Health

Eligible veterans, their war widows and widowers and dependants have access to health and other care services that promote and maintain self-sufficiency, well-being and quality of life.

Output 2.1: Arrangements for delivery of services

To provide quality, cost-effective health care and support services.

VHC's aim:

To enhance the independence and health outcomes of veterans by reducing the risk of avoidable illness and injury and assisting them to remain independent in their own homes as long as possible.

VHC's objectives:

- provide a comprehensive, coordinated and integrated range of basic maintenance and support services to eligible veterans;
- provide flexible, timely services that respond to the health care needs of eligible veterans;
- target eligible veterans not using services who are experiencing some difficulties with acts of daily living; and
- close the loop in DVA's provision of holistic health care and support to the veteran community.

Sources: Repatriation Commission, Department of Veterans' Affairs, National Treatment Monitoring Committee, September 2004, Annual Reports 2003–04, DVA, Canberra, pp.22, 74 and 85; VHC Guidelines, Section 1.2.1 and 1.2.2.

5.2 As required by the Australian Government's Outcomes & Outputs Framework[48], DVA has developed performance indicators for each of its outcomes and reports performance information against these outcomes in its annual Portfolio Budget Statements. VHC contributes to DVA's performance against Outcome 2.1, as illustrated by Figure 5.1. Performance information reported against Outcome 2.1 includes the number of health card holders and the unit cost of providing all DVA health and care services. The Framework does not require DVA to develop specific performance indicators or targets for reporting VHC's performance. DVA does, however, report a variety of information about VHC in its annual report. In DVA's 2003–04 annual report, this information included the number of veterans approved for services and the type of services approved, the amount DVA paid for assessment and service provision, and the progress of projects and reviews relevant to VHC. The information DVA provided in its annual report satisfies the Australian Government's minimum requirements as instructed by *Requirements for Annual Reports for Departments, Executive Agencies and FMA Act Bodies*.[49]

Monitoring service quality

Quality standards

5.3 DVA requires Agencies and Service Providers to provide high quality services to the veteran community in accordance with their contracts and with the VHC Standards outlined in the VHC Guidelines. That is, Agencies are required to provide efficient and effective assessments and effectively coordinate services for veterans. Service Providers are expected to provide high quality services. Agencies and Service Providers must also have appropriate quality assurance systems. Such systems should ensure Agencies and Service Providers comply with the Standards and assist them to improve their processes and procedures. Agencies and Service Providers must also ensure that personnel have the appropriate expertise, experience and capacity to perform their roles.

5.4 The VHC Standards outline the quality of service veterans can expect from the VHC program, and define the minimum standard of service expected from VHC assessors, co-ordinators and Service Providers. There are seven objectives in the Standards, each objective supported by consumer outcomes, service standard principles, and performance indicators. The objectives are reproduced in Figure 5.2.

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[48] Information on the Outcomes & Outputs Framework can be found on the Department of Finance and Administration's website at http://www.finance.gov.au.

[49] Department of Prime Minister and Cabinet, June 2004, *Requirements for Annual Reports for Departments, Executive Agencies and FMA Act Bodies*, PM&C, Canberra.

Figure 5.2

The VHC Standards - objectives

OBJECTIVE 1: ACCESS TO SERVICES To ensure that each eligible veteran's access to services is determined on the basis of assessed need in accordance with the overarching aims of VHC.
OBJECTIVE 2: INFORMATION AND CONSULTATION To ensure that each eligible veteran is informed about VHC assistance available and consulted about any necessary arrangements.
OBJECTIVE 3: EFFICIENT AND EFFECTIVE MANAGEMENT To ensure that eligible veterans receive the benefit of well-planned, efficient and accountable service management.
OBJECTIVE 4: COORDINATED, PLANNED AND RELIABLE SERVICE DELIVERY To ensure that each eligible veteran who is assessed as needing home support receives coordinated services that are planned, reliable and meet his/her specific ongoing needs.
OBJECTIVE 5: PRIVACY, CONFIDENTIALITY AND ACCESS TO PERSONAL INFORMATION To ensure that each eligible veteran's right to privacy and confidentiality is respected, and he/she has access to personal information held by the agency.
OBJECTIVE 6: COMPLAINTS AND DISPUTES To ensure that eligible veterans and other stakeholders are aware of the policy and procedures to provide feedback and deal with disputes.
OBJECTIVE 7: ADVOCACY To ensure that each eligible veteran has access to an advocate of his/her choice.

Source: VHC Guidelines, Section 10.2.

Monitoring service quality

5.5 DVA has a number of mechanisms to monitor quality of services. These mechanisms are discussed below.

Contract management visits

5.6 DVA visits Agencies and Service Providers as part of its contract management role. As Figure 5.3 shows, the ANAO found that contract management visits have been infrequent at best, particularly to Service Providers.

Figure 5.3

Contract management visits

	Agency	*Service Provider*
Number of files examined by the ANAO	7	18
Contract management visits by DVA since the start of the program[50]	6 Agencies received 1 visit each 1 Agency received >1 visits	5 Service Providers received 1 visit each
Topics discussed	time for assessment and approval; approval statistics; assessment effectiveness; veterans' comments and complaints; staff training; budgets	time for service delivery; service reliability; veterans' comments and complaints received by DVA

Source: ANAO analysis.

5.7 While DVA monitors the quality of services provided by individual Agencies and Service Providers through contract management visits, it does not consolidate and consider information gained from these visits. The ANAO considers that consolidation of results would assist DVA to identify quality of service issues common to Agencies and to Service Providers.

Reporting

5.8 The Guidelines and contracts require Agencies and Service Providers to demonstrate compliance with the VHC Standards on a six-monthly basis, and require Agencies to provide waiting list data on a monthly basis. As discussed in Chapter 2, reporting from Agencies and Service Providers to DVA has been irregular. In recognition of this, DVA is reviewing VHC reporting.

Client surveys

5.9 DVA conducts regular Veterans' Satisfaction Surveys. The report on the December 2003 Veterans' Satisfaction Survey, which reported on VHC users as a separate client group, reveals high levels of satisfaction with VHC. The survey found that:

- overall, 90 per cent of respondents were satisfied with VHC; no respondents were dissatisfied;
- 96 per cent of respondents were satisfied with the quality of VHC services they received; and
- 88 per cent were satisfied with the amount of VHC they received.

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[50] In addition, DVA met with three Agencies on one occasion each, and four Service Providers completed contract management checklists and returned them to DVA.

Complaints

5.10 Another mechanism used by DVA to monitor quality of service is the number and content of comments and complaints received from veterans and other stakeholders. Contracts with DVA require Agencies and Service Providers to have effective systems to collect consumer feedback. The Guidelines describe the basic principles for addressing complaints. Complaints commonly received by Service Providers concern the quality of services provided and timeliness issues (for example, the provider not arriving on time or at all). Generally, these complaints are relatively minor and are resolved quickly.

5.11 Complaints are also received directly by DVA or the Minister for Veterans' Affairs. All complaints are registered in DVA's Feedback Monitoring System. The ANAO found that the System was not widely used, particularly in the State Offices. The three State Offices visited by the ANAO developed their own methods of receiving and registering veterans' comments and complaints.

5.12 The number of complaints DVA received about VHC was not substantial. For example, the register of complaints and issues of one State visited by the ANAO recorded a total of 78 comments since the start of the program in 2001. From 1 January to 30 June 2004, when correspondence and complaints rose following the culmination of the budget issues in October 2002, the Minister received 183 letters regarding VHC. This decreased to 89 during the following six months.

5.13 DVA discussed all comments and complaints with Agencies and Service Providers during contract management visits, and monitored complaints received by Agencies via the six-monthly reports to DVA. However, as discussed above, reporting and contract management visits have been infrequent. In addition, DVA did not analyse feedback data to identify common issues or trends. The ANAO suggests that DVA collect and use the feedback received from stakeholders, identifying common issues or trends that may assist it to improve the VHC process and manage the demand for VHC services.

VHC service variations

5.14 While these mechanisms provided DVA with some assurance about the quality of service individual clients received, ANAO's analysis of VHC data revealed considerable variations in the program, as discussed in Chapter 4. For example, analysis of the number of hours approved shows that veterans in Victoria received an average of 40.6 hours of service (excluding respite) in 2003–04 compared to 29.8 hours in Queensland. The reasons for these variations may be outside DVA's control and may not be strictly related to varying application of the VHC Guidelines. However, DVA has not

determined why these variations are occurring or what level of variation between the states is acceptable or valid. DVA's current quality assurance mechanisms do not, to the extent possible, control for, or monitor, these variations or the possible reasons for them.

New contract management processes

5.15 In May 2004, DVA commenced a review of the VHC and Community Nursing programs contract management processes, which included an examination of DVA's quality assurance processes. DVA expects that the review, which reported in February 2005, will assist it to improve its contract management, including its quality assurance and management.

Recommendation No.6

5.16 The ANAO recommends that DVA ensure that its contract management procedures satisfy the VHC Guidelines and its contractual agreements with Agencies and Service Providers, particularly in the areas of:

- reporting from Agencies and Service Providers;
- monitoring the quality of VHC services; and
- monitoring regional budgets and Agency budget management.

DVA's response

5.17 Agreed. DVA undertook an independent review of the VHC program in 2004–05 and, as a result, will be implementing an enhanced contract management framework for VHC in 2005–06, which will address:

- contract management processes;
- quality assurance processes;
- financial audit processes; and
- records management processes to support the above.

Has Veterans' Home Care been effective?

5.18 DVA has not evaluated whether VHC is meeting its aim of enhancing the independence and health outcomes of veterans by reducing the risk of avoidable illness and injury and assisting veterans to remain independent in their own homes as long as possible. DVA has engaged a number of consultants to review various aspects of VHC. For example, in 2003 DVA engaged a consultant to determine whether VHC had resulted in increases or reductions in DVA's spending on health. The review examined, in part, the impact of VHC on a range of health care services (including allied health,

general practitioners, specialists and private hospitals). While the report is heavily qualified, it states that the analysis indicates that VHC has resulted in cost savings to the Australian Government, and that these saving are growing. DVA repeated this study in 2004–05.

5.19 In addition, the UNSW Evaluation commissioned by DVA found that VHC increased the access to home care services for veterans and war widow(er)s. It found that approximately 74 per cent of veterans receiving VHC services were accessing such services for the first time. The report concluded that the VHC program had made a significant contribution to community-based aged care services in Australia. However, as discussed earlier, DVA does not have reliable data on the number of veterans receiving other community care services, such as HACC. This affects DVA's ability to estimate the extent to which VHC has increased the number of community care services available to veterans.

5.20 As discussed in Chapter 2, DVA has commissioned a study of veterans' use of state and Australian Government aged care services and the relationships between usage of aged care services, health services and allied health services. This study, to be completed in July 2007, will increase DVA's understanding of the use of aged care services by veterans and will be used to further develop DVA's aged care programs, including VHC.

Recommendation No.7

5.21 The ANAO recommends that DVA periodically evaluate whether VHC is meeting is stated aims and objectives.

DVA's response

5.22 Agreed.

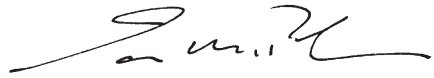
Chapter summary

5.23 DVA has not developed specific performance indicators or targets for reporting VHC performance. However, the VHC information DVA reported in its 2003–04 annual report satisfied the Australian Government's minimum requirements.

5.24 The VHC Standards define the minimum quality of service to be provided to veterans. One mechanism DVA uses to monitor quality is contract management visits to Agencies and Service Providers. The ANAO found that these visits occurred infrequently and that DVA does not consolidate information gained from them. Another mechanism DVA uses is comments and complaints received about the program, which are generally minor and quickly resolved. However, DVA does not consolidate or analyse feedback to identify common issues or trends. DVA also regularly surveys veterans, and

has found that veterans are satisfied with the quality of service they received under VHC. These mechanisms provided DVA with some assurance about the quality of service individual clients received. However, DVA's current quality assurance mechanisms do not control for, or monitor, variations in service levels or possible reasons for them.

5.25 DVA has evaluated various aspects of VHC. These evaluations concluded, with some qualifications, that VHC had resulted in cost savings to the Australian Government, increased veterans' access to home care services, and made a significant contribution to community-based aged care. The ANAO recommended that DVA evaluate whether VHC is meeting is aim of enhancing the independence and health outcomes of veterans by reducing the risk of avoidable illness and injury and assisting veterans to remain independent in their own homes as long as possible.



Canberra ACT
17 May 2005

Ian McPhee
Auditor-General

Appendices

Appendix 1: Veterans' Home Care Services

Domestic assistance

Means assistance with domestic chores, including help with general cleaning, dish washing, washing and ironing and bed making. It may also include help with some meal preparation if this service is not being provided separately. In rural areas, it may also include activities such as collecting firewood.

Personal care

Includes assistance with daily self-care tasks, such as eating, bathing, toileting, dressing, grooming, getting in and out of bed and moving about the house. These are tasks that the person would normally do themselves, but because of illness, disability or frailty, they require the assistance of another person.

Home and garden maintenance

Includes such tasks such as replacing light bulbs and tap washers or other tasks agreed between the veteran and the service provider. Home and garden maintenance does not include major home repairs such as gutter replacement, landscaping and garden tasks such as branch lopping, tree felling or tree removal. Nor does it include routine, cosmetic or ornamental gardening services such as maintenance of flower beds, regular lawn mowing and pruning or roses, unless there is a safety hazard. Home and garden maintenance does not include the provision of materials.

Respite care

Means relief for a carer who has responsibility for the ongoing care, attention and support of another person who is in ill health or incapacitated. It provides an alternative form of care and enables carers to have a break. Respite care services may be provided in an appropriate accommodation setting or at home (including overnight or emergency care), or a combination of these.

Source: VHC Guidelines, Section 1.4.

Appendix 2: Community Care Programs

The VHC Guidelines lists the following DVA and community care programs under the following headings:

DVA Programs	*Community Programs*
Allied Health Services	Aged Care Assessment Team
Community Nursing Program	Community-based Medication Management
Rehabilitation Appliances Program	MediList
HomeFront	MediWise
Home Maintenance Helpline	Carer Respite Centres
Repatriation Transport Scheme	Carer Resource Centres
Pharmaceuticals	Commonwealth Carelink Centres
Veterans' Affairs Network	Community Day Care Services or Adult Learning Centres
Veterans' Affairs Network Outreach Program	Public Guardian
Vietnam Veterans Counselling Service	The Protective Commissioner
Veterans' Vocational Rehabilitation Scheme	Continence Aids Assistance Scheme
Returned & Services League Day Clubs	National Continence Helpline
Health Promotion	Centrelink – Financial Information Services
Veteran and Community Grants	Australian Hearing Services
Resources	Australian Communication Exchange
Provider education	Translator and Interpreting Services
Information on DVA's pension payments and services	Australian Red Cross Services
	Australian Red Cross Telecross Service and DVA Telefriend service
	Red Cross Dementia Alarm Service
	Aboriginal & Torres Strait Islander services Advocacy service
	Ex-Service Organisations

Source: VHC Guidelines, Appendix D.

The ANAO notes that the above list does not include HACC.

The Community Care Review lists the following community care programs funded through Health:

Community Care Programs	
Community Aged Care Packages	National Continence Management Strategy
Community Aged Care Package Establishment Grants	Assistance with Care and Housing for the Aged
Extended Aged Care at Home	Aged Care Assessment Program
Home and Community Care Program (a jointly funded program)	Dementia Support for Assessment
National Respite for Carers Program	Commonwealth Carelink Program
Day Therapy Centres	Dementia Education and Support Program
Psychogeriatric Units	Safe at Home
Continence Aids Assistance Scheme	Carers Information and Support Program
Community Sector Support Scheme	

Source: Community Care Review, Appendix 1.

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