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Performance Audit

Defence's Management of Health Services to Australian Defence Force Personnel in Australia

Department of Defence

Australian National Audit Office

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Canberra ACT
24 June 2010

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in the Department of Defence in accordance with the authority contained in the *Auditor-General Act 1997*. I present the report of this audit and the accompanying brochure. The report is titled *Defence's Management of Health Services to Australian Defence Force Personnel in Australia*.

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

A handwritten signature in black ink, appearing to read 'Ian McPhee', is positioned above the printed name and title.

Ian McPhee
Auditor-General

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

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Abbreviations

ACHS	Australian Council of Healthcare Standards
ADF	Australian Defence Force
AHS	Area Health Service
ANAO	Australian National Audit Office
APS	Australian Public Service
CDF	Chief of the Defence Force
CHP	Contracted Health Professional
CJHLTH	Commander Joint Health
COSC	Chiefs of Service Committee
COTS	Commercial Off-the-Shelf
Defence	Department of Defence and the ADF
DGGHS	(Former) Director General Garrison Health Support
DHS	Defence Health Services
DHSB	Former Defence Health Services Branch (now JHC)
DHSCC	Defence Health Service Steering Committee
DHSD	Former Defence Health Services Division (now JHC)
DISG	Former Defence Information Systems Group
DMO	Defence Materiel Organisation
DOSD	Defence Online Services Domain
DRN	Defence Restricted Network

DSG	Defence Support Group
eHIS	e-Health Information System
FTE	Full-time Equivalent
HealthKEYS	Health Key Solution (health management information system)
HLTHSPO	Health Systems Program Office (in DMO)
ISO	International Organization for Standardization
IT	Information Technology
JeHDI	Joint e-Health Data Information system
JHC	Joint Health Command
JHSA	Joint Health Support Agency
JOC	Joint Operations Command
KPI	Key Performance Indicator
LAN	Local Area Network
MIMI	Medical Information Management Index (health management information system)
MO	Medical Officer
MSA	Materiel Sustainability Agreement
NATA	National Association of Testing Authorities
NPOC	Net Personnel and Operating Costs
NSA	National Support Area
OSGADF	Office of the Surgeon General ADF

PBS	Pharmaceutical Benefits Scheme
PMKeyS	Personnel Management Key Solution (personnel management system)
PMO	JHC's Portfolio Management Office
PSS	Psychology Support Section
RACGP	Royal Australian Council of General Practitioners
RHD	Regional Health Director
SGADF	Surgeon General ADF
SHO	Senior Health Officer
SLA	Service Level Agreement
SMO	Senior Medical Officer
SRP	Strategic Reform Program
VCDF	Vice Chief of the Defence Force
WAN	Wide Area Network

Glossary

e-health	The combined use of electronic communication and information technology in the health sector.
Garrison Health Services	Garrison Health Services is used in this report to refer to health support provided to non-deployed ADF members in garrison in Australia.
Medic	A 'Medic' is an ADF Medical Assistant. Each Medic receives basic training as a Medical Assistant. This may be supplemented by service specific training, such as a course in Rotary Wing Aero Medical Evacuation, as well as advanced training.
NSA	<p>In addition to Garrison Health Services in Australia, the National Support Area includes:</p> <ul style="list-style-type: none">• external health services to which ADF members are referred by health personnel working on ships alongside any Australian or international port, and that which is purchased from external primary, secondary and tertiary health support providers; and• support to ADF members who are posted overseas other than on operations (and may also include health support to dependants of members who accompany them on postings). <p>It does not include offshore operations, force assigned personnel, collective training, exercises and work-up activities and field training areas.</p>

Summary and Recommendations

Summary

Introduction

1. Australian Defence Force (ADF) personnel must be fit and free from illness or disability so that they can perform effectively under operational conditions. Accordingly, it is important that ADF members maintain a high level of preparedness for operational deployments. These can occur at short notice and have increased in number in recent years. For this reason, free health care, including dental and other ancillary health care¹, is a condition of service in the ADF.²
2. The provision of comprehensive health care to ADF members as a condition of their employment is also seen as playing a role in attracting and retaining members in the forces. Recruitment and retention of ADF personnel is always an important issue for Defence given the significant investment required to train personnel and generate capability.
3. The level of health care provided to ADF members is that which is: 'deemed necessary by the Chief of the Defence Force'.³ While the level of health care provided to the general community under Medicare is used as a guiding principle in determining the *basic* level of health care to which ADF members are entitled, Defence health policy recognises that the health services provided to ADF members will usually exceed this level of care so that the ADF requirement for members to meet and maintain operational readiness can be satisfied.
4. For example, members of the community with a medical condition that is not immediately life-threatening, seeking to have it treated under Medicare, may have to wait until a place is available for that condition to be treated. However, in the context of the ADF, such a medical condition is expected to be treated in a timely way to maximise the operational availability of the ADF member.

¹ Ancillary health care includes services such as physiotherapy, optical and podiatry services.

² *Defence Force Regulations 1952* regulation 58F(1) provides authority for the provision of health care to Australian Defence Force (ADF) personnel.

³ Defence Instruction (General) Pers 16–1 *Health Care of Defence Force Personnel* Dated 8 May 2002, paragraph 4.

5. The ADF employs medical, dental and ancillary support health professionals, including members of the ADF Reserves, to support its military operations. These staff may also provide services to ADF members while they are not on deployment (that is, while 'in garrison'). Defence also engages civilian health professionals (Contracted Health Professionals) to work exclusively or on a sessional basis, within ADF health facilities and provides its members with off-base health care that it generally pays for on a fee-for-service basis. Because of the difficulties involved in recruiting sufficient numbers of medical, dental and ancillary support health professionals for full-time service in the ADF, health professionals who are members of the ADF Reserves (Health Reservists)⁴, provide specialist skills that are not available in the full-time military staff and generate additional operational capability.

6. There are some 104 health facilities around Australia currently providing health support services to ADF personnel in garrison. These facilities include ADF hospitals on military bases, a whole ward of a civilian hospital, health centres, regimental aid posts and sick bays providing outpatient services, psychology support units and rehabilitation services.

7. Joint Operations Command (JOC) and the single Services (Navy, Army and Air Force) are responsible for Operational Health Support (that is support for offshore operations, force assigned personnel, collective training, exercises and work-up activities and field training areas).

8. Non-Operational Health Support (that is, health support for non-deployed ADF personnel 'in garrison' in Australia and any other health support that is not part of the Operational Health Support listed in paragraph 7) involves both the single Services and Joint Health Command (JHC). This support has to date mainly been provided by the single Services, in facilities that are attached to ADF units, but some Defence health facilities are managed and operated by JHC. In this audit report, health support provided to non-deployed ADF members in, or arranged by, Defence health facilities is termed 'Garrison Health Services'. The range of services provided as part of Garrison Health Services is summarised at Figure S 1.

⁴ The term 'Health Reservists' encompasses the members of the ADF Reserves (Army, Navy and Air Force) who are health professionals.

Figure S 1**Garrison Health Services**

Medical readiness and medical employment classification checks
Medical assessments and checks of ADF personnel to determine their medical readiness for deployment, current medical employment classification and rehabilitation needs.
Health care
<p>The following services are either provided directly by the garrison health facility or arranged by the facility:</p> <ul style="list-style-type: none"> • Primary medical and dental care • Inpatient care • Surgical procedures • Pharmacy services • Pathology services • Radiology services • Physiotherapy services • Mental health and psychology support services • Rehabilitation services • Other ancillary services (for example, physiotherapy, optical, podiatry and audiology services).

Source: ANAO analysis.

9. The provision of Garrison Health Services occurs in what Defence terms the National Support Area (NSA). In addition to its shared responsibility for the provision of Garrison Health Services, JHC has been responsible for the provision of other health support in the NSA.⁵ It also develops strategic health policy, provides strategic level health advice and exercises technical control of ADF health units.

10. Recognising a need to simplify the complex command and control arrangements for the delivery of Defence's health services and to improve the management of the services, the ADF's Chiefs of Service Committee (COSC)

⁵ This includes:

- external health services to which ADF members are referred by health personnel working on ships alongside any Australian or international port, and that which is purchased from external primary, secondary and tertiary health support providers; and
- support to ADF members who are posted overseas other than on operations (and may also include health support to dependants of members who accompany them on postings).

decided in July 2008 that responsibility for health services in the ADF should in future be split between:

- JHC, which will provide health care to ADF personnel within the NSA (that is, chiefly at the garrison level and in the other circumstances described in footnote 5), but with augmentation of resources from the single Services for Garrison Health Services; and
- JOC and the single Services, which will be responsible for health aspects of deployable capability.

11. As part of the 2009 Defence White Paper, the Government committed to extensive reform of Defence business to improve accountability, planning and productivity.⁶ In response to this, in June 2009, Defence announced the *Strategic Reform Program, Delivering Force 2030* (the 'SRP'). Under the SRP, Defence has committed to make gross savings of some \$20 billion over the ten years from 2009–19.⁷ Defence expects to realise savings in the provision of health care of around \$118 million in the budget of JHC over the 10 years of the SRP as part of the non-equipment procurement savings stream. JHC aims to realise efficiencies to achieve these savings by making better use of Defence health resources (for example, by consolidating the number of Defence health facilities into a single or small number of linked facilities at each base or regional location).

Audit approach

12. The objective of the audit was to assess whether Defence is effectively managing the delivery of health services to ADF personnel in Australia (chiefly Garrison Health Services).

13. In particular, the audit reviewed Defence's reform of health services delivery to non-deployed ADF personnel in Australia, including the role of JHC and implementation of the revised arrangements for Garrison Health Services. The audit also examined the cost of Garrison Health Services and other health support provided by JHC, Defence's health information management systems and Defence's management of a trial, announced in the

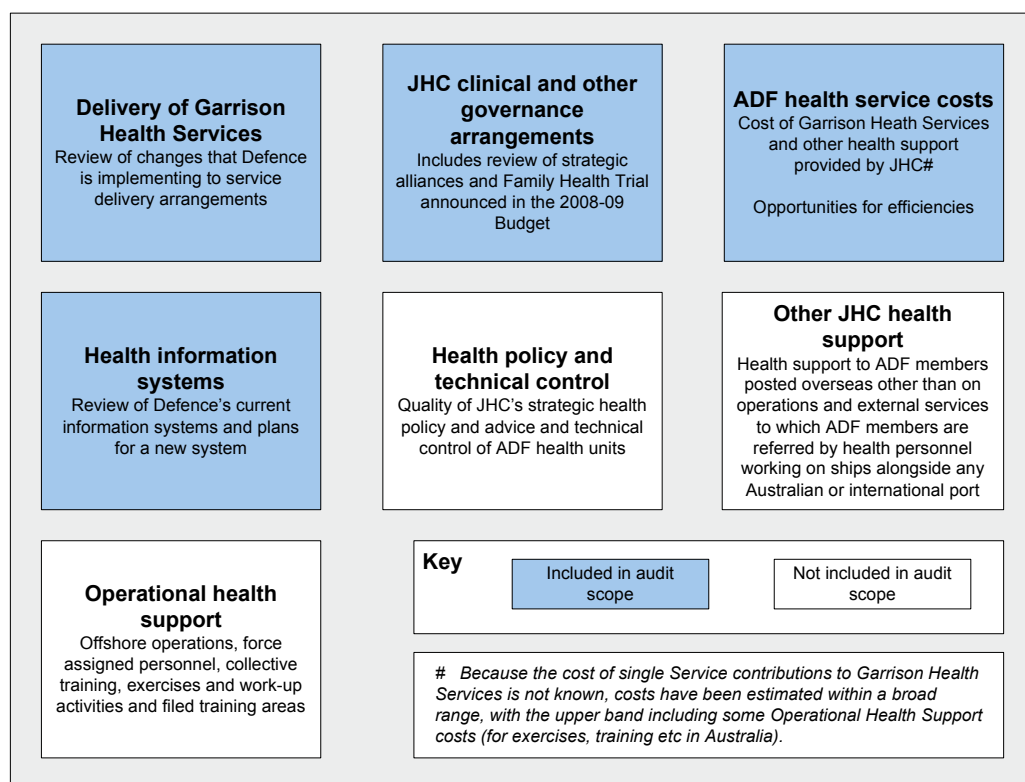
⁶ Department of Defence, *Defending Australia in the Asia Pacific Century: Force 2030*, Defence, Canberra, 2009.

⁷ Department of Defence, *The Strategic Reform Program: Delivering Force 2030*, Defence, Canberra, 2009, p. 3.

2008–09 Budget and that was under way during the audit, of the provision of basic medical and dental services to dependants of full-time ADF members. The audit scope is depicted at Figure S 2. It did not include a review of Operational Health Support.

Figure S 2

Audit scope – Health Services to ADF personnel in Australia



Source: ANAO analysis.

14. The high level criteria for the audit were that:

- Defence has effective arrangements for improving the delivery of ADF health services and, in particular, of Garrison Health Services; and
- Defence has effective information and patient records systems that support the delivery of ADF health services.

Overall conclusion

15. Defence provides comprehensive health support to around 55 000 ADF personnel.⁸ However, Defence recognises that there is scope to significantly improve the efficiency and effectiveness of its Garrison Health Services and is in the process of implementing reforms to the management and delivery of these services. While the overall direction of these changes is sound, because they are in the early stages of implementation and will take some years to complete, the ANAO has not been able to assess their effectiveness.

Defence health services reforms

16. Two previous ANAO audits (1997⁹ and 2001¹⁰) and several internal and external reviews of JHC's predecessors¹¹ have highlighted the difficulties posed for effective and efficient management of health care delivery to ADF members by the complex command and control arrangements for ADF health personnel. Defence's decision in July 2008 that JHC should have overall responsibility for Garrison Health Services will help to simplify somewhat the command and control of ADF personnel involved in delivery of Garrison Health Services, albeit that command and control arrangements for health personnel attached to single Service units who are involved in the delivery of Garrison Health Services continue to be complex.

17. Defence's planned model of health care delivery at the garrison level represents an improvement on the current model and should realise significant efficiencies if implemented effectively. Currently, there can be up to 11 Regimental Aid Posts and other medical facilities on a single base. The revised health care delivery model envisages consolidation of a range of services in a single facility (or a small number of linked or 'hubbed' facilities) at each base or regional location, providing the opportunity for a more holistic health response. Basic services are to be provided from 'hubbed' garrison

⁸ ADF Permanent Force Average Funded Strength in 2008–09 is 55 081—see Defence Annual Report 2008–09, Volume 1, p. 27. Reservists undertaking full-time service are included in this figure. Employees on forms of Leave Without Pay are not included.

⁹ Australian National Audit Office 1997, *Australian Defence Force Health Services Performance Audit*, Audit Report No.34, 1996–97, ANAO, Canberra.

¹⁰ Australian National Audit Office 2001, *Australian Defence Force Health Services Follow-up Audit*, Audit Report No.51, 2000–01, ANAO, Canberra.

¹¹ JHC has in the past has been variously called the Office of the Surgeon General of the ADF (OSGADF), the Defence Health Services Branch (DHSB) and the Defence Health Services Division (DHSD).

locations and higher level and specialist services supplied from civilian facilities off-base.

18. JHC has negotiated service level agreements (SLAs) with each of the Services that provide endorsement of the new service model. These SLAs will be given effect at a local level through regional level agreements (RLAs) that JHC is currently in the process of negotiating.¹² Defence has also sought to strengthen the management of JHC and of Garrison Health Services by moving to provide better oversight and support of health facilities¹³, transferring responsibility for JHC from DSG to the Vice Chief of the Defence Force (VCDF) Group and increasing to three the number of one-star ADF branch head positions in JHC.¹⁴

Governance arrangements for Garrison Health Services

19. Governance arrangements that Defence has in place for Garrison Health Services include high level oversight by senior Defence committees, an advisory committee and a well developed system of health directives¹⁵, instructions and manuals. Defence has also made a number of organisational changes to support health care delivery. However, there are further opportunities to improve the governance arrangements for Garrison Health Services including by:

- strengthening the performance monitoring and accountability framework for Garrison Health Services;

¹² The RLAs will detail the services, responsibilities and expected requirements of JHC and each single Service at military locations in each JHC region. The arrangements that will apply at each location will be dependent on the needs of the particular location. The completion of the RLAs has not yet been finalised, although JHC has made considerable progress in understanding the services that are required in each region.

¹³ Currently, JHC has nine regions, but these are to be reduced to five, mirroring regional boundaries already adopted by the Defence Support Group (DSG). Senior Regional Health Directors (RHDs) are to be appointed to head these new JHC regional offices and improve direction of them.

¹⁴ One each from the three Services (an additional one-star position was created in JHC for this purpose and a fourth branch head position, headed by an Australian Public Service (APS) officer, has also been established to manage Defence's mental health services). The three one-star officers, in addition to their JHC responsibilities, are responsible for representing the interests of each Service as a means of improving coordination between the three Services.

¹⁵ All JHC personnel (whether APS, contract or ADF) and ADF health personnel in single Service health elements must comply with instructions or directions issued in JHC Health Directives and Health Bulletins. They are general orders issued by, or under the authority of, the Commander Joint Health. All JHC personnel and health personnel in single Service health elements are required to ensure they are aware of Health Directives and Health Bulletins that are applicable to them. Other single Service health instructions are of no effect if they are inconsistent with JHC Health Directives and Health Bulletins.

- ensuring that the continued application of all health directives is reviewed every three years in accordance with current Defence policy;
- building on existing arrangements and reforms currently being implemented to enhance Defence's clinical governance framework;¹⁶
- analysing the nature, frequency, types and underlying causes of complaints and the effectiveness of complaint resolution arrangements; and
- improving collection and analysis of information on health incidents as a means of identifying opportunities to further improve health care delivery.¹⁷

20. Going forward, it will be important for the governance arrangements for ADF health support (including for both Operational and Garrison Health Services) to be sufficiently flexible to support innovative solutions Defence is adopting to address some of the particular challenges it faces in having sufficient access to appropriately qualified health personnel and services. In this context, Defence is currently exploring strategies to facilitate the timely release of health professionals who are members of the ADF Reserves (Health Reservists) from their regular employment to assist with emergency situations in the future.¹⁸ Defence has reached an agreement with the University of Queensland for the establishment of an inaugural Chair of Military Surgery to help strengthen, shape and lead military surgery, research and training for military surgeons. Defence also has local arrangements in place with various civilian hospitals for ADF health professionals to gain clinical experience in acute care.

21. As part of Garrison Health Services, JHC is also seeking to develop strategic alliances with state and territory hospitals for the provision of

¹⁶ Including by putting in place mechanisms to ensure that there is adequate clinical supervision of Contracted Health Professionals and that they are aware of and are applying ADF health policies.

¹⁷ Defence does not have an electronic system for collection and storage of reports on health incidents. JHC informed the ANAO that it is taking steps to introduce paper-based arrangements to collect and analyse information on health incidents as a means of identifying opportunities to further improve health care delivery.

¹⁸ For example, Defence is considering entering into strategic alliances with state and territory public hospitals at which many Health Reservists are currently employed to develop teams of personnel, who would continue to work in the public hospitals on a day-to-day basis, but who as Health Reservists could also be released for Defence deployments at short notice. Such an alliance is currently being explored with the Royal Brisbane and Women's Hospital and the Queensland Department of Health.

services. Defence already has a commercial arrangement with St Vincent's Hospital in Sydney that provides good access for ADF members to surgical facilities at the hospital and recovery in an ADF ward at the hospital. Defence considers that this arrangement provides a good model for the provision of acute care to ADF members in other locations in the future, should this be needed.

Managing the cost of ADF health services

22. Defence does not have in place mechanisms to monitor the total cost of Defence health services or its major components such as Garrison Health Services, other JHC activities and Operational Health Support.¹⁹ While Defence has not routinely monitored all costs related to the provision of Garrison Health Services, a 2006 review commissioned by the Chiefs of Services Committee (COSC) attempted to establish the total costs. The review calculated that the total annual cost of health care provided to ADF members at garrison level had increased in the period from 2001–02 to 2005–06 by around 16.7 per cent per annum to \$293 million.²⁰ In 2008–09 prices, this would equate to about \$335 million. However, since health care costs in the community, and in Defence, have increased more rapidly than consumer prices, the estimate of \$335 million is likely to be understated. For example, over the ten years to 2007–08, total health expenditure in Australia increased in real terms by around 5.2 per cent a year.²¹

¹⁹ Operational Health Support is not confined to health support provided for offshore operations, it also includes health support to force assigned personnel, collective training, exercises and work-up activities and field training areas.

²⁰ This figure was based, in part, on an estimate of the number of ADF personnel providing Garrison Health Services; it did not include the cost of all single Service ADF health personnel.

²¹ Australian Institute of Health and Welfare, *Health Expenditure Australia 2007–08*, September 2009, p. 14.

23. The ANAO estimates that expenses on Garrison Health Services currently range between \$455 million²² and \$654 million.²³ As Defence is unable to identify the proportion of their time that ADF single Service health members are spending on Garrison Health Services, the ANAO's estimates cover a wide band. However, these estimates are broadly consistent with previous estimates of total Garrison Health Services expenses.

24. Monitoring is necessary to provide assurance that the overall cost of Defence health services, including Garrison Health Services, is being effectively managed. JHC manages only part of the cost of Garrison Health Services; the remaining cost components are the responsibility of the single Services, the Defence Support Group (DSG)²⁴ and the Defence Materiel Organisation (DMO).²⁵ Current Defence financial systems do not effectively support the identification of relevant costs across the various parts of the agency that aggregate to form the total cost of health care provided to ADF members.

25. There was rapid growth in Defence's expenditures related to purchased health professional services²⁶ over the five years from 2004–05 to 2008–09, with total expenditures increasing from \$162 million in 2004–05 to \$261 million in 2008–09. Over the same period, expenditure by JHC on ADF employees fell around eight per cent from \$42 million in 2004–05 to \$39 million in 2008–09. Accordingly, to assist in reducing reliance on these contractor resources, it is important that Defence maximise the use of the ADF health personnel already in garrison to provide Garrison Health Services, consistent with operational requirements and the requirement for them also to gain experience in acute care settings to ready them for deployment.²⁷ Defence is

²² Excluding the cost of ADF single Service health members involved in providing Garrison Health Services.

²³ Including the cost of all ADF health members in garrison, although some of their time will be spent in preparing for operations and other matters, rather than in providing Garrison Health Services.

²⁴ DSG is responsible for costs relating to Defence-owned health facilities.

²⁵ DMO is responsible for health materiel costs.

²⁶ Defence purchases health professional services in a range of ways: through individual contracts or via a prime contract arrangement; through fee for service arrangements with civilian health professional service providers; and through arrangements for health professional service providers to provide services on a sessionalist basis, for example they might provide services at a Defence health facility one day a week.

²⁷ Acute care experience is not generally available in Defence owned and operated health facilities in Australia.

also examining the scope to increase the number of Australian Public Service (APS) health personnel employed by the department, who have been assessed as less expensive overall than contractors, as a means of reducing the current high cost of using Contracted Health Professionals.

26. Other opportunities to reduce the cost of Garrison Health Services include:

- ensuring that the level of health support provided to ADF members is aligned with operational requirements;²⁸
- redirecting ADF health care resources away from work that adds limited value;²⁹ and
- transferring responsibility for administrative tasks from health personnel to administrative support staff, where it is professionally appropriate and cost effective to do so.

Health information systems

27. Defence does not currently have effective information and patient records systems to support the delivery of ADF health services. These systems are needed to help realise efficiencies (for example, through the provision of better management information) in the provision of appropriate health care for ADF members.

28. Defence has previously attempted to introduce a patient records system, the Health Key Solution or HealthKEYS. However, users found HealthKEYS difficult to use (for example, moving between different screens is not easy and the system has poor response times). For this reason, only some health facilities currently use HealthKEYS and Defence has now decided to introduce a replacement system which is currently under development. A lesson learnt from the failure of HealthKEYS is the need for the system to meet user needs. Defence expects to progressively deploy its replacement system, to be developed based on commercial off-the-shelf products and to be called the

²⁸ That is, by ensuring that, where the health support provided to ADF members exceeds that available to members of the general community, there is an operational requirement for this.

²⁹ For example, the current mandatory annual health assessments undertaken for all ADF members may not provide an efficient and cost effective means of determining an ADF member's readiness for deployment or of promoting the health of ADF members.

Joint e-Health Data Information system (JeHDI), between July 2011 and December 2013.

Key findings

Defence health service reforms (Chapter 2)

Command and control of Garrison Health Services

29. A 1997 ANAO audit and several internal and external reviews of JHC's predecessors have previously highlighted the difficulties posed for effective and efficient management of health care delivery to ADF members by the complex command and control arrangements for ADF health personnel.

30. Defence's decision in July 2008 that JHC should have overall responsibility for Garrison Health Services will help to simplify the command and control of ADF personnel involved in delivery of Garrison Health Services. However, there may be the potential to simplify command and control arrangements relating to health care delivery in garrisons even further by integrating the single Services' health units within JHC. For example, it would be possible for all ADF health personnel to be employed by JHC, but be formally transferred to units for the duration of a deployment and be available for training with units in preparation for deployments. When on deployment, the health personnel would come under the command and control of the deployed unit's commander. Under this approach, there would no longer be a requirement to retain separate health agencies in each of the single Services. A similar option was proposed in the 1997 ANAO performance audit. In the longer term, the ANAO suggests that Defence re-examine this option.

Efficiency and effectiveness of Garrison Health Services

31. Defence's planned model of health care delivery at the garrison level represents an improvement on the current model and should realise significant efficiencies if implemented effectively. Currently, there can be up to 11 Regimental Aid Posts and other medical facilities on a single base. The revised health care delivery model envisages consolidation of a range of services in a single facility (or a small number of linked or 'hubbed' facilities) at each base or regional location, so providing the opportunity to provide a more holistic health response. Basic services are to be provided from 'hubbed' garrison locations and higher level and specialist services supplied from civilian facilities off-base. A diagram of this service model is at Figure 2.3.

Implementation of the new Garrison Health Services delivery model

32. JHC has negotiated service level agreements (SLAs) with each of the Services that provide endorsement of the new service model. These SLAs will be given effect at a local level through regional level agreements (RLAs) which will detail the services, responsibilities and expected requirements of JHC and each single Service at military locations in each JHC region. The arrangements that will apply at each location will be dependent on the needs of the particular location. The completion of the RLAs has not yet been finalised, although JHC has made considerable progress in understanding the services that are required in each region.

33. Defence has also sought to strengthen the management of JHC and of Garrison Health Services by:

- moving to provide better oversight and support of health facilities. Currently, JHC has nine regions, but these are to be reduced to five, mirroring regional boundaries already adopted by the Defence Support Group (DSG). Senior Regional Health Directors (RHDs) are to be appointed to head these new JHC regional offices and improve direction of them; and
- transferring responsibility for JHC from DSG to the Vice Chief of the Defence Force (VCDF) Group and increasing to three the number of one-star ADF branch head positions in JHC, one each from the three Services (an additional one-star position was created in JHC for this purpose and a fourth branch head position, headed by an APS officer, has also been established to manage Defence's mental health services). The three one-star officers, in addition to their JHC responsibilities, are responsible for representing the interests of each Service as a means of improving coordination between the three Services.

34. Although the direction of these reforms is sound, it is too early to assess the effectiveness of them, since some elements of the reforms are in the early stages of implementation. Much will also depend on the outcomes of negotiations on the new RLAs and the effectiveness of support to be provided by the new RHDs.

Governance arrangements for Garrison Health Services (Chapter 3)

35. Governance arrangements that Defence has in place for Garrison Health Services include high level oversight by senior Defence committees, an advisory committee and a well developed system of health directives, instructions and manuals. Defence has also made a number of organisational changes to support health care delivery. However, the ANAO considers that governance arrangements for Garrison Health Services can be improved.

Planning and performance monitoring

36. Significantly, JHC does not have a current strategic plan, which is required given the many changes to priorities flowing from Defence's reforms of Garrison Health Services and the Strategic Reform Program. Related to this, Defence also has few meaningful measures against which to monitor its performance and how well health services are being delivered, due in large measure to the lack of a reliable, robust and complete health management information system across the ADF. Defence's performance monitoring and accountability framework for Garrison Health Services could be strengthened by:

- developing both effectiveness and efficiency Key Performance Indicators (KPIs) that adequately reflect JHC's business performance and which can be progressively refined and implemented over the course of the reforms as improved management information becomes available; and
- including the provision of annual performance reports against these KPIs in the context of the Department's annual report or on its website.

37. In this context, Defence informed the ANAO that it has now commenced work on a new performance management framework.

Clinical governance

38. Defence has a well developed system of directives, instructions and manuals to support health care delivery to both deployed and non-deployed

ADF personnel.³⁰ While Defence's policy is that the continued application of all health directives should be reviewed every three years, this has not been occurring. The ANAO considers it is important that all health directives are reviewed in accordance with this policy, with performance against this benchmark being monitored and reported on.

39. There are also opportunities to improve Defence's clinical governance framework, which is built on the credentialing of health professionals, the accreditation of facilities, health incident reporting, the management of health complaints and the orientation of health staff.

40. To provide assurance on the credentialing of health professionals, Defence requires ADF health professionals to maintain their health credentials. Currently, this is monitored by the single Services, but, as JHC takes on responsibility for Garrison Health Services, it will need to put in place arrangements to monitor the credentials of all ADF health personnel working in its facilities.

41. Accreditation of health facilities is important in providing assurance that health care provision will not be compromised by facilities that do not meet recognised health standards. In the past, Defence has primarily accredited its facilities against International Organization for Standardization (ISO) standards. However, Defence is now planning to accredit most of its facilities against Royal Australian College of General Practice (RACGP) standards for ADF primary care, Australian Council on Healthcare Standards (ACHS) for inpatient facilities and National Association of Testing Authorities (NATA) standards for pathology laboratories. The standards for ADF primary care will be tailored to the specific needs of ADF health facilities. Defence is also planning to conduct internal audits of facilities against the new standards. Defence is considering the extension of the new accreditation arrangements to dentistry at a later stage. It is not yet possible to assess the effectiveness of these arrangements, since they have still to be implemented. However, if

³⁰ The Commander Joint Health's role involves the provision of advice and the development of policy on a range of health issues. Health policy that has general application to the administration of the ADF is promulgated in the form of either Defence Instructions (General) or Australian Defence Force Publications. Health policy instructions are issued in the form of JHC Health Directives or Health Bulletins. Health Directives are used to establish enduring health policy, whereas Health Bulletins are used to disseminate health policy that is short term in nature or which needs to be promulgated quickly. Table 3.1 lists the various categories of Health Directives.

effectively implemented, the new arrangements should provide the necessary assurance that health facilities meet recognised health standards.

42. The performance of each Contracted Health Professional working in ADF facilities is reviewed by JHC annually. However, there is little clinical supervision of them by ADF members. The ANAO considers that, with the significant number of Contracted Health Professionals working in Defence health facilities (786 in September 2009), there is a need for JHC to put in place mechanisms to ensure that there is adequate clinical supervision of them. This would, for example, help to ensure that Contracted Health Professionals are aware of and are applying ADF health policies.

43. Defence collects and monitors information on client feedback and complaints, but analysis of the nature, frequency, types and underlying causes of complaints and the effectiveness of complaint resolution arrangements would further improve these arrangements.

44. JHC does not have a system to collect information on reported health incidents. However, it has advised that it is taking steps to introduce paper-based arrangements to collect and analyse information on health incidents as a means of identifying opportunities to further improve health care delivery. The ANAO considers that an effective health incident management system is an essential part of an integrated clinical management system.

Strategic alliances

45. As noted in paragraph 20, it will be important for the governance arrangements for Defence health services (including for both Operational and Garrison Health Services) to be sufficiently flexible to support innovative solutions Defence is adopting to address some of the particular challenges it faces in having sufficient access to appropriately qualified health personnel and services.

46. Because of the ADF's ongoing need for Health Reservists, Defence has had in place for some time higher level Employer Support Payments in respect of medical, dental, nursing and allied health officers (who are within specified health disciplines) undertaking various forms of Defence service. However, in the event of an emergency, Defence needs to have quick access to the services of Health Reservists. Until now, the release of these members from their regular employment has been on an ad hoc basis. This relies heavily on the goodwill of state and territory hospitals and the personal availability of the Health Reservists themselves.

47. Accordingly, Defence is currently exploring strategies to facilitate the timely release of such health personnel to assist with emergency situations in the future. For example, Defence is considering entering into strategic alliances with state and territory public hospitals at which many Health Reservists are currently employed to develop teams of personnel, who would continue to work in the public hospitals on a day-to-day basis, but who, as Health Reservists, could also be released for Defence deployments at short notice. Such an alliance is currently being explored with the Royal Brisbane and Women's Hospital (RBWH) and the Queensland Department of Health. Defence has also reached an agreement with the University of Queensland for the establishment of an inaugural Chair of Military Surgery to help strengthen, shape and lead military surgery, research and training for military surgeons.

48. JHC is seeking to develop strategic alliances with state and territory hospitals for the provision of services for Garrison Health Services. It has a commercial arrangement with St Vincent's Hospital in Sydney that provides good access for ADF members to surgical facilities at the hospital and recovery in an ADF ward at the hospital. Defence considers that this arrangement provides a good model for the provision of acute care to ADF members in other locations in the future, should this be needed.

49. Defence also has local arrangements in place with various civilian hospitals to provide clinical experience in acute care areas to ADF members as required. However, as JHC assumes responsibility for Garrison Health Services, the ANAO considers there would be benefit in it systematically developing and monitoring arrangements with civilian hospitals for ADF medical staff to gain the required clinical experience. These arrangements should be developed in cooperation with the single Services to ensure that all ADF medical personnel, including those not providing Garrison Health Services, are able to acquire beneficial clinical experience.

Family Health Trial

50. The Family Health Trial has only recently been implemented, and so it has not been possible to assess it fully. However, given risks identified with the trial, including its high cost, the ANAO suggests that Defence undertake a preliminary evaluation of it after it has been operating for a year.

Managing the cost of ADF health services in Australia (Chapter 4)

51. JHC's administered expenses are almost entirely made up of the cost of Contracted Health Professionals (employed either as individuals or via regional prime contracts) and the costs of medical and dental services provided by civilian health professionals on a fee-for-service basis. However, these costs make up only a small part of ADF health care costs. They do not include expenses related to ADF and APS health personnel working in garrison health facilities; the bulk of expenses related to health materiel; expenses incurred in maintaining and operating ADF health facilities; or corporate services expenses, such as information technology (IT) expenses.

52. JHC expenditures on purchased health professional services increased by around 60 per cent from \$162 million in 2004–05 to \$261 million in 2008–09, while its expenditures on ADF employees fell around eight per cent from \$42 million in 2004–05 to \$39 million in 2008–09.

53. Defence does not monitor the overall cost of Defence health care, including Garrison Health Services, provided to ADF members. Such monitoring is necessary to provide the required assurance that the overall cost of health care in Defence is being effectively managed and because changes in one part of Garrison Health Services can affect the cost in other areas. JHC manages part of the cost of Garrison Health Services; the remaining cost components are the responsibility of the single Services, the Defence Support Group (DSG)³¹ and the Defence Materiel Organisation (DMO).³² Current Defence financial systems do not support the identification of relevant costs across the various parts of the agency that aggregate to form the total cost of health care provided to ADF members. So that JHC can develop accurate estimates of the total cost of Defence health care and then monitor these costs, the other relevant areas of Defence will need to provide it with details of the cost of Garrison Health Services related services that they provide.

Estimated cost of Defence health care in Australia

54. The ANAO estimates that expenses on Garrison Health Services range between \$455 million, excluding the cost of non-JHC ADF single Service members providing Garrison Health Services, and \$654 million if all non-JHC

³¹ DSG is responsible for costs relating to Defence-owned health facilities.

³² DMO is responsible for health materiel costs.

ADF health members in garrison are included (although some of their time will be spent in preparing for operations and other matters, rather than in providing Garrison Health Services). These estimates are broadly consistent with previous estimates of total Garrison Health Services expenses.

55. The 1996–97 audit compared ADF health care costs with estimates of health costs in the community. At that time, the cost per ADF member was almost three times the Australian average. This cost included the cost of all ADF members providing health support (around 2382 members). The ANAO estimates that the cost per ADF member is now between about 1.7 (excluding non-JHC ADF members in garrison) and about 2.5 times (including non-JHC ADF members in garrison)³³ the cost per person in the wider Australian community.

56. There are several reasons why ADF health care costs exceed the cost per person in the community. These relate to the maintenance of a military that is well prepared for operational duty and government policy that, for this purpose, ADF members should be provided with free health care.

Reducing the cost of Defence health care

57. There is scope for Defence to reduce the cost of health care to ADF members and one of the objectives of the current health reforms by Defence is to realise efficiencies in its health care delivery. Contracted Health Professional, fee-for-service and sessional provider health services costs are rising largely in response to reducing numbers of ADF health personnel who are providing Garrison Health Services. It is important therefore that ADF health personnel are actively used by Defence to provide Garrison Health Services, consistent with operational requirements and the need for such staff also to gain experience in acute care settings. Defence is also examining the scope to increase the number of APS health personnel employed by the department as a means of reducing the current high cost of using Contracted Health Professionals.

58. Other opportunities to reduce the cost of Garrison Health Services include:

³³ The ANAO's cost estimate of \$654 million mentioned in the previous paragraph was adjusted to include an allowance for the cost of capital as allowance for the opportunity cost of capital was included in the 1996–97 audit cost estimate.

- ensuring that the level of health support provided to ADF members is aligned with operational requirements;³⁴
- redirecting ADF health care resources away from work that adds limited value. For example, the current mandatory annual health assessments undertaken for all ADF members may not provide an efficient and cost effective means of determining an ADF member's readiness for deployment or of promoting the health of ADF members; and
- transferring responsibility for administrative tasks from health personnel to administrative support staff, where it is professionally appropriate and cost effective to do so.

Health information systems (Chapter 5)

59. Defence has several electronic health (e-health) information systems but, despite considerable efforts over the past 20 years, it still does not have a single patient records management system. As a result Defence medical personnel continue to rely primarily on paper-based patient records. One of its existing systems, Health Key Solution or HealthKEYS, was intended to meet Defence's e-health patient records needs. However, it does not do so, because among other things the selected system was out-dated, not suited to Defence's preferred information architecture model and was not implemented efficiently and effectively. Another system used widely within Defence health facilities is the Medical Information Management Index (MIMI). However, this system was not developed as a fully functioning health information system and has many limitations. In most locations, it is facility based.

60. Defence recognises that the absence of a comprehensive e-health information system is inefficient and, as noted earlier, has decided that a new system, based on a suite of commercial off-the-shelf products and to be called the Joint e-Health Data Information system (JeHDI), should be developed. In February 2010, Defence called for tenders for the development of this system. Defence expects JeHDI to be progressively deployed between July 2011 and December 2013.

³⁴ That is, by ensuring that, where the health support provided to ADF members exceeds that available to members of the general community, there is an operational requirement for this.

61. The failed development and implementation of HealthKEYS emphasises the value of having strong project governance arrangements, independent assurance of the development of a system and effective change management during the implementation phase.

Defence response

62. Defence acknowledges the ANAO report findings in relation to *Defence's Management of Health Services to Australian Defence Force Personnel in Australia*. Defence agrees fully with five of the recommendations and agrees with qualification to one recommendation.

63. Joint Health Command within Defence has been undertaking a significant health reform program for the past 18 months as is acknowledged in the audit report. Defence's reform activities will address the requirements of the agreed recommendations.

64. Defence as a matter of course will continue to pursue continuous improvement in relation to the provision of Health Services for ADF personnel both in Australia and overseas.

Recommendations

Recommendation No.1
Paragraph 3.16 The ANAO recommends that, in accordance with established Defence policy, JHC review the continued application of all Health Directives every three years.

Defence response: Agreed.

Recommendation No.2
Paragraph 3.37 The ANAO recommends that JHC:

- (a) identify effectiveness and efficiency KPIs that adequately reflect its business performance and that can be progressively refined as the current Defence health services reform program is implemented; and
- (b) provide annual performance reports against relevant KPIs to inform internal management decisions in relation to JHC and to facilitate external scrutiny of JHC's performance, such as through the department's annual report.

Defence response: Agreed.

Recommendation No.3
Paragraph 3.63 The ANAO recommends that JHC:

- (a) establish mechanisms, in cooperation with each Service, to monitor the currency of credentials of all ADF health professionals working in JHC health facilities;
- (b) enhance its complaints management database to enable capture of information that will facilitate analysis of the nature, frequency, types and underlying causes of complaints and the effectiveness of complaint resolution arrangements;
- (c) collect and analyse information on health related incidents, including claims submitted to the Defence Insurance Office, and use this information to identify further opportunities to

improve Garrison Health Services; and

- (d) put in place mechanisms to ensure that there is improved clinical supervision of contracted health professionals working in JHC health facilities.

Defence response: Agreed.

**Recommendation
No.4**

Paragraph 4.43

To provide a better framework for effective management decisions on Defence health service delivery, and to improve financial transparency of Defence's health operations, the ANAO recommends that Defence establish mechanisms to collate and monitor the total cost of Garrison Health Services and other JHC activities.

Defence response: Agreed with qualification.

**Recommendation
No.5**

Paragraph 4.70

The ANAO recommends that Defence:

- (a) evaluate the current level of health services provided to ADF members under ADF health policies. Where such policies provide for a level of health services that exceeds community standards, Defence should ensure that they are cost effective and justified, including in improving the operational readiness of ADF members; and
- (b) consider the merits of adopting a risk-based approach in preference to annual individual readiness medical and dental checks.

Defence response: Agreed.

**Recommendation
No.6**

Paragraph 4.76

The ANAO recommends that JHC examine the scope to achieve efficiencies through reducing the administrative burden of health personnel by reallocating administrative tasks to administrative support staff, where possible.

Defence response: Agreed.

Audit Findings and Conclusions

1. Introduction

This chapter provides background information on Defence's health services and, in particular, on Garrison Health Services. It also explains the approach, objective and methodology of the audit.

Background

1.1 Australian Defence Force (ADF) personnel must be fit and free from illness or disability so that they can perform effectively under operational conditions. Accordingly, it is important that ADF members maintain a high level of preparedness for operational deployments. These can occur at short notice and have increased in number in recent years. For this reason, free health care, including dental and other ancillary health care³⁵, is a condition of service in the ADF.³⁶

1.2 The provision of comprehensive health care to ADF members as a condition of their employment is also seen as playing a role in attracting and retaining members in the forces. Recruitment and retention of ADF personnel is always an important issue for Defence given the significant investment required to train personnel and generate capability.

1.3 The level of health care provided to ADF members is that which is: 'deemed necessary by the Chief of the Defence Force'.³⁷ While the level of health care provided to the general community under Medicare is used as a guiding principle in determining the *basic* level of health care to which ADF members are entitled, Defence health policy recognises that the health services provided to ADF members will usually exceed this level of care so that the ADF requirement for members to meet and maintain operational readiness can be satisfied.

1.4 For example, members of the community with a medical condition that is not immediately life-threatening, seeking to have it treated under Medicare, may have to wait until a place is available for that condition to be treated.

³⁵ Ancillary health care includes services such as physiotherapy, optical, podiatry and audiology services.

³⁶ *Defence Force Regulations 1952* regulation 58F(1) provides authority for the provision of health care to Australian Defence Force (ADF) personnel.

³⁷ Defence Instruction (General) Pers 16–1 *Health Care of Defence Force Personnel* Dated 8 May 2002, paragraph 4.

However, in the context of the ADF, such a medical condition is expected to be treated in a timely way to maximise the operational availability of the ADF member.

1.5 The ADF employs medical, dental and ancillary support health professionals to support its military operations. These staff may also provide services to ADF members while they are not on deployment (that is while ‘in garrison’). Defence also engages civilian health professionals (Contracted Health Professionals) to work exclusively or on a sessional basis, within Defence health facilities and provides its members with off-base health care that it generally pays for on a fee-for-service basis. Because of the difficulties involved in recruiting sufficient numbers of medical, dental and ancillary support health professionals for full-time service in the ADF, health professionals who are members of the ADF Reserves (Health Reservists)³⁸, provide specialist skills that are not available in the full-time military staff and generate additional operational capability.

1.6 Joint Operations Command (JOC) and the single Services (Navy, Army and Air Force) are responsible for ADF Operational Health Support (that is, support for offshore operations, force assigned personnel, collective training, exercises and work-up activities and field training areas).

1.7 Non-operational health support (that is, health support for non-deployed ADF personnel ‘in garrison’ in Australia and is not part of the Operational Health Support listed in paragraph 1.6) is currently shared between the single Services and Joint Health Command (JHC). This support has to date mainly been provided by the single Services, in facilities that are attached to ADF units, but some ADF health facilities are managed and operated by Joint Health Command (JHC).³⁹ In this audit report, this health support provided to non-deployed ADF members is termed ‘Garrison Health Services’. The range of Garrison Health Services is summarised at Figure 1.1.

³⁸ The term ‘Health Reservists’ encompasses the members of the ADF Reserves (Army, Navy and Air Force) who are health professionals.

³⁹ JHC has in the past has been variously called the Office of the Surgeon General of the ADF (OSGADF), the Defence Health Services Branch (DHSB) and the Defence Health Services Division (DHSD).

Figure 1.1**Garrison Health Services**

Medical readiness and medical employment classification checks
Medical assessments and checks of ADF personnel to determine their medical readiness for deployment, current medical employment classification and rehabilitation needs.
Health care
<p>The following services are either provided directly by the garrison health facility or arranged by the facility:</p> <ul style="list-style-type: none"> • Primary medical and dental care • Inpatient care • Surgical procedures • Pharmacy services • Pathology services • Radiology services • Physiotherapy services • Mental health and psychology support services • Rehabilitation services • Other ancillary services (for example, physiotherapy, optical, podiatry and audiology services).

Source: ANAO analysis.

1.8 In addition to its shared responsibility for the provision of Garrison Health Services, JHC has been responsible for the provision of other health support in what is termed the National Support Area (NSA), as shown in Figure 1.2.

Figure 1.2**National Support Area**

National Support Area
<ul style="list-style-type: none"> • Garrison Health Services. • External health services to which ADF members are referred by health personnel working on ships alongside any Australian or international port, and that which is purchased from external primary, secondary and tertiary health support providers. • Support to ADF members who are posted overseas other than on operations (and may also include health support to dependants of members who accompany them on postings).

Note: Does not include offshore operations, force assigned personnel, collective training, exercises and work-up activities and field training areas.

Source: JHC.

1.9 JHC also develops strategic health policy, provides strategic level health advice and exercises technical control of ADF health units. It is now

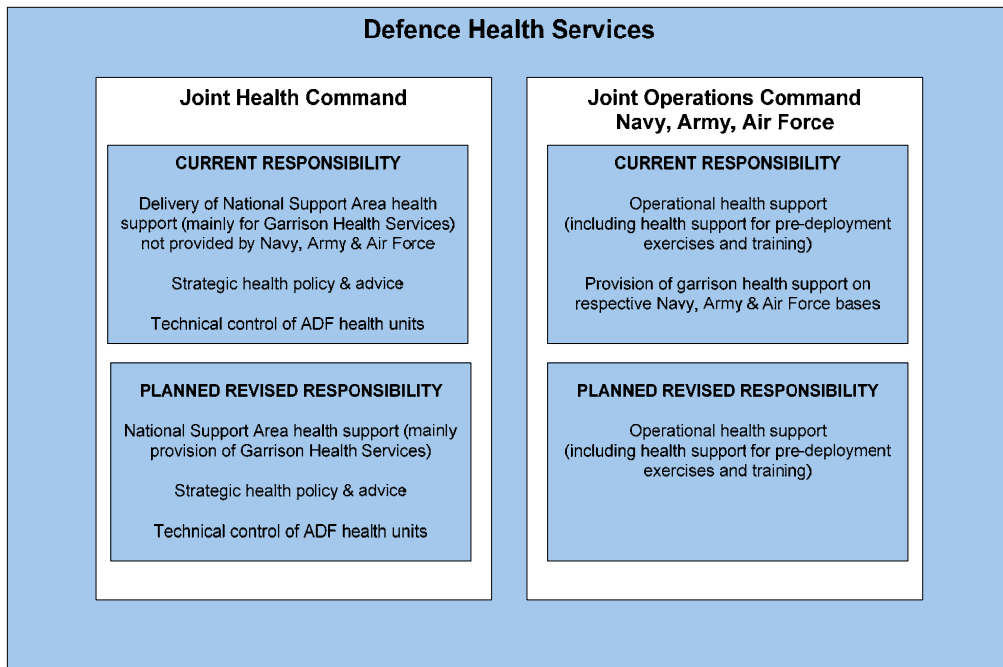
headed by the Commander Joint Health (CJHLTH), who is also the Surgeon-General of the ADF (SGADF).

1.10 Recognising a need to simplify the complex command and control arrangements for the delivery of Defence's health services and to improve the management of the services, the ADF's Chiefs of Service Committee (COSC) decided in July 2008⁴⁰ that responsibility for health services in the ADF should in future be split between:

- JHC, which will provide health care to ADF personnel within the NSA (that is, chiefly at the garrison level and in the other circumstances described in Figure 1.2), but with augmentation of resources from the single Services; and
- JOC and the single Services, which will be responsible for health aspects of deployable capability.

1.11 The current and revised split of primary responsibilities is depicted at Figure 1.3.

⁴⁰ Defence Health Services Command Arrangements, COSC Paper Agendum 50/08, 11 July 2008.

Figure 1.3**Current and planned revised split of primary responsibilities for health care support in the ADF**

Source: ANAO analysis.

1.12 Because of the large amount of work needed to implement the revised arrangements, and lags arising from the annual posting cycle for ADF personnel, it is likely to be some years before implementation of the revised arrangements is complete. The single Services therefore currently continue to play a major role in the provision of Garrison Health Services.

1.13 As part of the 2009 Defence Strategic Reform Program (SRP)⁴¹, Defence's response to the Government's 2009 Defence White Paper⁴², which seeks to improve Defence's accountability, planning and organisation, Defence expects to realise savings of around \$4.4 billion over 10 years in non-

⁴¹ Under the SRP Defence is required to generate some \$20 billion in gross savings over the ten years 2009–19 in order to fund the acquisition of required major capital equipment for the achievement of Force 2030 as outlined in the Defence White Paper 2009. *The Strategic Reform Program 2009: Delivering Force 2030* was announced by the Government on 4 June 2009.

⁴² Department of Defence, *Defending Australia in the Asia Pacific Century: Force 2030*, Defence, Canberra, 2009.

equipment procurement, of which health support is a part. These include savings of \$118 million in the budget of Joint Health Command in the 10 years 2009–10 to 2018–19, with most of the savings expected to occur from 2013–14. It is therefore also important that the provision of health support to ADF members is efficient and cost effective.

1.14 There are currently 104 individual health facilities that provide ADF Garrison Health Services. These range from base hospitals (for example, 1st Health Support Battalion (1HSB) at Holsworthy Army Base in Sydney or 2HSB at Enoggera Army Base in Brisbane) or a whole ward of a civilian hospital (St Vincent’s Hospital in Sydney) to health centres (medical and dental), small regimental aid posts and sick bays providing outpatient services, psychology support units and rehabilitation services. Defence plans to consolidate and so reduce the number of these facilities in the future to reduce costs and make better use of its health resources. This should assist Defence in meeting its agreed SRP savings.

Previous audit reports and other reviews

1.15 The ANAO conducted a performance audit of Defence Force health services in 1997⁴³, which was examined by the Joint Committee of Public Accounts and Audit⁴⁴, and a follow up audit in 2001.⁴⁵ The 1997 audit found that the ADF provided high quality health services to its members. However, it also found that:

- health service administrative structures were complex and fragmented. This led to inefficiencies and inequities in the provision of health services;
- the cost of service delivery by the then Defence Health Services Branch was relatively high; and
- the systems in Defence for providing health care should be improved.

⁴³ Australian National Audit Office 1997, *Australian Defence Force Health Services Performance Audit*, Audit Report No.34, 1996–97, ANAO, Canberra.

⁴⁴ Joint Committee of Public Accounts and Audit, *Review of Auditor-General’s Reports 1996–97, Fourth Quarter Report 359*, March 1998. A public hearing was held on 25 July 1997.

⁴⁵ Australian National Audit Office 2001, *Australian Defence Force Health Services Follow-up Audit*, Audit Report No.51, 2000–01, ANAO, Canberra.

1.16 The 2001 follow-up audit found that many of the 19 recommendations of the 1997 audit had not been implemented or had only been partially implemented. Of particular concern in the follow-up audit was the continued absence of up-to-date information on the cost of providing health services.

1.17 There have also been a number of reviews of Defence's health services, and in particular Garrison Health Services, in recent years. These include:

- a wide-ranging review of the ADF health services in 2004 (the 'Stevens Review');⁴⁶
- a review in 2006 for COSC of the cost of providing health care to the ADF in the National Support Area (the 'COSC Cost Review');⁴⁷
- a review in 2007 of the risk and cost assessment of different health delivery options (the 'Grosvenor Review');⁴⁸ and
- a review for COSC and presentation of a paper to it in July 2008 (the 'Alexander Review')⁴⁹, which led to the decision mentioned in paragraph 1.10 to centralise responsibility for Garrison Health Services under JHC.

1.18 In addition, Professor David Dunt conducted a review of mental health in the ADF in 2008. His report, which was released in January 2009⁵⁰, made 52 recommendations. Defence agreed to 49 of these and partially to the other three. The Government has committed \$83 million over four years to implement the reform agenda proposed by the review.

⁴⁶ Department of Defence, *Review of the Defence Health Service 2004*, Defence, Canberra, 2004, p. ii. The Stevens Review identified many issues with ADF health services, including the need for improved command and control arrangements, responsive health standards and policies, efficient health services, professional, motivated and competent health personnel, training to ensure the health staff are competent and ADF health facilities are fully functional, responsive acquisition and supply of health equipment, stores and pharmaceutical items and readily accessible individual health records.

⁴⁷ Cogent Business Solutions, *Conduct of a Study into Health Care Costs in the Defence Health Service*, April 2006.

⁴⁸ Grosvenor Management Consulting, *Risk and Cost Assessment of Health Delivery Options*, March 2007.

⁴⁹ Defence Health Services Command Arrangements, Agendum 50/08, 11 July 2008.

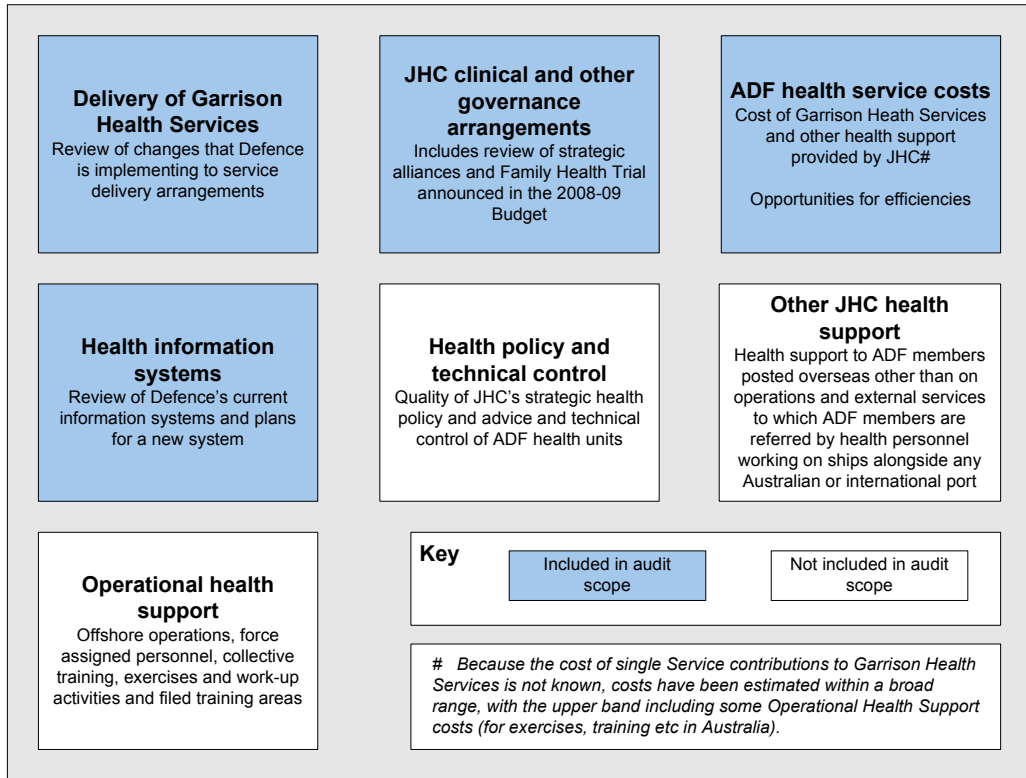
⁵⁰ Professor David Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, Canberra, 2009.

Audit objective, scope and criteria

1.19 The audit objective was to assess whether Defence is effectively managing the delivery of health services to ADF personnel in Australia (chiefly Garrison Health Services).

1.20 The audit reviewed Defence's reform of health services delivery to non-deployed ADF personnel in Australia, including the role of JHC and implementation of the revised arrangements for management and effective delivery of these services. The audit also examined the cost of Garrison Health Services and other health support provided by JHC, Defence's health information management systems and Defence's management of a trial, announced in the 2008–09 Budget and currently under way, of the provision of basic medical and dental services to dependants of full-time ADF members.

1.21 The scope of the audit is depicted in Figure 1.4.

Figure 1.4**Audit scope: Health Services to ADF personnel in Australia**

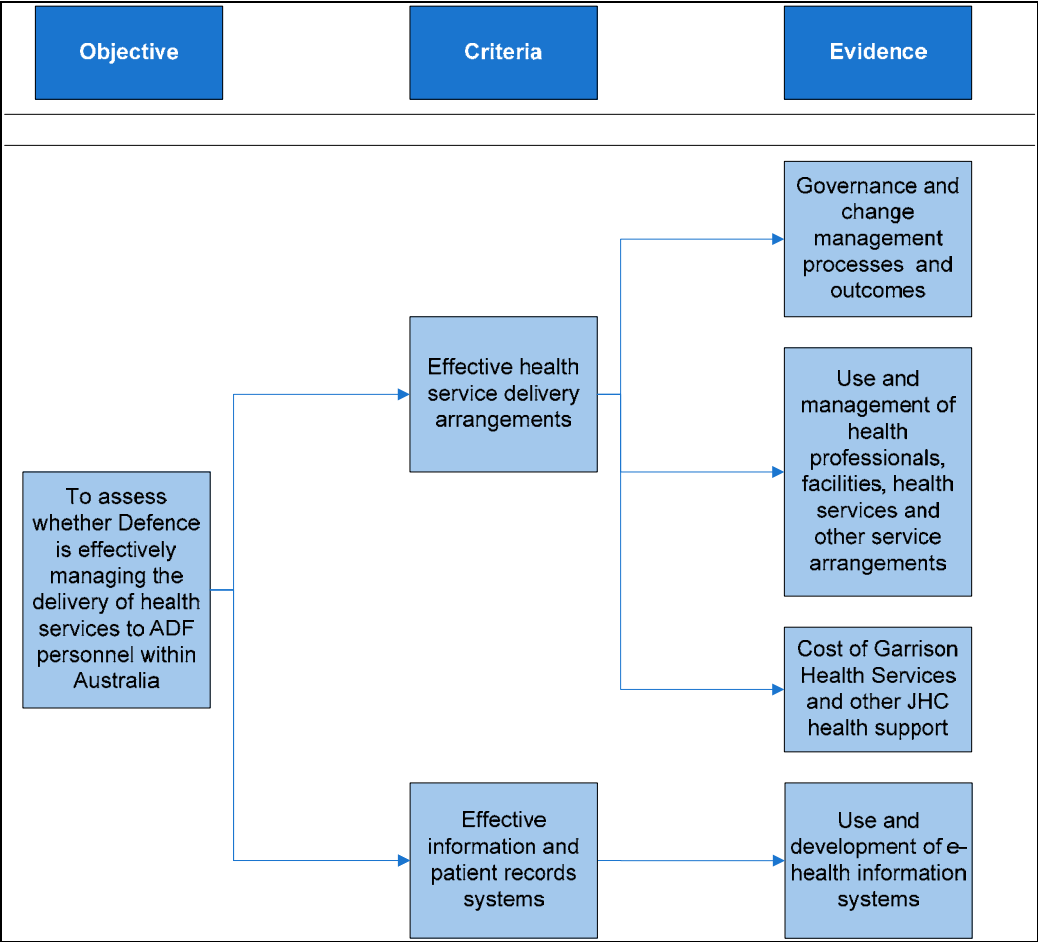
Source: ANAO.

1.22 The high level criteria for the audit were that:

- Defence has effective arrangements for improving the delivery of ADF health services and, in particular, of Garrison Health Services; and
- Defence has effective information and patient records systems that support the delivery of ADF health services.

1.23 Figure 1.5 depicts the audit approach.

Figure 1.5
Audit approach



Source: ANAO.

1.24 The audit was conducted in accordance with ANAO auditing standards at a cost to the ANAO of approximately \$367 000. Resolution Consulting Services provided the ANAO with assistance in the conduct of the audit.

Structure of the report

1.25 The remainder of the report is organised into four chapters:

- Chapter 2 outlines the Defence health services reforms, and in particular Garrison Health Services reforms, that are being implemented by Defence;

- Chapter 3 assesses the adequacy of governance arrangements that Defence has in place for the management of Garrison Health Services. It also examines strategic alliances that have been developed, or are being developed, with civilian hospitals to both support operational preparedness in the ADF and the delivery of Garrison Health Services. The chapter also reviews the implementation of the Family Health Trial;
- Chapter 4 examines the cost of Garrison Health Services and other support provided by JHC and provides an estimate of its total cost. The chapter also explains the extent to which, and reasons why, the cost of health support to the ADF dependency exceeds the cost of health care in the wider community and examines options to contain future cost increases; and
- Chapter 5 reviews the health information systems currently being used by Defence and assesses the efforts being made by JHC to improve them.

2. Defence Health Service Reforms

This chapter outlines reforms to the management and delivery of Defence health services in Australia that are being implemented by Defence.

Introduction

2.1 One of the main objectives of Defence's health service reforms that were approved by the Chiefs of Service Committee (COSC) in July 2008 is to simplify the existing complex command and control responsibilities for Garrison Health Services. A second major objective is to improve the efficiency and effectiveness of Defence health services. The main changes and their current status are summarised in Table 2.1. It indicates that six of the 10 COSC decisions have been completed and that the remaining four are ongoing.

Table 2.1

Reforms of Garrison Health Services agreed by the Chiefs of Service Committee

	Reform	Status
1	Appointment of Commander Joint Health (CJHLTH) with responsibility for the delivery of garrison health care in addition to exercising technical control as Surgeon General ADF of all ADF health services.	Completed.
2	Transfer of (then) Defence Health Services Division (DHSD) to the Vice Chief of the Defence Force (VCDF) Group.	Completed.
3	Creation of a third one-star position in DHSD, with each of the one-star occupants having responsibility for representing a single Service's health interests as well as being responsible for a DHSD function.	Completed.
4	CJHLTH to conclude Service Level Agreements (SLAs) with the Chiefs of Navy, Army and Air Force for the delivery of Garrison Health Services by 1 January 2009.	Completed.
5	CJHLTH to appoint Regional Health Directors (RHDs) and lead the development of Regional Level Agreements (RLAs), which are to be in place no later than 1 January 2010.	In progress.
6	Centralise unit level support within hub facilities providing Garrison Health Services, with details to be specified in the RLAs.	In progress. Expected to take some years to complete.
7	CJHLTH to assume lead capability manager responsibility for health materiel procurement from Chief of Army.	Completed.

	Reform	Status
8	Commercial off-the-shelf e-health products be investigated as a means of fast-tracking the implementation of a comprehensive health information system.	Investigation completed.
9	Review Area Health Service (AHS) personnel and establishments and examine alternative models to deliver Garrison Health Services.	Linked with the development of RLAs.
10	CJHLTH examine alternative operational health delivery models as part of the ongoing JP2060 Phase 3 ^A development process. ⁵¹	Ongoing.

Source: JHC.

2.2 Consideration of Item 10 of COSC's decision, that CJHLTH examine alternative operational health delivery models as part of the ongoing JP2060 Phase 3^A development process, was outside the scope of this audit.

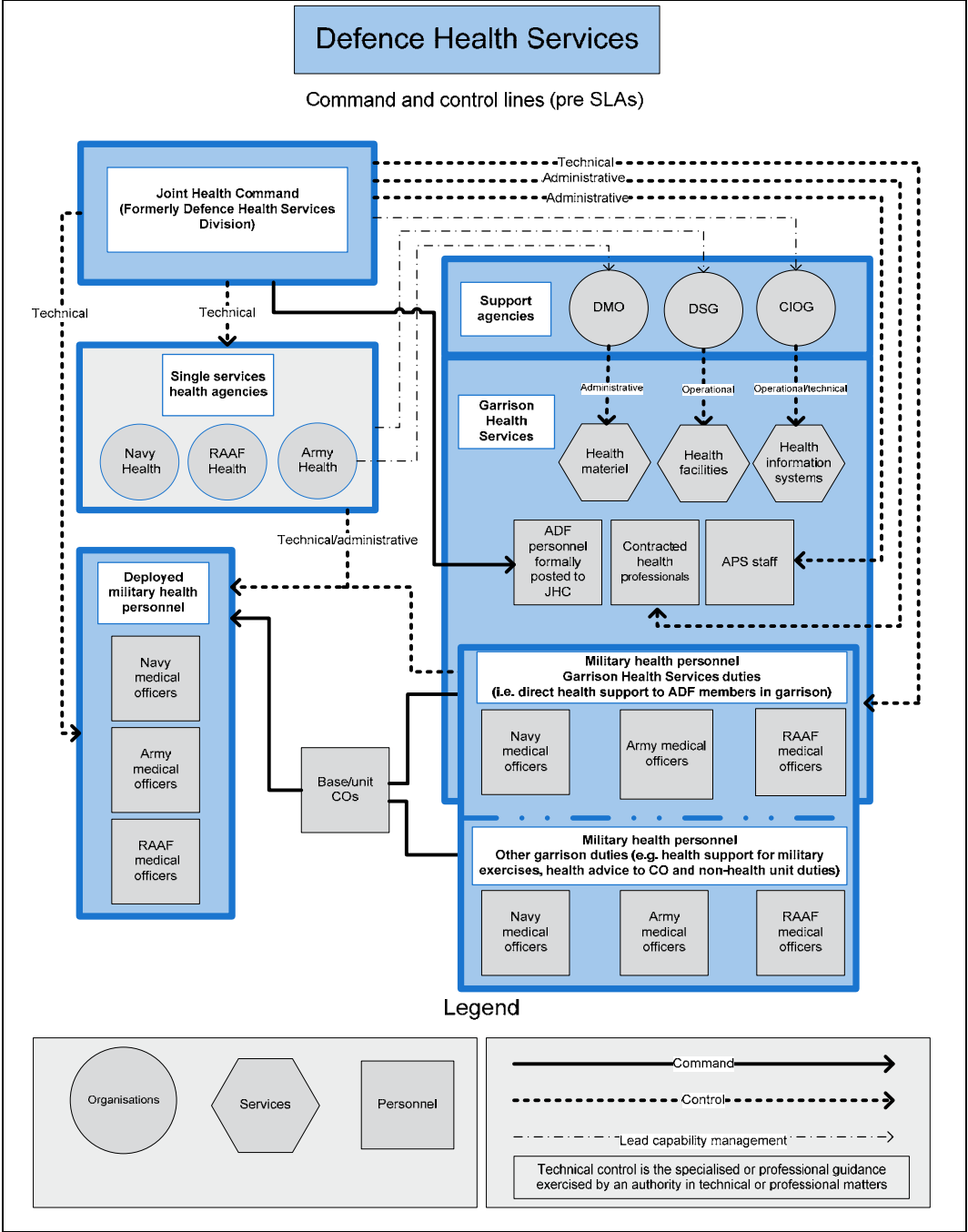
Command and control of Garrison Health Services

2.3 A number of previous reviews of ADF health services, including the previous ANAO audits, have highlighted the complex command and control relationships that exist and the difficulties that this has posed for the efficient and effective management of Garrison Health Services.

2.4 Figure 2.1 depicts the existing command and control responsibilities for ADF health support.

⁵¹ Joint Project 2060 Phase 3^A is intended to improve the existing ADF deployable health capability to deliver optimum quality services for the prevention, treatment and evacuation of casualties. It intends to achieve this through the adoption of a whole of system approach to the delivery of health support, addressing each of the following five Health Operating Systems: preventative health; treatment; medical evacuation; health information systems (command, control, communications, intelligence and information management systems); and health services logistics.

Figure 2.1
Current command and control of ADF health support



Source: ANAO analysis.

2.5 Figure 2.1 indicates that:

- JHC and the single Services currently share responsibility for the provision of Garrison Health Services;
- other groups within Defence are responsible to a 'lead capability manager' (currently comprised of both JHC and the single Services) for different aspects of health care delivery support: in particular, the Defence Materiel Organisation (DMO) for health materiel, the Defence Support Group (DSG) for Defence health facilities and the Chief Information Officer Group (CIOG) for information and technology support; and
- JHC is responsible for strategic health policy, providing strategic level health advice and exercising technical control of all ADF health units, although individual Service health agencies also have a role in providing technical support to their Services' ADF health personnel.⁵²

2.6 To simplify these very complex command and control responsibilities, the ANAO's 1996–97 audit recommended (Recommendation No 6) that:

the [then] Surgeon General be given responsibility for the command and control of all ADF health resources, that appropriate human and financial resourcing be transferred to the OSGADF [Office of the Surgeon General of the ADF] and that formal agreements be developed with operational commanders in relation to the provision of resources for operational purposes.

2.7 This recommendation arose from the ANAO's finding that:

Current health service administrative structures are complex and fragmented and lead to inefficiencies and inequities in the provision of health services. The division of responsibility among various Service commands has led to different priorities being adopted for the allocation of resources and to the duplication of services. A more effective management of health services could

⁵² Technical control is the specialised or professional guidance and direction exercised by an authority in technical or professional matters. While ADF health units come under the command of their base and unit commanding officers, they are expected to comply with health policies issued by JHC (for example, on the prevention and treatment of certain medical conditions). In this way, JHC exercises technical control of health policy and treatment. JHC health policies must also be followed by deployed ADF health personnel. ADF health personnel in each of the Services provide support consistent with JHC health policies.

be achieved if these structures were rationalised and placed under centralised command and control.⁵³

2.8 This recommendation of the 1996–97 performance audit report envisaged that the OSGADF would:

- have command and control of all ADF health care assets; and
- when health care assets were required for exercises or operational deployment, command and control would be assigned to the operational commanders.

2.9 The ANAO's 2000–01 audit found that full command and control of all health resources had not been transferred to the then Defence Health Services Branch (formerly the OSGADF) because Defence considered such an arrangement to be inconsistent with the command and control paradigm that operates in the ADF. The ANAO noted that Defence had instead agreed in 1998 to transfer all non-operational units to DHSB, but that DHSB still did not have direct command and control over non-operational uniformed medical personnel. These remained under the command and control of base commanders.⁵⁴

2.10 The Alexander Review was undertaken for the COSC and resulted in the presentation of a paper to it in July 2008. The review stated that:

6. When the ANAO reports and the Stevens' Review, along with the early findings of the current review, are brought together it is evident that current command and control for health care delivery in the garrison is problematic. Unity of command and a single point of responsibility are absent, resulting in:

- a. multiple convoluted command relationships and associated responsibility for elements of the health system;
- b. a lack of clear ownership of organisations, infrastructure and personnel;
- c. a culture of cost shifting; and
- d. ambiguous accountability and responsibility.

7. Whilst Head Defence Health Services has always had technical control, technical control alone is insufficient. The solution is to appoint an authority

⁵³ Australian National Audit Office 1997, *Australian Defence Force Health Services Performance Audit*, Audit Report No.34, 1996–97, ANAO, Canberra, paragraph 6.

⁵⁴ ANAO Audit Report No.51, 2000–01, op. cit., paragraphs 3.3–3.4.

who is responsible and accountable for the delivery aspects of Garrison Health Support. The title Commander Joint Health (CJHLTH) sends a clear message. This aligns with Recommendation Six of the [1996–97] ANAO audit which was agreed by Defence but never implemented.⁵⁵

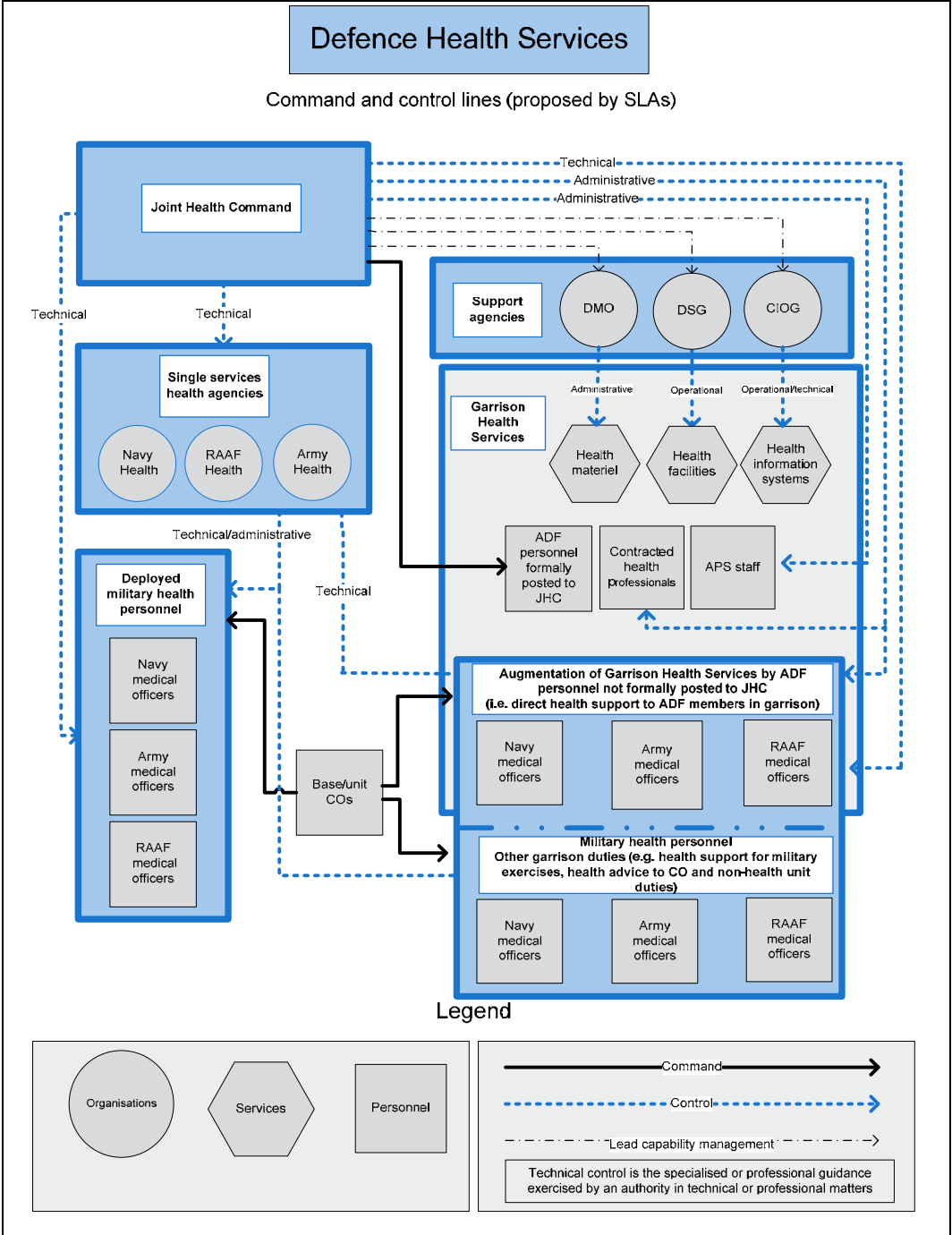
2.11 In response to the Alexander Review, the COSC sought to simplify the complex command and control arrangements for the provision of Garrison Health Services by:

- creating JHC, based on the former Defence Health Services Division, and giving it responsibility for the provision of Garrison Health Services, with augmentation of resources from the single Services; and
- transferring from Army to JHC the lead capability manager responsibility for health materiel procurement (pharmaceuticals, medical equipment).

2.12 The revised command and control relationships are shown at Figure 2.2.

⁵⁵ COSC Paper Agendum 50/08, 11 July 2008, op. cit., paragraphs 6–7.

Figure 2.2
Planned command and control of ADF health support



Source: ANAO analysis.

ANAO Audit Report No.49 2009–10
 Defence's Management of Health Services to
 Australian Defence Force Personnel in Australia

2.13 The ANAO notes that, while Defence's planned approach does help to clarify the command and control of Garrison Health Services, if the single Services' health units were integrated with JHC, it would be possible to further simplify command and control of health care delivery.⁵⁶ For example, it would be possible for all ADF health personnel to be employed by JHC, but be formally transferred to units for the duration of a deployment and be available for training with units in preparation for deployments. When on deployment, the health personnel would come under the command and control of the deployed unit's commander. Such an approach would have the potential to substantially streamline health support because, for example, there would no longer be a requirement to retain separate health agencies in each of the single Services. In the longer term, the ANAO considers that there may be merit in Defence examining this option further.

Improving the efficiency and effectiveness of Garrison Health Services

2.14 In 2007, Defence commissioned a review by an external provider to consider the risks and costs of a number of options for the delivery of health services to ADF members. This review, known as the Grosvenor Review, identified twelve options that ranged from maintaining the then current state to models where only ADF personnel delivered services or in which all services would be provided through private health insurance paid for by the ADF.⁵⁷ It found that four of these were viable Garrison Health Services delivery models available to the ADF.⁵⁸

⁵⁶ Recognising the complex command and control issues that arise in the provision of health support to the military, South Africa established Health Support as a separate Service, (separate from the other Services: Navy, Army, Air Force) in 1979 in order to consolidate the health resources of the various Services. Germany also has a Central Medical Service, although personnel assigned to the Service remain part of their originating Service.

⁵⁷ Grosvenor Management Consulting, March 2007, op. cit.

⁵⁸ The four viable Garrison Health Service delivery models identified by the Grosvenor Review were:

- re-engineering the existing service delivery model (for example, by refurbishing current facilities and consolidating existing contracts);
- rationalising and re-engineering the existing service delivery model (which would also involve closing some facilities close to one another);
- outsourcing health service provision at Defence bases (replicating the model used at the Puckapunyal and Albury-Wodonga bases); and
- increasing the use of standing offers for engagement of contracted health professionals, which envisaged converting individual contracts for them into standing offers.

2.15 While not an exhaustive examination of potentially viable options available to Defence to deliver health support to ADF members⁵⁹, the Grosvenor Review did provide Defence with guidance on which service delivery models might be effective in reducing the costs of the health care provided to ADF members in garrison. The Review estimated that, in adopting any of the four identified viable service delivery models, Defence could anticipate savings of up to five per cent annually from the then current state.⁶⁰

2.16 The Alexander Review identified the need to consolidate or centralise garrison health resource assets to ensure better utilisation of personnel and materiel.⁶¹ There can be up to 11 Regimental Aid Posts and other medical facilities on a single base.⁶² Under the arrangements agreed by the COSC in July 2008, these are to be rationalised with the numbers being reduced to one, two or three facilities on each base.⁶³ The revised health care delivery model is shown at Figure 2.3.

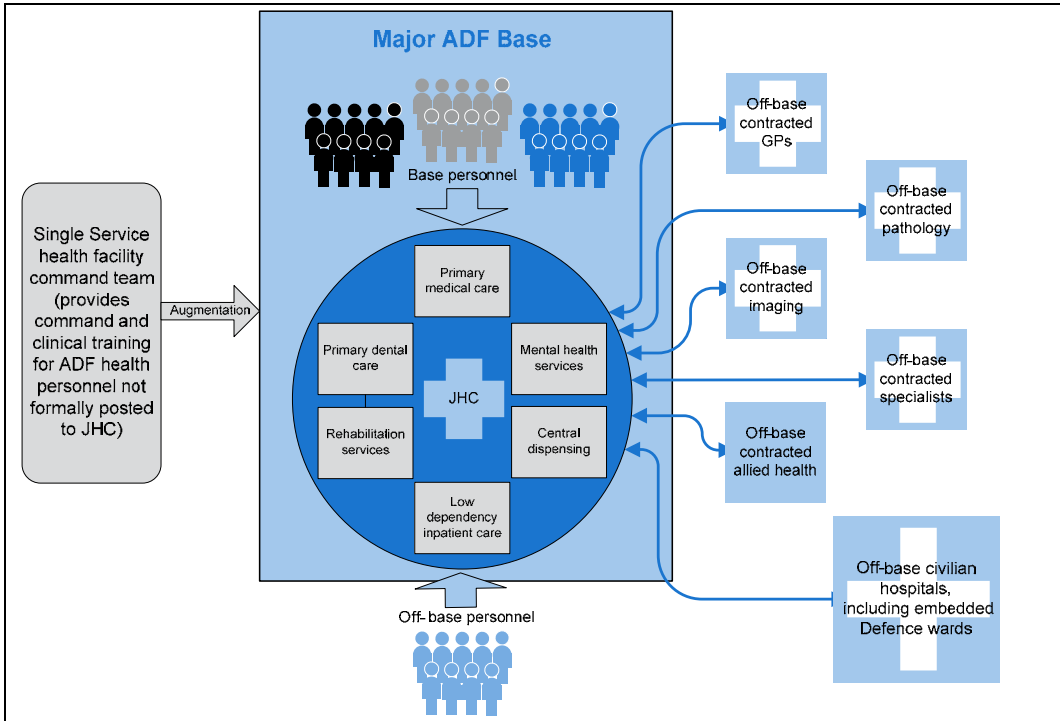
⁵⁹ The Review did not, for example, fully explore the means by which obstacles to the implementation of many of the other eight options considered might be overcome.

⁶⁰ Grosvenor Management Consulting, March 2007, op. cit., p. 6. The report considered rationalisation and re-engineering to be the most cost effective viable service delivery model for the delivery of Garrison Health Service.

⁶¹ COSC Paper Agendum 50/08, 11 July 2008, op. cit., paragraphs 20–22.

⁶² Gallipoli (Enoggera) Barracks in Brisbane has 11 health facilities.

⁶³ The numbers of health facilities on each base will depend on such things as the size of the base, the number of facilities that are deemed to be 'fit-for-purpose' and the cost of centralising facilities (for example, Defence may need to expand an existing facility to centralise services and it may not be cost effective to do this if other suitable facilities already exist).

Figure 2.3**Planned Garrison Health Services delivery model**

Source: ANAO adaptation of JHC diagram.

2.17 The planned Garrison Health Services model provides for:

- primary health care in garrison locations;
- low dependency regional inpatient care (that is, this care is provided at an ADF health facility in the same region that the ADF member is located but not necessarily at the base to which they are posted);
- higher acuity in-patient facilities in a small number of locations (for example, the ADF Ward at St Vincent's Hospital in Sydney⁶⁴ and 2nd Health Support Battalion (2HSB) at Enoggera Army Base in Brisbane); and
- outsourcing of other services using fee-for-service contracts.

⁶⁴ Defence has a commercial arrangement with St Vincent's Hospital in Sydney, which involves the lease by Defence of a ward in the hospital. See paragraph 3.71 for further information about this arrangement.

2.18 The model envisages consolidation of a range of services in a single facility (or a small number of linked or ‘hubbed’ facilities) at each location, so providing the opportunity to provide a more holistic health response. Under the ‘hubbed’ model, there may, for example, be a single large health facility, and one or more smaller facilities, on a base or in a regional location. Health resources would be used in such a way as to provide coordinated health services to ADF members on the base or the regional location. Basic services would be provided from the ‘hubbed’ garrison locations and higher level and specialist services supplied from civilian facilities off-base.

2.19 To further support the better management of Garrison Health Services, Defence:

- transferred responsibility for JHC from the Defence Support Group (DSG) to the Vice Chief of the Defence Force (VCDF) Group;
- created a third one-star (SES Band 1) position in JHC, with each of the three one-star positions, in addition to having responsibility for a JHC function, also representing a single Service so as to better coordinate health care delivery across the three Services and ensure that the differing interests of the three Services are taken into account;
- is planning to replace its nine existing Area Health Services (AHSs) with five new regional health services⁶⁵ and to strengthen these new services by appointing senior Regional Health Directors (RHDs);⁶⁶ and
- is planning to develop a new electronic patient record system. Development of the new system is considered further in Chapter 5.

2.20 The 2004 Stevens Review had previously concluded that:

placement of the DHS [Defence Health Service] under the VCDF would have merit in reinforcing the importance of health issues and in reflecting that health preparation of forces for deployment and provision of health care during deployment are operational matters.⁶⁷

⁶⁵ These five regions will be the same as the five existing Defence Support Group Regions, namely, Queensland, Northern NSW, Southern NSW, Victoria & Tasmania and Central & West Region.

⁶⁶ The RHDs will be appointed at the Medical Officer 4 level, which in terms of seniority is an Australian Public Service Executive Level 2 equivalent.

⁶⁷ Stevens Review, op. cit., p. iii.

2.21 The July 2008 COSC Paper (the Alexander Review) noted that this proposal had not been supported at the time in part because, while VCDF had responsibility for operational matters, he did not have joint capability responsibilities. The COSC's decision to transfer JHC to VCDF Group in 2008 was made in the context that VCDF had acquired joint capability responsibilities since the 2004 Stevens Review and health support was clearly a joint capability.⁶⁸

2.22 JHC's current organisational structure, which came into effect in January 2010, is shown at Figure 2.4. It comprises:

- four branches, three of which are headed by a one-star officer from each of the three Services and the fourth by an Australian Public Service (APS) officer. In addition to their JHC responsibilities, each of the one-star officers is responsible for representing their Service. In response to the Dunt Review of Mental Health Services⁶⁹, the remit of the APS officer includes specific responsibility for managing mental health in the ADF;
- the Surgeon General Defence Health Reserves, who is responsible for the Defence Health Reserves; and
- the Director Corporate Management.

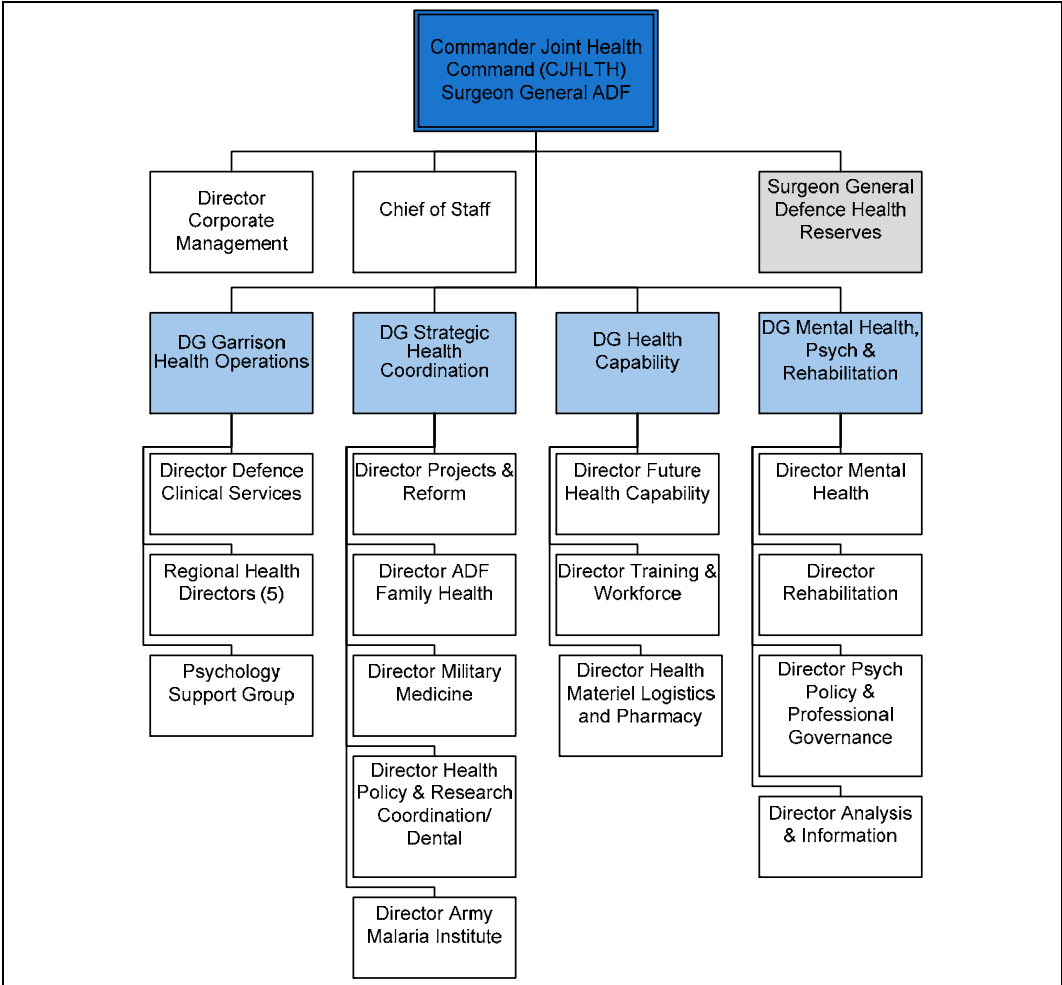
⁶⁸ COSC Paper, July 2008, op. cit., paragraphs 8–9.

⁶⁹ Professor David Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, Canberra, 2009, Recommendation No 3.7, p. 22:

The Directorates of Mental Health and Psychology should merge to become the Directorate (or Branch) of Mental Health and Psychology (DMHP) with a SES Band 1 level Director to lead this combined entity.

Figure 2.4

JHC organisational structure



Source: JHC.

2.23 The Garrison Health Operations Branch now coordinates the provision of Garrison Health Services and the Director Projects and Reform is responsible for overall coordination of the health reforms approved by the COSC and other agreed changes, including efficiencies required under the

Defence Strategic Reform Program and changes flowing from the implementation of the Dunt Review recommendations.⁷⁰

2.24 Defence is in the process of filling the RHD positions. The RHD appointments aim to provide local commanders with a single point of contact for all Garrison Health Services concerns.⁷¹ The RHDs will be accountable for the performance of their regional health services and compliance with agreements between JHC and each of the Services. They are expected to play a key role in ensuring that there is strong oversight and management of health services at the regional level and in providing strong support to the Director General Garrison Health Operations.

Implementation of the new Garrison Health Services delivery model

2.25 To implement the new Garrison Health Services delivery model, the COSC decided that there should be:

- Service Level Agreements (SLAs) between JHC and each single Service which specified the respective responsibilities of JHC and the single Service; and
- Regional Level Agreements (RLAs) which will detail the services, responsibilities and expected requirements of JHC and each single Service at military locations in each region.

Service level agreements

2.26 The SLAs with each of the Services were signed in May 2009.⁷² While they are similar in structure, the responsibilities of each Service and JHC are specified differently in each SLA, although in practice the differences are not significant.

2.27 Under the new arrangements, individual ADF health members from each of the three Services will engage with Garrison Health Services through:

⁷⁰ Before the current organisational structure came into effect in January 2010, the Projects and Reform Directorate was called the Portfolio Program Office and reported directly to CJHLTH.

⁷¹ For example, *Service Level Agreement 1/09 Garrison Health Support for period 27 May 2009 to 27 May 2010 between the Vice Chief of the Defence Force Group and the Chief of Army*, Annex C.

⁷² These SLAs were signed on 27 May 2009 and cover the period to 27 May 2010.

- formal posting to a JHC health facility, where they will be held against a JHC position; or
- agreed SLA/RLA arrangements to augment the Garrison Health Services to the local dependency (that is, the number of ADF personnel covered by the relevant RLA and for whom health support will need to be available).

2.28 They may also receive clinical placements in civilian organisations, under strategic alliances managed by JHC, to ensure that they gain acute care clinical experience needed for operational deployments.

2.29 ADF members who are formally posted to JHC will come under the command of the RHD and manager of the health facility to which they are posted. However, ADF health service members belonging to the Service elements covered by a particular RLA, and who are provided by the Service elements to augment Garrison Health Services provided by JHC, will come under the operational control of the RHD and the relevant facility manager only in regard to their work in the health facility. They will otherwise remain under the overall command of their base or unit commander. That commander will decide whether or not the ADF member will be available to augment the Garrison Health Services. If the RLA specifies that a required level of support is to be provided by the relevant Service element and that support is not forthcoming, the SLAs provide, among other things, for the ADF unit to meet the cost of engaging other health support from the civilian sector or that there should be a reduction in the level of service and/or capability that is provided to unit members.⁷³

2.30 In implementing the new arrangements, it will be important that the single Services carry out their responsibilities to provide the resources agreed

⁷³ For example, paragraph 3 of Annex C to the SLA with Army (SLA 1/09 Garrison Health Support, 27 May 2009 to 27 May 2010) states that:

Any gap between asset and liability shall trigger an agreed business rule where the RHD may consider (and have the authority to implement after consultation) the following or any combination of the following:

- a. Commit the transfer of funds (JHC or Army) to address the shortfall utilising contracts and contractors for civilian health providers;
- b. Transfer assets;
- c. Transfer liabilities; or
- d. Implement a reduction of service across capability and/or time.

under the SLAs/RLAs to augment Garrison Health Services, having regard also to their primary operational and training responsibilities.

Regional level agreements

2.31 The arrangements that will apply at each ADF location will be dependent on the needs of each location (and hence the need to develop RLAs for each region). JHC commissioned studies of the needs of each location to underpin the decision on how the new service model should be applied in the various regions.⁷⁴ Factors that are likely to affect the agreed arrangements include:

- the size and characteristics of the ADF dependency at the location;
- the services that will need to be provided at the location;
- the number of existing health facilities at the location and the number of facilities that will be needed in the future;
- the quality of the existing health facilities (in some locations, new purpose-built facilities are available, while in others the facilities are not considered fit-for-purpose);
- the extent to which new or expanded facilities may be needed under the new service model (many health facilities will need to be expanded in order to handle the increased dependencies being supported from the facilities);
- the operational requirements of the units at particular locations (units at some locations are more likely to be deployed on operations and to be involved in exercises in preparation for such deployments than units at other locations);
- the likely available ADF health workforce at the particular location (in some locations, there are few ADF medical personnel and it is also more difficult to attract personnel to transfer to some locations); and
- the extent to which the single Services are willing and able to contribute to the augmentation of garrison health personnel.

⁷⁴ For example, JHC commissioned studies by external consultants of a service model for Darwin (and, in particular, Robertson Army Barracks) and of a service model for Canberra.

2.32 The success or failure of Defence's reform of health services will depend to a significant extent on how well the arrangements are implemented at the regional (and particularly the base) level. This is because its success will be heavily dependent on the extent to which unit commanders:

- agree to uniformed ADF medical staff, for whom they will continue to be responsible, being made available to augment health support personnel resources in garrison health centres or other health facilities; and
- consider that the new arrangements facilitate operational requirements.

2.33 Engaging unit commanders in the reform process and obtaining their support will be crucial to the success of the new arrangements. During fieldwork for this audit, some commanding officers interviewed by the ANAO raised some concerns that they had in relation to the new arrangements, including:

- a perceived reduction in flexibility to carry out pre-deployment exercises, because unit medical staff may not be available to support such exercises;⁷⁵ and
- less control over the management of their unit's members because, they argued, some members would 'shop around' for doctors who are more inclined than others to excuse members from unit exercises on medical grounds. They would also have less ready access to advice on presenting medical issues that may assist in the management of their units.

2.34 Notwithstanding these concerns, it should be easier to support unit operations under a 'hubbed' model than is currently the case. For instance, under a 'hubbed' model, it should be easier to support ADF members who are unable to deploy on operations or participate in exercises because of medical issues given that the Garrison Health Services for these members will be provided by JHC and not by their own unit, whose health resources have been depleted by the deployment. It may also be easier to provide the necessary

⁷⁵ When exercises are being conducted, a health support plan needs to be prepared. This will usually require the presence of a treating doctor and other medical support staff. It may also require emergency evacuation arrangements, where this cannot be provided in a timely way by civilian evacuation teams. Units also require their medical staff to participate in exercises. Unit medical staff therefore need to be available for exercises, even when they are not on deployment.

medical support for units undertaking exercises because, by sharing health resources across units, units should have greater flexibility to roster personnel for both planned exercises and Garrison Health Services activities.

2.35 While the RLAs have yet to be finalised and agreed with the Services, the hub model is expected to reduce the number of ADF health facilities. For example:

- in Queensland, the preferred models for the delivery of Garrison Health Services to Army that have been endorsed by CJHLTH will result in the following reductions in the number of health facilities:
 - Lavarack Barracks (Townsville): three primary health care centres, instead of the current seven facilities; and
 - Gallipoli Barracks (Brisbane): two primary health care centres, instead of the current 11 health care facilities; and
- in the ACT, JHC is planning on having a single facility (instead of the current four facilities). The Duntroon operating theatre was closed on 31 December 2009 (with surgery now being carried out in civilian hospitals) and arrangements for other services is under review.

2.36 A major component of the initiative to centralise unit-level health support, including within hub facilities, is the rationalisation of facility infrastructure and equipment. JHC is developing a strategic infrastructure plan and health facility plans. A cost effective, efficient and coordinated approach to health facility planning is essential to the long-term sustainability of Defence health infrastructure and support.

2.37 Defence's posting cycle and the rationalisation of facilities are significant constraints in the timely completion of the negotiated regional arrangements to be set out in RLAs. This is because it will take up to three years to complete the deployment of ADF personnel to JHC or to some ADF locations under the new service delivery model and some facilities will need to be expanded to accommodate the consolidation of services. For this reason, suitable transitional arrangements will be needed.

3. Governance Arrangements for Garrison Health Services

This chapter assesses the adequacy of governance arrangements that Defence has in place for the management of Garrison Health Services, including planning and performance monitoring and clinical governance. It also examines strategic alliances that have been developed, or are being developed, with civilian hospitals to both support operational preparedness in the ADF and the delivery of Garrison Health Services. The chapter also reviews the implementation of the Family Health Trial.

General governance arrangements

3.1 Effective governance arrangements are critical to the successful implementation of the new Garrison Health Services model. The following section reviews the various components of Defence's governance arrangements for Garrison Health Services, including JHC's organisational arrangements and health-related directives, instructions and manuals.

Organisational arrangements

3.2 As noted in Chapter 2, Defence has already made a number of organisational changes as part of its efforts to improve its management of Garrison Health Services, including:

- strengthening the senior management and leadership of Garrison Health Services (see Figure 2.4);
- improving coordination with the single Services by appointing an ADF member from each of the three Services to three Director General positions in JHC (each of these officers has the authority, on behalf of their Service Chief through their single Service health directorates, to represent their Service's health requirements);
- negotiating SLAs with each of the Services on Garrison Health Services; and
- transferring JHC from the Defence Support Group to the VCDF Group.

Management committees

3.3 Defence has a number of senior level committees that provide high level oversight and coordination of strategic issues. These include:

- the COSC, which approved the reforms of Defence Health Services in Australia in July 2008; and
- the Defence Committee⁷⁶, which is supported by a number of other senior level committees that provide oversight of Defence capability and investment, personnel, IT, financial management, occupational health and safety and other issues.⁷⁷

3.4 Defence has arrangements in place to monitor progress against decisions of these committees. For example, JHC provides bi-monthly outcomes reports to the COSC. These reports are in a 'traffic light' format and appear to provide an appropriate high level view of the status of key deliverables/outcomes.

3.5 In addition to these governance arrangements, JHC has established an Advisory Committee (the ADF Health Services Advisory Committee), with both senior ADF membership (the VCDF and CJHLTH) and senior external representation.⁷⁸ This committee met for the first time in September 2009 and is expected to meet on a quarterly basis. Its role is to:

provide strategic and professional advice on health business best practice to Defence senior leadership. In particular the committee will provide advice aimed at ensuring the ADF Health Services continue to meet the Australian Community standards, not only in terms of clinical practice but also in terms of health management and administration.⁷⁹

3.6 There may be benefit in this committee generating an annual report that could be provided to the Secretary and CDF to provide assurance regarding the committee's work. Consideration could also be given to the inclusion of such a requirement in the committee's terms of reference.

⁷⁶ The Defence Committee is the primary advisory body, supporting the Secretary and Chief of the Defence Force (CDF) in meeting their joint obligations under the Ministerial Directive for the management and administration of Defence. It is chaired by the Secretary and provides holistic senior management advice to the Secretary and CDF on strategic management and governance issues and monitors the overall performance of Defence.

⁷⁷ Defence also has a number of committees that are overseeing the implementation of the SRP initiatives, including those affecting JHC.

⁷⁸ Membership of the Committee is: Chair – VCDF; Deputy Chair – CJHHL; Member – Professor Dunt, public health specialist; Member – Associate Professor John Overton; Member – Mr David Lermonth, Deputy Secretary Department of Health and Ageing; Member – Mr Mark Cormack, ACT Health Chief Executive; and Member – Mrs Kate Carnell, Chief Executive Officer of the Grocery Council of Australia, formerly Chief Minister of ACT and Pharmacist.

⁷⁹ Terms of Reference for the ADF Health Services Advisory Committee.

3.7 JHC also has an internal management committee, the Joint Health Command Strategic Executive Committee, that is responsible for:

- setting priorities for health doctrine, policy and planning activities;
- assessing the adequacy of JHC resourcing to meet current and contingent operational needs;
- advising on measures to ensure that JHC is able to recruit, professionally develop and retain an adequate health workforce;
- informing the development of the JHC strategic plan;
- informing the strategic direction of JHC health capability;
- monitoring JHC to ensure it delivers health services to the standards agreed by the COSC;
- assessing the performance of JHC; and
- ensuring that scarce health resources are distributed efficiently across the ADF in order to maximise operational effectiveness.⁸⁰

3.8 Day-to-day coordination of JHC activities is currently provided by means of weekly meetings between the CJHLTH and his executive team. The CJHLTH also meets individually with members of his executive team, generally on a weekly basis. Weekly reports are also provided by JHC to VCDF, highlighting key upcoming events or issues and critical tasks.

Directives, instructions and manuals

3.9 Defence has a well-developed system of directives, instructions and manuals to support the delivery of Garrison Health Services, and the CJHLTH's role in providing advice and developing policy on a range of health issues. This system also underpins CJHLTH's exercise of technical control of ADF health units.

3.10 Health policy that has general application to the administration of the ADF is promulgated in the form of either Defence Instructions (General) or Australian Defence Force Publications. Health policy instructions are issued in the form of JHC Health Directives or Health Bulletins. Health Directives are used to establish enduring health policy, whereas Health Bulletins are used to disseminate health policy that is short term in nature or which needs to be

⁸⁰ Joint Health Command Steering Group—Terms of Reference, Defence Intranet, 22 July 2009.

promulgated quickly.⁸¹ Table 3.1 lists the various categories of Health Directives.

Table 3.1

Health Directive index

Series No	Category
000, 100, 200 and 300	Medical (military medicine; nuclear, biological and chemical medicine; underwater medicine; occupational and environmental medicine; health intelligence; clinical medicine; and aviation medicine)
400	Dental
500	Nursing
600	Health documentation (statistics, records, release of information)
700	Health materiel
800	Joint health operations, doctrine, plans, facilities and training
900	Administration and finance

Source: Joint Health Directive Index.

3.11 All health personnel (all ADF health personnel and JHC civilian, and contract personnel) must comply with instructions or directions issued in JHC Health Directives and Health Bulletins. They are general orders issued by, or under the authority of, CJHLTH. All JHC personnel and health personnel in single Service health elements are required to ensure they are aware of Health Directives and Health Bulletins that are applicable to them. Other single Service health instructions are of no effect if they are inconsistent with JHC Health Directives and Health Bulletins.

3.12 Extant Health Directives remain in force until revised or cancelled. However, Health Directives are expected to be reviewed by sponsors within JHC every three years, although amendment, cancellation or reissue may be effected at any time. Notwithstanding this review requirement, the ANAO identified that only 37 per cent of extant medical Health Directives, some of which were first issued as far back as 1991, had been revised since first being issued (see Table 3.2).

⁸¹ Health Directive No. 903 *Director General Defence Health Service Health Directives and Bulletins*, 8 June 2001.

Table 3.2**Percentages of Medical Health Directives revised since first being issued**

Category	Number of extant Health Directives	Percentage of these Health Directives that had been revised
Medical (000, 100, 200 and 300 Series)	73	36
Dental (400 Series)	21	33
Nursing (500 Series)	8	63
Health documentation (600 series)	2	50
Health material (700 Series)	4	25
Joint health operations, doctrine, plans, facilities and training (800 Series)	6	nil
Administration and finance (900 Series)	21	52
Total Directives	135	37

Source: ANAO analysis.

3.13 In relation to the low percentage of extant Health Directives on dental matters that have been revised, the Director of Defence Force Dentistry advised that staff shortages in Defence Force Dentistry over a number of years had adversely affected its ability to review Health Directives on dental matters in a timely way.

3.14 Some extant Health Directives clearly require revision. For example, Health Directive 902 prescribes that there will be a Defence Health Service Steering Committee. However, this committee has not operated since 2006 and has since been replaced by the Joint Health Command Executive Committee. The relationship between related Health Directives should also be fully referenced to ensure that the relationship between them is clearly understood. For example, Health Directive 289 on 'Mental Health Case Management' makes no reference to Health Directive 260 on the 'Management of Mental Health Problems in the ADF', notwithstanding that the two documents have similar aims:

Health Directive 289: To provide guidance to ADF mental health professionals and mental health specialists for the overall clinical case management of ADF members presenting with mental health problems and/or disorders.

Health Directive 260: To provide guidance to health professionals for the clinical and administrative management of ADF members presenting with a mental health problem.⁸²

3.15 Given the consolidation of Garrison Health Services under JHC that is now being implemented, it would be timely to review the currency of extant Health Directives. The continued application of outdated policies, particularly clinical policies, increases the risk of inappropriate application of technical or clinical practices and clinical mishaps. There are also potential efficiencies to be gained by adopting consistent practices (for example, forms) across the three Services. Monitoring performance against Defence's policy of updating Health Directives every three years is likely to help ensure stronger compliance against this performance measure.

Recommendation No.1

3.16 The ANAO recommends that, in accordance with established Defence policy, JHC review the continued application of all Health Directives every three years.

Defence response

3.17 *Agreed.* Defence has established a Defence Health Policy Steering Group which will ensure the continued application of all Health Directives every three years.

Planning and performance monitoring

Strategic planning

3.18 The most recent Strategic Plan for Defence Health Services was prepared by the former Defence Health Services Division for the period 2006–08.⁸³ Work has commenced on the development of a revised JHC Strategic Plan, but Defence has advised that this will not be completed until around June 2010. It is important that this revised plan reflects the goals,

⁸² Health Directive No 289, *Mental Health Case Management in the Australian Defence Force* (22 April 2009) and Health Directive No 260, *An Introduction to the Management of Mental Health Problems in the Australian Defence Force* (18 August 2003). While these two Health Directives are not cross-referenced, JHC has updated its Health Directives on mental health following the Dunt Review.

⁸³ Defence Health Services Division, Strategic Plan 2006–08.

objectives and priorities needed to achieve the garrison health reform outcomes Defence is seeking and identifies how JHC will make its required contributions towards the achievement of the Defence Strategic Reform Program obligations. It is sound practice to include in such a strategic plan:

- a clear explanation of how the strategic goals are to be achieved;
- identification of areas of risk and strategies to mitigate those risks; and
- an ‘implementation plan’ that allows progress against the plan to be monitored.

3.19 The 2006–08 Strategic Plan identified five major outcomes and key performance indicators (KPIs) for each outcome. These outcomes and KPIs are shown in Table 3.3.

Table 3.3

Former Defence Health Services Division, Outcomes and KPIs, 2006–08

Outcome	KPI
1. Provide a fit and healthy Force	The demonstrated ability to meet all operational personnel health requirements.
2. Prevent casualties	Decreasing incidence of preventable injury and illness.
3. Provide health care	The demonstrated ability to retain and rehabilitate personnel to be fit for purpose. Health facilities fully staffed with appropriately trained personnel.
4. Develop health capabilities	Implementation of JP2060 phase 2 and alignment of relevant training and doctrine.
5. Manage and sustain the health system	Provide effective and efficient health care within budget. Identify cost drivers to inform the selection of optimum service delivery models. Achieve a sustainable, fit for purpose, health workforce.

Source: Defence Health Services Division Strategic Plan 2006–08.

3.20 The Strategic Plan stated that these KPIs were selected on the basis that:

- each outcome has at least one performance indicator to measure improvement;
- financial expenditure can be attributable against priorities; and

- the effectiveness of the approach can be measured.⁸⁴

3.21 However, the outcomes set out in the Plan are very broad (for example, 'Provide health care'). Some of the criteria also require greater specification (for example, it is unclear whether the 'sustainable, fit for purpose, health workforce' refers only to ADF health personnel, to ADF and APS health personnel or it also includes Contracted Health Professionals). In addition, some of the KPIs included against outcomes (for example, 'Identify cost drivers to inform the selection of optimum service delivery models') are actions and not performance indicators. It will be important that the revised JHC Strategic Plan contains criteria that are sufficiently specified and also identifies meaningful and well specified KPIs.

Performance monitoring and reporting

3.22 The ANAO's 2003 Better Practice Guide on public sector governance suggests that a well-governed organisation will have:

A structured and regular system of performance monitoring. This system should be aligned with the organisation's outcomes and outputs structure and generate information that is appropriate for both internal performance management needs and external reporting requirements.⁸⁵

3.23 As indicated in Table 3.3, the former Defence Health Services Division's 2006–08 Strategic Plan contained some KPIs, but these have yet to be updated to reflect current strategic priorities although, as discussed above, work is underway on a new Strategic Plan for JHC.

3.24 Health Directive 920 *Key performance indicators of health care quality and readiness in the Australian Defence Force*, issued on 6 February 2004, sets out seven health related KPIs and the 'benchmark standards' or the levels of performance considered desirable and attainable. These are shown in Table 3.4. Health Directive 920 has not been revised, notwithstanding the fact that it is over three years since it was issued.

⁸⁴ Defence Health Services Division Strategic Plan 2006–08, op. cit., p. 2.

⁸⁵ Australian National Audit Office 2003, *Better Practice Guide—Public Sector Governance, Volume 1, July 2003*, ANAO, Canberra, p. 24.

Table 3.4**Health KPIs and benchmark standards set out in Health Directive 920**

Health KPI	Benchmark standard
Percentage female dependency offered Papanicolaou (PAP) smear within date	Green: 95–100 per cent Amber: 85–94.9 per cent Red: < 85 per cent
Satisfaction Classification Rating derived from Inpatient Satisfaction Survey	Green: ≥ 4 Amber: 3–3.9 Red: < 3
Satisfaction Classification Rating derived from Outpatient Satisfaction Survey	Green: ≥ 4 Amber: 3–3.9 Red: < 3
Percentage of Medical Employment Classification (MEC) 3 dependency in date for MEC review	Green: 98–100 per cent Amber: 95–97.9 per cent Red: < 95 per cent
Percentage of dependency in date for routine vaccinations	Green: 95–100 per cent Amber: 90–94.9 per cent Red: < 90 per cent
Percentage of dependency with medical examinations in date	Green: 95–100 per cent Amber: 90–94.9 per cent Red: < 90 per cent
Percentage of dependency who are dentally cleared for deployment	Green: 90–100 per cent Amber: 80–99.9 per cent Red: < 80 per cent

Source: Health Directive 920.

3.25 The Health Directive states that:

JHSA [Joint Health Services Agency] will use the data provided to generate quarterly performance reports.⁸⁶ These reports will be provided to the Director-General Health Service and appropriate committees such as the Defence Health Service Advisory Council and the Defence Health Service Steering Committee. This will allow feedback to Defence health facilities and to DHS customers.⁸⁷

3.26 During the audit, the ANAO was informed by the then Director General Garrison Health Support (DGGHS) and the Clinical Governance Section that collecting performance data against the KPIs has been problematic due to the lack of a reliable, robust and complete health management

⁸⁶ The JHSA was a predecessor agency to the Garrison Health Operations Branch. A Directorate of the same name with clinical governance and medical classification review functions continued to operate after the establishment of JHC within the then Garrison Health Support Branch. Those functions are now managed by the Clinical Services Directorate in the Garrison Health Operations Branch.

⁸⁷ HD 920: Health Performance Indicators in the Australian Defence Force.

information system across the ADF.⁸⁸ Nonetheless, reports on KPIs stipulated by Health Directive 920 were provided to the then Defence Health Service Steering Committee until 2006, when the committee ceased to function. After the cessation of the Steering Committee, reports, albeit incomplete and inaccurate, were provided to the DGGHS and respective Area Health Services.

3.27 In November 2007, JHSA Standard Operating Procedure (SOP) 01/07 – *Collection of Key Performance Indicators* was issued.⁸⁹ It provided guidance on the provision of KPI data to JHSA for health facilities in the National Support Area (that is, JHC's area of responsibility). The procedure prescribes that quarterly reports are required for individual readiness KPI data⁹⁰ and pap smear data, and annual reports for quality data. The intention was for health facilities to submit KPI data on a quarterly basis to the relevant Area Health Service, which would collate and analyse the data from all health facilities in its areas for submission to the Clinical Governance Section in JHSA, which would, in turn, provide a collated report of performance against KPIs and qualitative data to the DGGHS.

3.28 In September 2008, the DGGHS agreed to a request to change the quarterly KPI reports to biannual KPI reports.⁹¹ Following this decision, the first biannual report for July to December 2008 was produced and an annual report for 2009 was prepared.⁹²

3.29 Defence informed the ANAO that, in December 2009, JHC commenced work on developing a framework which will represent the key performance areas in which performance indicators will be identified for the measurement of the quality of services provided by the Garrison Health Services. It is desirable that JHC's KPIs reflect current Defence strategic and health priorities. There would also be benefit in them being consistent with the National Health

⁸⁸ Health management information systems are discussed in Chapter 5 of this report.

⁸⁹ Joint Health Support Agency Standard Operating Procedure – 01/07 issued 14 November 2007.

⁹⁰ To ensure that ADF members are ready for deployment, Defence requires that they undertake regular checks and that their assessed readiness or otherwise is recorded on Defence's personnel system, PMKeyS. Annual health assessments are required for each ADF member, which currently help to determine an ADF member's Medical Employment Classification. Further discussion of health assessments can be found at paragraphs 4.67–4.69.

⁹¹ Advice from DG-GHS, 24 September 2009.

⁹² An annual report for 2009 was prepared because staff shortages prevented completion of the biannual report for January to June 2009.

Performance Framework (NHPF)⁹³ and include both effectiveness and efficiency indicators, such as:

- *effectiveness indicators*: quality indicators (for example, these could be patient satisfaction, accreditation of facilities, patient rehabilitation, timeliness of service) and health operational readiness indicators; and
- *efficiency indicators*: cost of Garrison Health Services (for example, these could be total cost, average cost per ADF member, number and cost of Contracted Health Professionals), and progress against key garrison health reform milestones.

3.30 In 2000 Defence published the inaugural edition of the *Australian Defence Force Health Status Report*.⁹⁴ The report was Defence's first attempt to report comprehensively on the health status of ADF personnel. Based on health indicators that were available at the time, it aimed to provide a baseline for assessing the health status of the ADF over time. In the introduction to the report the then DGGHS anticipated that the report would be updated biennially. However, Defence has not since reproduced the report.

3.31 Reports such as the *Australian Defence Force Health Status Report* are important because, unlike much performance reporting in the health area that must necessarily measure outputs (for example, numbers of hospital separations and conditions treated), this was an attempt to measure outcomes (in particular the actual health status of ADF members). Updating the 2000 *Australian Defence Force Health Status Report* and publishing it on a regular basis (for example, every five years) would provide an indication of the effectiveness of ADF health services and may assist JHC in prioritising health needs and identifying strategies to minimise preventable injuries and illnesses.

3.32 Defence informed the ANAO that, in the absence of a workable and effective health information system, JHC currently has difficulty in obtaining

⁹³ The NHPF has been adopted by Australian health ministers for reporting the performance of the Australian health system. The framework describes six dimensions for a health system performance domain: effectiveness, safety, responsiveness, continuity of care, accessibility, efficiency and sustainability. The framework is endorsed by the National Health Information Standards and Statistics Committee. For more information on the framework and its application to the Australian health system see Australian Institute of Health and Welfare 2009. *Australian hospital statistics 2007–08* (Health services series no. 33. Cat. no. HSE 71. Canberra), chapter 4.

⁹⁴ Department of Defence, *Australian Defence Force Health Status Report, First Edition*, Defence, Canberra, 2000.

accurate and reliable data that would allow it to produce this kind of report. While noting these problems, it is nonetheless important for JHC to progressively implement reporting against relevant and meaningful KPIs as soon as possible. The ANAO suggests that Defence consider publishing regular updates of a report along the lines of the 2000 *Australian Defence Force Health Status Report* as soon as it is able to obtain reliable statistical data on the health status of ADF members. There would also be benefit in performance against KPIs being made available publicly, either in Defence's annual report or on its website.

3.33 Until a suitable electronic health information management system is available, manual procedures and other workarounds may be needed to capture relevant, meaningful and reliable data for monitoring, analysis and reporting of its financial and clinical performance against pre-determined benchmarks. Significant variations from expected benchmarks could be investigated for identification of trends and/or systemic problems, so that corrective action can be taken by all levels of management on a regular basis. Such a performance monitoring and reporting regime is a fundamental element of a well-governed organisation.

3.34 The lack of a formal, rigorous and structured performance monitoring and reporting regime in JHC has in the past constrained its ability to manage performance and resources effectively. For example, persistent overspends of JHC's budget allocations for ADF health services provision by an average of around \$15 million each year between 2004–05 and 2008–09 are a reflection of past poor management. The ANAO, however, recognises that JHC has improved its performance in this regard, with only a small budget overspend in 2008–09 and a projected budget underspend in 2009–10.

Risk management and fraud control planning

3.35 JHC has developed a risk management plan,⁹⁵ which identifies a number of high-level risks concerning the success or otherwise of the reforms currently underway following the COSC's July 2008 decision. The JHC Risk Plan forms part of the VCDF Group's risk management plan. The process used by JHC to develop its Risk Plan followed the Defence Risk Management Framework and templates.

⁹⁵ JHC Risk Management Plan, V2, updated in August 2009.

3.36 JHC does not have a separate Fraud Control Plan, but the VCDF Group has a Fraud Control Plan, which is intended also to cover JHC.⁹⁶ However, this Plan has not been updated following the transfer of JHC to the Group and the ANAO suggests that it be reviewed to ensure that JHC-related fraud risks are being adequately managed.

Recommendation No.2

3.37 The ANAO recommends that JHC:

- (a) identify effectiveness and efficiency KPIs that adequately reflect its business performance and that can be progressively refined as the current Defence health services reform program is implemented; and
- (b) provide annual performance reports against relevant KPIs to inform internal management decisions in relation to JHC and to facilitate external scrutiny of JHC's performance, such as through the department's annual report.

Defence response

3.38 *Agreed.* Defence has developed a framework which will represent the key performance areas in which performance indicators will be identified for the measurement of the quality of Garrison Health Services.

Clinical governance

3.39 JHC's clinical governance framework is built on the following five pillars:

- credentialing of health professionals;
- accreditation of ADF health facilities;
- management of health complaints;
- health incident reporting; and
- orientation of health staff working in the ADF environment.

⁹⁶ VCDF Group, Fraud Control Plan 7, November 2007.

Credentialing of ADF health professionals

3.40 There are two Health Directives that provide advice on the credentialing of ADF health professionals, namely Health Directive No. 909 – *Registration of ADF Health Service Professional Officers*⁹⁷ and Health Directive No. 822 – *Maintenance of Defence Health Service Personnel Clinical Competency and Currency*.⁹⁸

- Health Directive 909 requires all ADF Health Service Professional Officers, including medical practitioners, dentists, nurses and pharmacists who belong to a profession for which registration with a professional board of a state or territory is mandatory in civilian practice, to maintain the registration, and to provide evidence of registration annually to the authority charged with exercising technical control over their activities;⁹⁹ and
- Health Directive 822 requires each health employment category or qualification gained within the ADF to be subjected to regular assessments of currency and competency.

3.41 Defence informed the ANAO that training and competency maintenance for individual ADF health service members is single Service based and managed at the unit level. Nonetheless, as JHC proceeds to assume responsibility for all Garrison Health Services, it will need to ensure that it has arrangements in place to monitor the competency requirements of all ADF health personnel working in its health facilities.

3.42 JHC requires all Contracted Health Professionals to be qualified and to maintain their qualifications, and it relies on prime contractors to ensure that this is done for all of their personnel whose services they provide to Defence. There are annual reviews of Contracted Health Professionals and this provides the opportunity to review their qualifications.

⁹⁷ Health Directive No. 909 – Registration of Australian Defence Force Health Service Professional – 7 June 2004.

⁹⁸ Health Directive No.822 – Maintenance of Defence Health Service Personnel Clinical Competency and Currency – 29 June 2000.

⁹⁹ Technical control is the specialised or professional guidance and direction exercised by an authority in technical or professional matters.

Accreditation of ADF health facilities

3.43 A strong clinical governance framework is important for a number of reasons. These include promoting such aspects as quality health care to ADF members; staff development and thus better staff morale, particularly among junior ADF health professionals; and retention of ADF health personnel.

3.44 ADF facilities have employed different accreditation systems over the years, depending on the type of facility and the purpose for which the accreditation was being sought, but the majority attained accreditation against International Organization for Standardization (ISO) standards. This provided some level of standardisation of processes.

3.45 An internal review of accreditation of ADF health facilities was undertaken in 2008. After considering the available options for the accreditation, CJHLTH instructed the Clinical Governance Section in the Defence Clinical Services Directorate in the Garrison Health Operations Branch to coordinate accreditation with the Royal Australian College of General Practice (RACGP) standards for ADF primary care, the Australian Council on Healthcare Standards (ACHS) for accreditation for inpatient facilities and the National Association of Testing Authorities (NATA) for accreditation of pathology laboratories.¹⁰⁰ The decision to adopt RACGP standards was related to its widespread use within primary health care facilities in Australia, while ACHS standards are widely used by Defence's 'partner' state and private hospital systems.¹⁰¹ In August 2009, JHC staff were assured that ISO accreditation would be maintained during the transition to the new system, but during fieldwork for this audit staff at some JHC facilities informed the ANAO that the facility's ISO accreditation had lapsed.¹⁰² This is not necessarily a concern, provided that there is no undue delay in accrediting facilities under the new system.

3.46 The Clinical Governance Section has been working with the RACGP to develop external standards that will meet the particular requirements of Defence primary health care facilities. This new clinical governance system

¹⁰⁰ Accreditation of ADF Health Facilities – Minute CJHLTH/SGADF, January 2009.

¹⁰¹ Primary health facilities, such as the Area Health Service ACT/SNSW, that had adopted ACHS accreditation previously, may continue to maintain this accreditation as JHC has concluded that there is no financial benefit in ceasing ACHS accreditation and replacing it with RACGP accreditation.

¹⁰² Letter to All Staff – Major-General CJHLTH dated 12 August 2009.

does not include dentistry at this stage, although it is expected that it will be extended to include dental health once the system is operational. While external standards will be used, accreditation of most garrison health facilities will be undertaken by Defence staff. The Clinical Governance Section has instead been developing an internal governance audit tool and audit schedule. The audits will be conducted by health system managers who will identify key health risks across each Regional Health Service (facility by facility), which will then be consolidated at the Regional Health Service and Defence-wide levels. Action will then be taken to address identified risks according to their priorities.

3.47 It is not possible to comment on the effectiveness of the new system for the accreditation of health facilities, as it is still under development. However, it will be important for the system to place adequate emphasis on the quality and consistency of clinical services, such as treatments and referrals, rather than just corporate governance processes, procedures, conditions and the health care environment that contribute to good clinical governance. Regular reviews of the facilities against the externally developed standards would provide assurance that the facilities are of an acceptable standard.

3.48 Most Defence health facilities that the ANAO visited during this audit were of a good standard.¹⁰³ However, staff at two of the health facilities visited informed the ANAO that the relevant facility did not comply with accreditation standards because they were either 'run down' or 'not fit for purpose'. For example, HMAS Coonawarra in Darwin currently occupies a building which is considered to be not 'fit for purpose'. A particular concern that was highlighted by ADF health personnel interviewed by the ANAO is that it does not have the required number of washing facilities in treatment areas.

¹⁰³ The ANAO visited health facilities at: Duntroon and Russell in the ACT; Holsworthy Army Base (1st Health Services Battalion, 3rd Royal Australian Regiment (RAR), Tobruk Lines) and RAAF Richmond in NSW; RAAF Laverton, HMAS Cerberus, Puckapunyal Army Base and Victoria Barracks in Victoria; and Robertson Army Base (1 Brigade, 1 Combat Service Support Battalion (1CSSB), 1CSSB Dental, 2nd Cavalry Regiment, 1st Combat Engineers Regiment, 7th RAR, 1 Armoured Regiment), RAAF Darwin, HMAS Coonawarra, Norforce and the Psychology Support Section Winnellie in the NT. The ANAO also had discussions with Area Health Services personnel in each location.

Management of health complaints

3.49 JHC has established a health complaints management system as prescribed by Health Directive 914 – *Management of Health Care Related Complaints* in the ADF.¹⁰⁴ Health Directive 914 requires that individual health facilities should have a complaint resolution mechanism that reviews the status of outstanding complaints on a regular basis and ensures that outcomes are in accordance with the ISO 9001:2000 – *Quality Management Systems – Requirements*. The system also records positive feedback received from ADF members.

3.50 The complaint system deals primarily with complaints against health care providers in the military setting. These may result from such things as:

- a communication failure between the patient and health care provider;
- a perception of poor quality of care;
- unintended consequences of treatment and/or poor outcomes;
- unrealistic expectations and demands; and
- alleged breaches of privacy, respect and trust.

3.51 Disputes related to the assessment of an ADF member's Medical Employment Classification, with implications for the member's employability and deployability, are not meant to be dealt with through the complaint process, but through a separate appeal process.

3.52 The intent of Health Directive 914 is to have rapid resolution of health care related complaints at the point of service delivery. Failing this, there are a number of options available to facilitate the processing of a complaint. They include:

- referral to the Director General Health Operations for reviews involving JHC facilities;
- referral to the Operational Health Adviser for complaints of professional negligence and misconduct, or complaints directly involving a Senior Health Officer/Senior Medical Officer as individuals; and

¹⁰⁴ Health Directive No. 914, 19 April 2004.

- Defence internal systems such as the Redress of Grievance system¹⁰⁵.

3.53 Health Directive 914 requires each Area Health Service (AHS)¹⁰⁶ to maintain an active database in the form of an electronic spreadsheet on all health care complaints and other feedback managed within their region. It also requires the Director Joint Health Support Agency (now the Director General Health Operations) and the Occupational Health Adviser to:

- maintain an active database of all complaints escalated to them for review; and
- prepare consolidated biannual reports of selected components of the central database for submission to the Defence Health Service Steering Committee (DHSSC), which no longer operates. Because the DHSSC no longer operates, the Clinical Governance Section prepares weekly reports for the Director General Health Operations.

3.54 The information captured on the complaint databases could be improved to better enable analysis of the nature, frequency, types and underlying causes of complaints and the effectiveness of complaint resolution arrangements. This would help JHC to derive intelligence which could be useful for the improvement of ADF health service delivery. Currently, there is insufficient information collected at the AHS level and collated at the national level to enable such analyses to be conducted.

Health incident reporting

3.55 Health Directive 904 – *Liability of the Commonwealth for Negligence of its Employees*¹⁰⁷ states that a member of the ADF Health Services would not normally be made personally responsible for meeting any judgement given in respect of negligent acts occurring in the course of their duty. However, if a member of the ADF is not satisfied with the degree of cover provided, he or she should seek appropriate professional indemnity insurance.

¹⁰⁵ The Redress of Grievance system provides for formal review and consideration of grievances that ADF members may have.

¹⁰⁶ As noted in paragraph 2.19, the existing nine AHSs are to be replaced by five regional health services.

¹⁰⁷ Health Directive No.904 – Liability of the Commonwealth for Negligence of its Employees, 31 October 1991.

3.56 Insurance cover for ADF health services members is provided by Comcover through the Defence Insurance Office (DIO). Claims based on allegations of medical malpractice are covered under the Professional Indemnity section of the ADF Comcover policy. All incidents, including in relation to ADF members as patients, that have the potential to lead to an allegation of medical malpractice must be reported to the DIO using Form AD088.

3.57 The ANAO notes that the number of health incidents occurring each year could be used as one indicator of the quality of health services in Defence. Analyses of statistics on health incidents and their causes would provide JHC with valuable information on the quality of the health system, and help identify possible opportunities for improvement, including opportunities to reduce the cost of JHC's insurance premium and hence overall health delivery costs. However, JHC does not currently have a health incident management system that would enable it to monitor the type and frequency of health incidents and no area of JHC liaises with DIO to manage health incidents, such as requesting statistics from DIO on health related claims. Defence informed the ANAO that a project is now under way to finalise and implement a paper-based Health Incident Management system using Webforms¹⁰⁸ and JHC is planning to request incident reports from the DIO.

Orientation of health staff working in the ADF environment

3.58 The Clinical Governance Section has developed a program to provide ADF health units with a health orientation pack for use by all health professionals as prescribed by Health Directive No.932 – *Health Orientation of Personnel Working in the Defence Health Environment*.¹⁰⁹ The product provides unit-specific information as well as policy documents and health sites relevant to health professionals working in health units.

3.59 An orientation checklist is meant to be completed by each individual three months after commencement and submitted to their supervisor for signature. All orientation checklists must be maintained on a central file in the health unit by the quality manager.

¹⁰⁸ Forms available on Defence's intranet.

¹⁰⁹ Health Directive No.932 – Health Orientation of Personnel Working in the Defence Health Environment, 23 December 2008.

3.60 The material in the health orientation pack, if utilised fully, is sufficiently comprehensive to provide all health personnel with a reasonable introductory working knowledge of the Defence health environment.

Other clinical management issues

3.61 With some 786 Contracted Health Professionals working in Defence's health facilities as at September 2009, there is a need to ensure that there is adequate clinical supervision of them and that Defence policies are met.

3.62 There are many Contracted Health Professionals employed by Defence who have had previous experience in Defence and/or may also be in the ADF Reserves. However, many others have had no previous experience of the military and the special requirements that apply to the ADF. To carry out their role efficiently, these Contracted Health Professionals must acquire a good understanding of Defence health policies and how they are to be applied.¹¹⁰ The contracts under which Contracted Health Professionals are engaged provide for annual reviews of the performance of Contracted Health Professionals. However, the ANAO considers that there would be benefit in considering other mechanisms to better inform annual reviews. These could include supervision by ADF medical personnel, where possible, auditing of identified risk categories or analysis of information from JHC's planned new health information management system.

Recommendation No.3

3.63 The ANAO recommends that JHC:

- (a) establish mechanisms, in cooperation with each Service, to monitor the currency of credentials of all ADF health professionals working in JHC health facilities;
- (b) enhance its complaints management database to enable capture of information that will facilitate analysis of the nature, frequency, types

¹¹⁰ For example, because of misunderstandings about Defence's policy on an ADF member's ability to be dentally fit for deployment, Defence has now instituted a policy that all new ADF dental officers and all contract dental professionals must have their selections of third molar removals approved by the senior Dental Officer of their dental unit until such time as they can demonstrate that they understand how deployment stressors, operational roles and individual risk factors influence third molar removal case selections.

and underlying causes of complaints and the effectiveness of complaint resolution arrangements;

- (c) collect and analyse information on health related incidents, including claims submitted to the Defence Insurance Office, and use this information to identify further opportunities to improve Garrison Health Services; and
- (d) put in place mechanisms to ensure that there is improved clinical supervision of contracted health professionals working in JHC health facilities.

Defence response

3.64 *Agreed.* With the implementation of the e-Health system (JeHDI) Defence will have the tool to accurately record, track and report clinical governance.

3.65 In addition, as noted by the ANAO Defence has developed and implemented a Governance Audit System, and Defence notes ANAO's comments for ensuring this tool delivers the governance required.

Strategic alliances

3.66 Going forward, it will be important for the governance arrangements for ADF health support (including for both Operational and Garrison Health Services) to be sufficiently flexible to support innovative solutions Defence is adopting to address some of the particular challenges it faces in having sufficient access to appropriately qualified health personnel and services.

Using strategic alliances to improve timely access to Health Reservists and to optimise sourcing of health facilities and services

3.67 Defence relies heavily on the services of health professionals who are members of the ADF Reserves (Health Reservists)¹¹¹ in responding to emergencies, such as the tsunami in Samoa and floods in Indonesia in 2009. These Health Reservists are part-time members of the Navy, Army or Air Force who help to ensure that the ADF has the capacity to draw on the skills of

¹¹¹ The term 'Health Reservists' encompasses all members of the ADF Reserves (Army, Navy and Air Force) who are health professionals.

health professionals who are not full-time members of the Services, including specialist skills that may not be available in the ADF. Because of the ADF's ongoing need for Health Reservists, Defence has had in place for some time higher level Employer Support Payments¹¹² in respect of medical, dental, nursing and allied health officers (who are within specified health disciplines) undertaking various forms of Defence service.

3.68 However, because of the categories of medical skills required, Health Reservists generally work in the state and territory hospitals. In the event of an emergency, Defence needs to have quick access to the services of these Health Reservists. Until now, the release of these members from their regular employment has been on an ad hoc basis. This relies heavily on the goodwill of state and territory hospitals and the personal availability of the Health Reserve members. Defence is currently exploring strategies to facilitate the timely release of such health personnel to assist with emergency situations in the future. For example, Defence is considering entering into strategic alliances with state and territory public hospitals at which many Health Reservists are currently employed to develop teams of personnel, who would continue to work in the public hospitals on a day-to-day basis, but who as Health Reservists could also be released for Defence deployments at short notice. Such an alliance is currently being explored with the Royal Brisbane and Women's Hospital (RBWH) and the Queensland Department of Health.

3.69 Southeast Queensland is a high population growth area, experiencing the associated pressure on its infrastructure including health infrastructure, with high quality educational and health facilities. There are also substantial ADF personnel and facilities located there. Accordingly, JHC has focussed recently on looking for opportunities in this area. Defence has signed an agreement with the University of Queensland to establish an inaugural Chair in Military Surgery to help strengthen, shape and lead military surgery, research and training and provide academic scrutiny to resuscitative and emergency care on the battlefield.¹¹³ Also being discussed is the possible

¹¹² The Employer Support Payment (ESP) Scheme provides financial assistance to eligible employers to help offset the costs of releasing employees for most categories of Australian Defence Force service. Unless otherwise authorised in the case of substantial financial hardship or loss or under capability related approvals by the Chief of the Defence Force, ESP is paid at a weekly rate (currently \$1183.10 per week) regardless of the employee's salary, and there are no restrictions on the way in which employers can use the money.

¹¹³ ABC News, *UQ creates first Chair of Military Surgery* [Internet]. ABC News Online, 23 April 2010, available from <<http://www.abc.net.au/news/stories/2010/04/23/2881204.htm?section=...> 27/04/2010>.

provision of access for the RBWH to Defence's 2nd Health Support Battalion (2HSB) health facilities at Enoggera in Brisbane, including access to the 2HSB hospital to undertake day surgery for civilian patients.

3.70 While these negotiations are continuing, and the terms of any arrangements have still to be finalised, these innovative approaches being explored by Defence offer the opportunity for Defence to:

- secure the necessary access at short notice to health professionals to assist in ADF responses to emergencies, without incurring the onerous costs associated with all of such personnel being full-time members of the ADF (even if Defence could secure that many health professionals willing to serve full-time); and
- optimise sourcing of health facilities and services and reducing costs through shared use arrangements with civilian facilities.

3.71 Defence has already developed a commercial arrangement with St Vincent's Hospital in Sydney, which involves the lease by Defence of a ward in the hospital. This lease was initially entered into on a temporary basis, while refurbishments were made to the Defence ward at Balmoral Hospital. However, it has worked so well that JHC is now planning to lease a ward on a long-term basis.¹¹⁴ The arrangement has enabled Defence to treat acute care patients because of the ready availability of specialists who work at the hospital and the access that is provided to St Vincent's high class operating theatres for ADF patients. The arrangement with St Vincent's is also providing the opportunity for ADF medical personnel to obtain acute care clinical experience that is more relevant to operational deployments. It is also not cost effective for JHC to continue to run surgical operating theatres, and most have now been closed or are being closed.

3.72 Arrangements similar to that at St Vincent's Hospital for the treatment of acute care cases are being considered for other locations, including with the RBWH as part of its possible strategic alliance with that hospital.

¹¹⁴ Defence is unable to continue the lease of the existing ward because this is required by the NSW Department of Health. However, Defence is negotiating a lease in a new building under construction at St Vincent's Hospital.

Working with the broader health sector to obtain access for ADF health personnel to acute care experience

3.73 ADF health personnel need experience in the provision of acute care, because these are the skills that will be primarily needed when these personnel are deployed on operations. This acute care experience is generally only available in civilian settings, such as in the accident and emergency departments of public hospitals. ADF health personnel also need to have a minimum level of ongoing practical experience in order to maintain the currency of their qualifications. The ANAO found that most Defence owned and operated health facilities visited have developed local arrangements with nearby hospitals for ADF medical personnel to gain experience in acute care areas. Some doctors also have arrangements with local private practices to gain the required level of ongoing practical medical experience.

3.74 Under the SLAs between JHC and the single Services, JHC is required to ensure that ADF personnel working with it are provided with appropriate clinical skills development. It will therefore be important that JHC establish mechanisms to ensure that these personnel have access to the necessary skills experience. In this regard, JHC could consider systematically developing and monitoring arrangements with civilian hospitals for ADF medical staff to gain the necessary clinical experience. To ensure that all ADF health personnel, including those not providing Garrison Health Services, are able to acquire the necessary clinical experience, a cooperative approach between JHC and the single Services would be required.

3.75 Defence's ability to date to provide experience for ADF medics in civilian hospitals has been limited, because these personnel do not have qualifications that are recognised in the civilian setting.¹¹⁵ As a result, they require supervision by a registered nurse, and Defence is not always able to make registered nurses available to do this. However, Defence is in the process

¹¹⁵ Unlike enrolled nurses in the civilian sector, medics do not have experience in some areas, such as paediatrics and gerontology. The reasoning for this was that ADF medics do not need this experience. However, as ADF personnel are increasingly required to assist with community emergencies, such as tsunamis, this experience is in fact now needed.

of changing the training for medics and in the future ADF medics will have an enrolled nurse qualification.¹¹⁶

3.76 In addition to gaining experience in acute care areas of civilian hospitals, ADF health personnel still require basic health experience in Defence facilities.¹¹⁷ There would therefore be benefit in Defence seeking to maximise these opportunities for ADF health personnel.

Family Health Trial

3.77 In the 2008–09 Budget the Government committed \$12.2 million over four years to provide free basic medical and dental care to 2700 dependants living in Singleton (NSW), the Karratha/Pilbara region (WA), Sale (VIC), Far North Queensland (Cairns, Mt Isa, Weipa and Thursday Island), (Katherine (NT) and Derby (WA)).¹¹⁸ The trial in these regions commenced on 1 May 2009.¹¹⁹ The main features of the trial are shown at Figure 3.1.

¹¹⁶ This will coincide with the introduction of a new National Registration and Accreditation Scheme for the Health Professions from 1 July 2010, which was announced by the Council of Australian Governments (COAG) at its meeting of 26 March 2008. This new scheme, which will replace the various state and territory registration and accreditation schemes, has been designed to help health professionals move around Australia more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce. The new national registration and accreditation arrangements means that all ADF health personnel will need to meet the new national standards.

¹¹⁷ The ANAO visited 1st Health Services Battalion at Holsworthy Army Base where some Army health personnel were no longer providing any health support, but instead spent much of their time checking and familiarising themselves with equipment on the basis that this is an operational requirement. While not doubting the importance of ADF health personnel being familiar with their equipment, the ANAO suggests that there is also a need to support the health facility and provide personnel with ongoing basic clinical experience.

¹¹⁸ Budget Paper No.2, 2008–09 Budget, Expense Measures, 'Australian Defence Force – general medical and dental care'.

¹¹⁹ The Budget measure stated that the trial would commence in February 2009.

Figure 3.1**Main features of the Family Health Trial**

<ul style="list-style-type: none"> • Dependants of ADF members are able to access basic medical services from medical practitioners who agree and are approved to participate in the trial and dental services from any dental practitioner.
<ul style="list-style-type: none"> • ADF dependants who participate in the trial are issued with an ADF Family Health Card, which is used by the medical or dental practitioner to verify the person's eligibility to access services under the trial.
<ul style="list-style-type: none"> • Both the ADF member and his or her dependants must agree to participate in the trial (an ADF member whose dependants participate in the trial may incur a taxable fringe benefit).
<ul style="list-style-type: none"> • In most locations, participating medical practitioners are paid \$19 to bulk bill eligible Medicare item numbers when a registered dependant attends their medical practice. In three locations, registered dependants can claim full gap reimbursement for eligible Medicare items.¹²⁰ The gap payment is the difference between the medical practitioner's fee for the service and the applicable Medicare rebate where a medical practitioner submits a claim for payment to Medicare Australia. Medicare Australia then bills Defence for \$19. Medicare continues to meet the cost of the scheduled fee.¹²¹
<ul style="list-style-type: none"> • For dental services, ADF dependants can access up to \$300 a year per dependant for non-cosmetic dental surgery.
<ul style="list-style-type: none"> • Naval Health Ltd has been engaged by Defence to manage the dental component of the trial, following a public tender. Naval Health Ltd processes all payments against the \$300 limit, issues the ADF Family Health Card, processes medical claims for 'gap' payments in areas where there are no participating medical practitioners and full reimbursement for registered dependants not currently eligible for Medicare benefits.

Source: ANAO summary of information provided by JHC.

3.78 In October 2008, the Government announced the expansion of the trial to an additional 13 300 dependants in Townsville and Tully (QLD), Darwin, including Alice Springs and Nhulunbuy (NT), Broome and Kununurra (WA) and Puckapunyal (VIC).¹²² Provision for this expansion was later included in

¹²⁰ Weipa (Qld), Katherine (NT) and Carnarvon (WA), where practitioners have declined to participate in the trial.

¹²¹ Under a Service Level Agreement between Medicare Australia and Defence, Medicare Australia administers the registration of medical practitioners, as well as the claims processing services associated with the ADF Family Health program payment. In locations where there is effectively only one provider who is willing to participate in the trial, the payment is more than \$19 because Defence has only been able to secure their participation by agreeing to provide additional payment. Defence also meets the cost of the scheduled fee of dependants who are not Australian citizens. For these dependants, Defence provides full reimbursement of eligible Medicare items. In some locations, there are no private medical practices, and Defence families continue to access medical services at their local government health facility.

¹²² Announcement by the Minister for Defence Science and Personnel, the Hon Warren Snowdon, MP, 17 October 2008.

the 2009–10 Budget.¹²³ The second stage commenced on 1 October 2009 and the trial (stages 1 and 2) is planned to conclude in June 2012.

3.79 The Government's decision to conduct the trial was in response to an election commitment: 'to progressively extend free health care currently provided to ADF personnel to ADF dependent spouses and children' in regional and remote localities where access to health care was difficult.¹²⁴

3.80 Defence provided the Government with 11 options on how the trial might operate before the Government selected the option outlined in Figure 3.1. Subsequently, Defence has developed an evaluation strategy for the trial and Defence appears to have managed the administrative arrangements for the trial well.

3.81 Risks identified by Defence with the trial are:

- its high cost—up to \$64 million over four years to provide services to only 22 per cent of an estimated total ADF dependant population of 70 000; and
- indications that: 'the trial has proven to be inflammatory to ADF Members and ADF dependants that will not benefit from it'.¹²⁵

3.82 As at 1 March 2010, the overall take-up for Stage 1 by the applicable ADF members and their dependants was 40 per cent¹²⁶ and for Stage 2 was 16 per cent.¹²⁷ Defence advised that the department spent \$3.35 million on the trial in 2008–09 (most of which was on systems development and other set-up costs). While the trial may have been successful in ensuring that ADF families included in the trial are able to gain access to medical services in some areas, in others, such as Katherine, it has not done so.

3.83 As the trial has only been operating for a relatively short time, it has not been possible to assess it fully at this stage. However, given the identified risks with the trial, the ANAO suggested that Defence conduct a preliminary

¹²³ Budget Paper No.2, 2009–10 Budget, Expense Measures, 'Australian Defence Force Trial – expansion'.

¹²⁴ Labor's Plan for Defence, Election 2007 Policy Document, p. 9.

¹²⁵ Background Brief on Australian Defence Force Family Health, 18 August 2009, paragraph 23.

¹²⁶ Far North Queensland (Cairns, Mount Isa, Weipa and Thursday Island) 43 per cent; Katherine 27 per cent; Pilbara Region 91 per cent; Singleton 43 per cent; and Sale 55 per cent.

¹²⁷ Puckapunyal 16 per cent; Townsville 17 per cent and Darwin 16 per cent.

evaluation of it once it has been operating for 12 months. Defence informed the ANAO in June 2010 that JHC is currently undertaking an evaluation of the ADF Family Health Trial, including a survey of participating and non participating families.

4. Managing the Cost of ADF Health Services in Australia

This chapter examines the cost of Garrison Health Services and other JHC activities and provides an estimate of their total cost. The chapter also explains the extent to which, and reasons why, the cost of health support to the ADF dependency exceeds the cost of health care in the wider community and examines options to contain future cost increases.

Introduction

4.1 Under the Strategic Reform Program, JHC is expected to realise savings of around \$118 million between 2009–10 and 2018–19. JHC is expected to find these savings against a background of health care costs in Australia that are rapidly rising.¹²⁸ This requires JHC to have a sound understanding of the main cost components of the health services it is providing to the ADF and their drivers and a coherent management strategy to manage and contain these costs.

Components of ADF health service costs

4.2 The main components of the cost of Garrison Health Services and other JHC activities are:

- employee and purchased health professional services expenses;
- health materiel expenses (such as pharmaceuticals and medical equipment);
- health facility and other corporate expenses; and
- other supplier expenses.

¹²⁸ Between 1997–98 and 2007–08, Australia's expenditure on health in real terms (after adjustment for inflation), grew at an average of 5.2 per cent per year, compared with average growth in real GDP over this period of 3.5 per cent per year (see The Australian Institute of Health and Welfare in its report *Health expenditure Australia 2007–08*, September 2009, p. 9). The National Health and Hospitals Reform Commission in its report, *A healthier Future for All Australians Final Report*, June 2009, also noted that health and residential aged care costs as a percentage of GDP are projected to rise from 9.3 per cent in 2002–03 to 12.4 per cent in 2032–33, see p. 58.

Employee and purchased health professional services expenses

4.3 Personnel providing Garrison Health Services include:

- ADF clinical, administrative and support personnel who are formally posted to JHC (657 as at October 2009, of whom 510 provided direct Garrison Health Services);
- ADF members attached to the single Services working in garrison health facilities that, until now, Service units have managed (1725 as at October 2009).¹²⁹ In addition to working in the garrison health facilities, these personnel are engaged in other military duties (such as training exercises and their own physical military preparedness) and in providing health advice to the unit's commanding officer;
- Australian Public Service (APS) clinical, administrative and support personnel (403 as at November 2009, of whom 233 were providing direct Garrison Health Services); and
- Contracted Health Professionals (786 as at September 2009).¹³⁰

4.4 Further details of the total Defence health workforce¹³¹ of 3571 in Australia as at October 2009 are shown at Appendix 1.¹³² At that time, of the total of 3571 personnel, 1529 (or 43 per cent) were providing full-time clinical support in garrison. The remaining 57 per cent were providing non-clinical support or were augmenting clinical support in garrison on a part-time basis.

4.5 Employees in other parts of Defence, such as the Defence Materiel Organisation for health materiel procurement and DSG for health facilities, also support ADF health services.

¹²⁹ This assumes, conservatively, that at any one time around 12 per cent of military medical personnel are deployed, and therefore not included in the cost assessment.

¹³⁰ Defence also purchases health professional services from the private sector on a fee-for-service basis.

¹³¹ That is, non-deployed ADF health personnel whether posted to JHC or to Single service units, APS health personnel and civilian health professionals contracted on either an exclusive, sessional or fee for service basis.

¹³² These figures include ADF health personnel on deployment overseas at the time. As noted in footnote 129, these figures were discounted by 12 per cent to calculate the number of ADF health personnel providing Garrison Health Service.

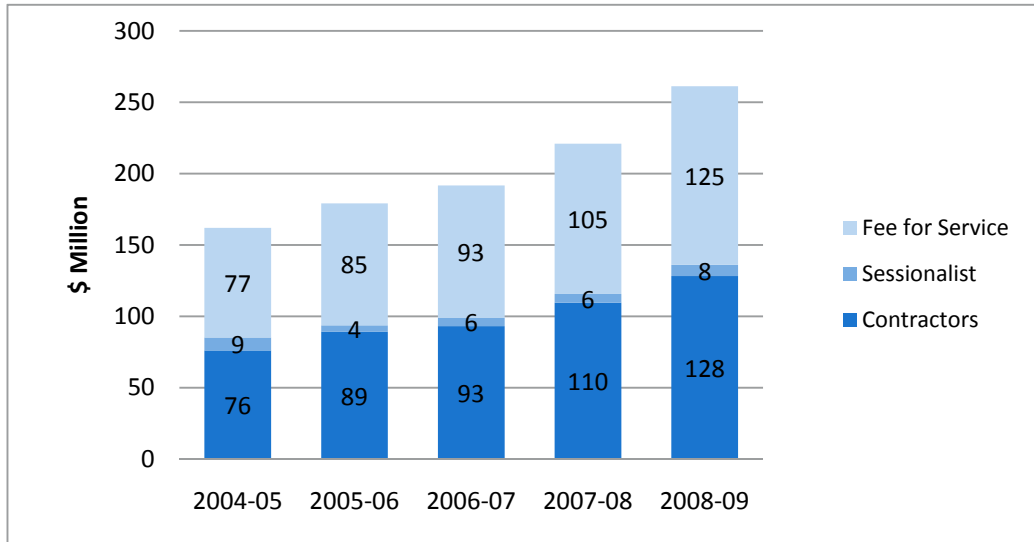
Purchased health professional services

4.6 JHC’s administered expenses are almost entirely made up of the cost of purchased health professional services. Defence purchases health professional services in a range of ways: through individual contracts or via a prime contract arrangement (these providers are termed Contracted Health Professionals); through fee-for-service arrangements with civilian health professional service providers; and through arrangements for health professional service providers to provide services on a sessional basis, for example, they might provide services at a Defence health facility one day a week.

4.7 In 2008–09, expenditures on Contracted Health Professionals, fee-for-service and sessionalist providers totalled \$261.2 million, of which 49 per cent was for Contracted Health Professionals, 48 per cent for services provided on a fee-for-service basis and three per cent for sessional providers. Figure 4.1 shows the rapid growth in expenditures related to purchased health professional services over the past five years, with expenditure rising by around 60 per cent from \$162 million in 2004–05 to \$261 million in 2008–09. Over the same period, expenditure by JHC on ADF employees fell around eight per cent from \$42 million in 2004–05 to \$39 million in 2008–09.

Figure 4.1

JHC expenditures on purchased health professional services, 2004–05 to 2008–09

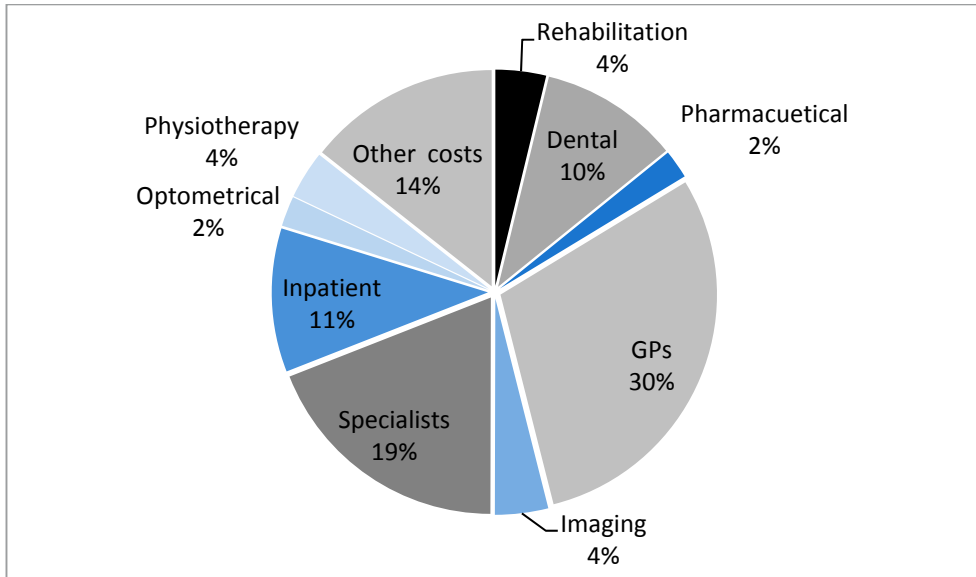


Source: JHC.

4.8 These expenses relate to a wide range of health services. Figure 4.2 shows JHC's main expenditure items as a proportion of the total of \$261.2 million in purchased health professional services costs in 2008–09.

Figure 4.2

JHC main expenditure items (all health professional services provider types) 2008–09



Source: JHC.

4.9 One of JHC's current strategies to help contain costs is to seek to convert some Contracted Health Professional positions to APS positions, which are less costly. It also recognises that Contracted Health Professional costs need to be carefully managed. As noted in paragraph 3.34, Defence informed the ANAO that JHC is projecting a budget underspend for 2009–10. Defence further informed the ANAO that part of the reason for this projected underspend is the more rigorous approach that JHC is now taking to managing the cost of Contracted Health Professionals.

Contracted Health Professionals

4.10 Since 1 January 2008, JHC has had a number of 'prime' contracts for the provision of a regional health practitioner workforce. There is generally one prime contractor (and up to two) covering each of the current nine regions, and a limited number of contracts with individual practitioners. Service level requirements for prime contracts are detailed in Statements of Work (SOW) attached to each contract. Requirements for the employment of Contracted

Health Professionals are detailed in general and occupation specific Statements of Requirement (SOR) in each contract.¹³³

4.11 Prime contractors are responsible under their contracts with Defence for managing the Contracted Health Professionals they provide to the department and ensuring that these Contracted Health Professionals perform their services in accordance with the contracts. JHC does not generally become involved in the selection process of potential Contracted Health Professionals that it employs under prime contracts. Rather, Contracted Health Professional selection is undertaken by the prime contractors. However, JHC reviews the performance of all Contracted Health Professionals at least annually.

4.12 Service providers (prime contractors) are reviewed at the national level using criteria that include:¹³⁴

- turnover of Contracted Health Professionals;
- audit of Contracted Health Professional registration or credentials;
- provision of qualified Contracted Health Professionals to back-fill positions;
- outcome of Contracted Health Professional performance reviews;
- accuracy of contract invoicing;
- availability of the designated point of contact; and
- currency of required insurance and professional board registrations.

4.13 Day-to-day contract management is the primary responsibility of the relevant JHC Area Health Service and each health facility is responsible for the verification of attendance and timesheet records for Contracted Health Professionals and assisting with the daily management of the contracts. Under JHC policy, Area Health Services meet with independent Contracted Health Professionals every four months and prime contractors every month.

4.14 In both Puckapunyal and the Albury-Wodonga Military Area, Aspen Medical is responsible for the provision of all health services to ADF

¹³³ Defence has also engaged Contracted Health Professionals under national standard offers, or standing requests for services, as well as individual contracts. Under the national standing offers Contracted Health Professionals are engaged on standard rates of payment that apply to each state or territory.

¹³⁴ These performance criteria are listed in the 'Statement of Work' in the contract with the service provider.

personnel. These services include primary health care, specialist outpatient services, inpatient services, diagnostic and allied health services as well as dental services. The implementation of this model at Puckapunyal and the Albury-Wodonga Military Area has demonstrated that, in some locations, the contracting out of responsibility for health services represents good value for money and may assist Defence in making good use of its scarce health resources.¹³⁵

4.15 JHC has established a pathology services standing offer panel to supplement a limited number of in-house pathology laboratories (which are maintained primarily to support a deployable ADF pathology capability).¹³⁶ Similarly, optometry services are accessed by Area Health Services under standing offer arrangements.¹³⁷ Standing offer panels are managed under Deeds of Standing Offers which allow Area Health Services to place orders with one or more of the approved civilian service providers on the panels.

Health materiel expenses

4.16 Health materiel expenses include pharmaceuticals, medical and dental consumables as well as medical and dental equipment. Until 2008–09, these expenses were administered by the DMO on behalf of Army, as the ADF's lead capability manager. On 1 July 2009, JHC assumed lead capability manager responsibility from Army for health materiel sustainment and new minor capability costs under a new Materiel Sustainment Agreement (MSA) with the DMO.

4.17 Figure 4.3 shows the cost of health materiel (excluding repairs and maintenance costs) increased from \$25.3 million in 2000–01 to \$35.0 million 2008–09 (or by around 38 per cent).

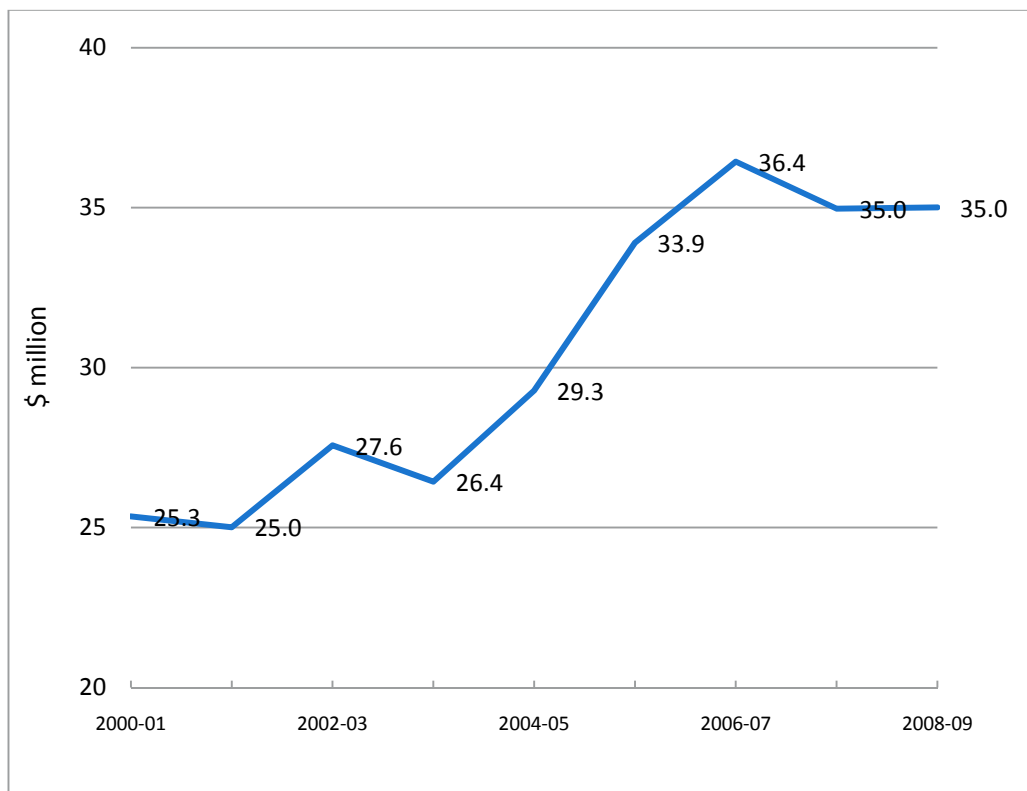
¹³⁵ JHC advised that the arrangements at Puckapunyal and the Albury-Wodonga Military Area represented the least average cost per dependent ADF member for all of its health facilities.

¹³⁶ Health Directive No 928- *Delivery of Pathology Services to the Australian Defence Force*, 20 September 2006, provides an outline of procedures for utilising civilian pathology services. The ADF maintains pathology laboratories at: the 2nd Health Support Battalion (2HSB) located at Enoggera Barracks; 3 Combat Support Hospital (3CSH) located at Richmond; Army's 1st Health Support Battalion (1HSB); Army's 1st Combat Service Support Battalion (1CSSB); and Army's 3CSSB.

¹³⁷ Health Directive No 221- *Visual Assessment and Optical Aids*, 10 March 2005, outlines policy regarding the provision of optometry services to members of the ADF. Circular Memorandum No 10/2005 provides procedures for accessing the optometry services standing offer panel and a list of approved optometry service providers.

Figure 4.3

Defence Health Services materiel expenses, 2000–01 to 2008–09



Note: These expenses exclude expenditure on repairs and maintenance, for which separate figures are not available for the entire period shown. Defence supply arrangements may not always enable expenditure on operational and non-operational health material to be clearly separated. While a small amount of the expenditure represented in this figure may have been used in support of operations (including pre-deployment preparation and post-deployment reconstitution), by and large it related to the provision of Garrison Health Services.

Source: JHC.

4.18 JHC is now working closely with the DMO to contain the cost of health materiel. The original allocated budget for the Health MSA for 2009–10 (\$38.8 million, including \$6.07 million for repairs and maintenance) was less than the actual expenditure in 2008–09 (\$41.1 million). The budget was reduced in anticipation of savings in relation to health materiel that JHC had expected to make through its program of ‘hubbing’ health facilities and closing operating theatres. These savings have not yet been fully realised. Accordingly, in December 2009, the DMO requested additional funding of \$4 million to cover a forecast shortfall in the allocation for health materiel procurement in 2009–10 (meaning that expenditure in 2009–10 is now expected to be slightly

more than the \$41.1 million expended in 2008–09). JHC was able to meet this request through a transfer of an unspent portion of its budgetary allocation.

Operating cost of health facilities

4.19 The financial arrangements that are in place for the operation of Defence health facilities reflect those of other parts of Defence. In simple terms, the process of funding and establishing Defence facilities involves provision for the whole of life cycle costs of the facility, including calculation of net personnel and operating costs (NPOC) that notionally cover the total cost of operating the facility over its life. These project funds are then transferred to DSG to administer and operate the facility according to service level agreements with the Defence user.

4.20 DSG is also responsible for the lease of facilities for Defence users. Accordingly, the lease of the ADF Ward at St. Vincent's Hospital in Sydney is also funded and administered by DSG.

4.21 DSG does not separately identify the actual cost of operating and maintaining ADF health facilities (these are subsumed within the overall cost of maintaining facilities on a Defence base), and so JHC does not monitor this aspect of the cost of Defence health service delivery. The 2006 COSC Cost Review estimated the annual cost of operating and maintaining Defence health facilities at around \$33.65 million at that time.¹³⁸

4.22 Reducing the number of health facilities under the planned Garrison Health Services reforms will reduce operating and capital costs attributed to Garrison Health Services. With this in mind, JHC is currently preparing a Strategic Infrastructure Plan that it advises will be completed around June 2010. However, these savings in costs directly related to the provision of Garrison Health Services will not necessarily be 'captured' as a health support efficiency improvement, because Defence currently does not monitor these costs at this level.

4.23 Excluding the costs of operating and maintaining facilities may distort decisions on the number of garrison health facilities that should be maintained. Because facilities costs are generally attributed to DSG, JHC may, perhaps

¹³⁸ Cogent Business Solutions, *Conduct of a study into health care costs in the Defence Health Service*, April 2006, op. cit., p. 5.

understandably, in the past have treated facilities costs as not being a significant consideration for it in decisions relating to providing health services efficiently.

4.24 JHC is now developing a facilities strategy against a background where a range of facility projects were initiated by the single Services prior to the establishment of JHC. The strategy seeks to support initiatives to develop strategic alliances with established civilian health institutions, develop a coordinated and efficient patient transport system and provide the structural basis for JHC's program of 'hubbing' health services. However, since some facilities are already under construction, JHC's ability to rationalise garrison health facilities will in some instances be constrained.

Supplier expenses

4.25 Supplier expenses (\$10.4 million in 2008–09) relate mainly to the functioning of JHC administration. They include such items as domestic and international travel, vehicle leasing, office consumables, training, non-technical professional services, depreciation, amortisation and other miscellaneous expenses.

Estimated cost of Garrison Health Services

ANAO's estimate of the cost of Garrison Health Services

4.26 Defence does not publish, nor does it monitor, the full cost of its health services. This is mainly because Defence does not generally allocate its budget and report costs in a way that readily allows for these costs to be ascertained and reported.¹³⁹ JHC, DSG and the DMO receive separate budget allocations for the health services components that they manage and each of the three Services receives budget allocations for the employment of health-related personnel and other ancillary costs. Defence does not consolidate these costs to indicate the total cost of Garrison Health Services (or indeed of all ADF health support costs, including Operational Health Support to the ADF).

¹³⁹ This is a circumstance that extends to other areas, not just health services. For example, in 2004 the ANAO reported that Defence did not monitor and report the costs of Army Individual Readiness Notices see: Australian National Audit Office 2004, *Army Individual Readiness Follow-up Audit*, Audit Report No.45, 2003–04, ANAO, Canberra, paragraphs 2.6–2.14. Also see ANAO Audit Report No.43 2009–10, *Army Individual Readiness Notice*, paragraph 3.67, p. 71.

4.27 In its annual financial statements, Defence reports some health expenses as an employee benefit. These expenses, shown in Table 4.1, mainly comprise the cost of Contracted Health Professionals and medical and dental costs incurred by JHC on a fee-for-service basis as shown in Figure 4.1.¹⁴⁰ They do not include expenses related to ADF and APS personnel working in garrison health facilities, the bulk of expenses related to health materiel (equipment and pharmaceuticals), expenses incurred in maintaining and operating ADF health facilities (such as electricity and repairs) or corporate services expenses (such as information technology (IT) expenses). The reported ADF employee benefit expenses therefore comprise only a small part of the cost of Defence health services.

Table 4.1

ADF employee benefit health expenses, 2004–05 to 2008–09

Year	\$ million
2004–05	163
2005–06	180
2006–07	192
2007–08	222
2008–09	262

Source: Defence annual reports, 2004–05 to 2008–09.

4.28 In calculating the cost of Garrison Health Services, it is reasonable to exclude the estimated cost of the time that ADF health personnel who are not formally attached to JHC spend on operational and other unit duties, such as support for unit training exercises or personal physical training in preparation for deployment, since these are not directly related to the provision of Garrison Health Services. However, there is no information available on the proportion of time that ADF health personnel spend on Garrison Health Services and how much time they spend on operational and other unit duties. In light of this, any allocation of costs between Garrison Health Services and other operational or other unit duties would necessarily be arbitrary and it is only possible to

¹⁴⁰ In addition to amounts for Contracted Health Professionals, fee-for-service and sessionalist providers, expenses included in the total amount of \$262 million for that year include the costs of medical services to overseas posts (\$7.5 million), medical appliance repairs (\$0.7 million) and some pharmaceutical consumables costs (\$0.7 million) (that is, around three per cent of total ADF employee health expenses reported by Defence).

provide cost estimates based on excluding and including the cost of non-JHC military personnel in garrison. The ANAO's estimate of total expenses for Garrison Health Services¹⁴¹ in 2008–09 is between \$455 million (excluding the cost of non-JHC ADF health personnel in garrison) and around \$654 million (including the cost of all ADF health personnel in garrison).¹⁴² The breakdown of the \$455 million estimate is shown at Figure 4.4.

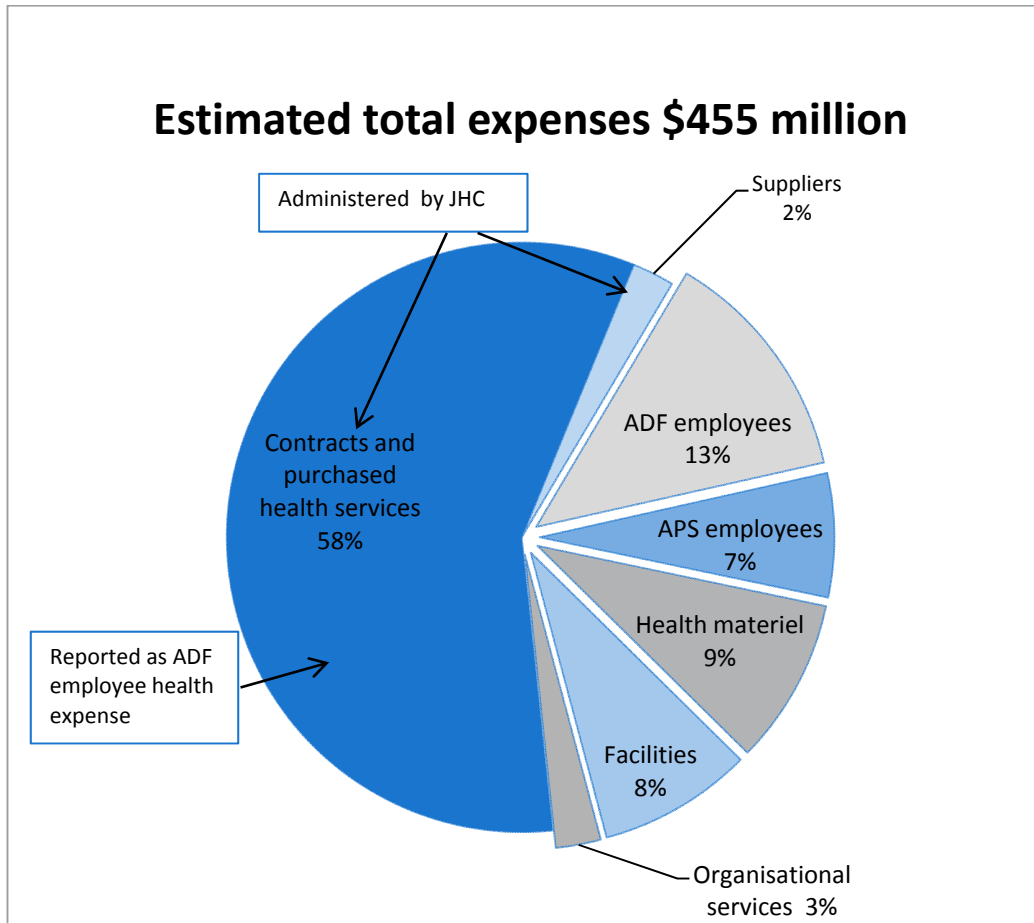
¹⁴¹ This estimate includes the costs of JHC's non-Garrison Health Service activities (see Figure 1.2 in Chapter 1).

¹⁴² The estimate of \$455 million, excluding the cost of non-JHC health personnel, was calculated from Defence expenditure data for ADF personnel, contracted and purchased health services and APS employees and for health materiel. IT and facilities operating costs were calculated by adjusting for inflation the amounts provided by Defence to the 2006 COSC Review on the cost of health care in the Defence health service. Organisational costs were estimated calculated at \$5225 per position (using a Defence New Policy Proposal template).

The cost of all health military personnel in garrison in the estimate of \$654 million was calculated by applying an average ADF personnel cost to the number of ADF health personnel in the single Services, some of whom are augmenting Garrison Health Service. The number of these personnel was calculated by discounting the figure of 1725 at paragraph 4.3 by 12 per cent for personnel conservatively assumed to be on deployment.

Figure 4.4

Estimated Garrison Health Services expenses in 2008–09 (excluding non-JHC ADF employees providing Garrison Health Services)



Source: ANAO analysis.

Comparisons with other estimates of the cost of Garrison Health Services

4.29 While Defence has not routinely monitored all costs related to the provision of Garrison Health Services, the 2006 COSC Cost Review was an attempt to establish these costs. The review calculated that the total annual cost of health care provided to ADF members at garrison level had increased in the period from 2001–02 to 2005–06 by around 16.7 per cent per annum to \$293 million. This figure was based, in part, on an estimate of the number of ADF personnel providing Garrison Health Services; it did not include the cost

of all single Service ADF health personnel. In 2008–09 prices, it would equate to about \$335 million. However, since health care costs in the community, and in Defence, have increased more rapidly than consumer prices, the estimate of \$335 million is likely to be understated.¹⁴³

4.30 As well as identifying total costs, the 2006 COSC Cost Review stressed the need for improved financial management of Defence health services, citing difficulties in attaining accurate financial data on Defence health services activities and health care costs in Defence rising well above those in the wider community.

4.31 The Stevens Review in 2004¹⁴⁴ also looked at the cost of health services and, while its estimate of the cost of providing Defence health services was significantly less than that calculated by the 2006 COSC Cost Review, it was consistent in finding that the cost of Defence health services was rising rapidly. This review reported that, between 2000–01 and 2002–03, annual health care costs had risen 73 per cent (to \$130 million).¹⁴⁵ However, these costs only related to those costs managed by the then Defence Health Services Branch, which is equivalent to the ADF employee benefit health expenses reported in the Department’s annual financial statements (see paragraph 4.27).

¹⁴³ For example, over the ten years to 2007–08, total health expenditure in Australia increased in real terms by around 5.2 per cent a year.

¹⁴⁴ Stevens Review, *op. cit.*, see paragraph 1.17.

¹⁴⁵ *ibid.*, p. 44.

4.32 The 1996–97 ANAO audit estimated the cost of ADF health services at around \$400 million in 1995–96¹⁴⁶, which, adjusted to 2008 prices using health price inflation estimates¹⁴⁷, is approximately \$600 million.¹⁴⁸

Comparisons with community costs

4.33 The 1996–97 audit compared the costs of health care per ADF member with the cost per person in the wider Australian community. At that time, it found that cost per ADF member was almost three times the Australian average.¹⁴⁹ Using a similar methodology to make comparisons for 2008–09 (see footnote 148), the cost per non-deployed ADF member is now estimated at between around 1.7 and 2.5 times that of the cost per person (\$5169) in the wider Australian community (see Figure 4.5).¹⁵⁰ For the reasons given at paragraph 4.28, the lower ANAO estimate of the per person cost of Garrison

¹⁴⁶ ANAO Audit Report No. 34 1996–97, op. cit., paragraph 2.18.

¹⁴⁷ Figures from the Australian Institute of Health and Welfare's health price index for each year from 1995–06 to 2007–07 and the average of 1997–08 to 2007–08 for the 2008–09 year were used for this purpose.

¹⁴⁸ The cost calculated by the ANAO at this time included both Garrison Health Services costs and the cost of maintaining the ADF's deployable health support capability. It included the employee costs of all regular ADF members providing medical support (around 2382 members). At the time, unlike the situation at present, nearly all of these were providing Garrison Health Services because Australia did not have the current substantial requirement to support overseas military operations. The 1996–97 audit cost also included an allowance for the opportunity cost of capital. In order to make allowance for the cost of capital in the estimate for 2008–09, it would be reasonable to assume a uniform cost of capital of eight per cent of the estimated asset value of ADF health facilities (using the total net book value of facilities exclusively used for Defence health purposes at 31 December 2009 as listed in Defence's financial management system, ROMAN). This rate is used on the basis that the long-term bond rate averaged five per cent in 2008–09 and a low rate of return of three per cent would be required for ADF health expenditures. Using this rate, the ANAO's estimate of the cost of Defence Health Services in Australia in 2008–09 of \$654 million would increase to around \$669 million.

As noted, in paragraph 4.29, health expenditure in Australia increased more rapidly than health prices over this period (by 5.2 per cent a year in real terms over the 10 years to 2007–08). If the previous ANAO estimate were adjusted for increases in health expenditures in Australia, the figure would be around \$1.18 billion.

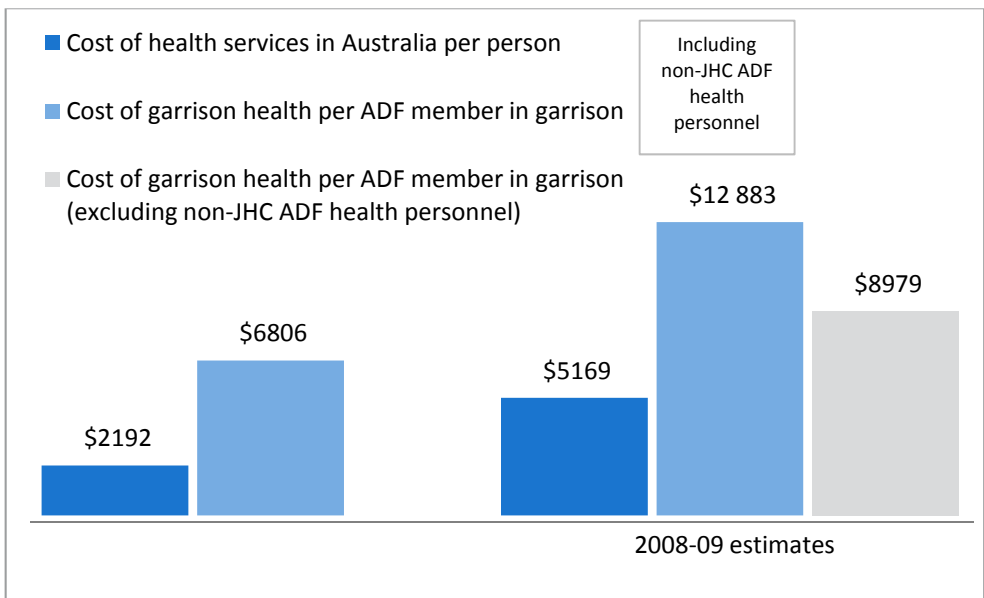
¹⁴⁹ ANAO Audit Report No. 34 1996–97, op. cit., paragraph, 2.17.

¹⁵⁰ For the purpose of this analysis, the Australian Institute of Health and Welfare (AIHW) estimate of health costs in the Australian community for 2007–08 was inflated by the average annual increase for the previous 10 years to arrive at an estimate for 2008–09. The AIHW estimate of community costs comprises all government and non-government health expenditures and, in addition to medical and dental services, includes public health, community health, patient transport, medications, aids and appliances, research and capital and other health expenditures. To arrive at a per person cost, this was divided by the Australian population as at 30 March 2009 as per *ABS 3101.0 - Australian Demographic Statistics*, March 2009.

Health Services in 2008–09 (\$8979¹⁵¹) does not include the costs associated with the contribution of non-JHC ADF health personnel providing Garrison Health Services. The higher ANAO estimate (\$12 883¹⁵²) includes all ADF health personnel who are not on deployment but who will also be undertaking other military duties (such as participating in training exercises in preparation for deployment).

Figure 4.5

Health costs per person—ADF and Australian community



Source: ANAO analysis.

4.34 Any comparison of the cost of health care provided to ADF members with the cost of health care provided to the wider Australian community needs to have regard to differences in the care that is provided and the reasons for this. These differences have been accepted by the Australian Government as

¹⁵¹ Total Defence health costs as calculated in this report (\$455 million), divided by the estimated average total members in garrison to determine an average per person cost.

¹⁵² Total cost as calculated assumes all military health personnel at base provide health services and includes a uniform cost of capital of eight per cent (see footnote 148). This has then been divided by estimated average total members in garrison to determine an average per person cost.

reasonable (as it has been by governments in other countries for their armed forces).¹⁵³

4.35 In the Australian community, governments subsidise health care costs mainly through direct funding of hospitals and other medical services as well as Medicare benefits, a rebate on private health insurance and subsidisation of pharmaceuticals through the Pharmaceutical Benefit Scheme (PBS). Such government subsidies, however, generally only partially cover the cost of the relevant health services. Accordingly, civilians are frequently required to contribute to their health costs. In addition to the Medicare levy, individuals may purchase private health insurance and/or make personal contributions to cover the gap between the medical charges levied and the applicable Medicare rebate. People without private health insurance may be required to meet the full cost of services, such as dental care, optical aids and other ancillary services such as physiotherapy. Individuals also make a contribution for medications on the PBS.¹⁵⁴

4.36 By contrast, Defence meets all health care costs of ADF members, who are not required to pay the Medicare levy in relation to themselves and do not need to take out private health insurance to cover their ancillary health costs.¹⁵⁵

4.37 Defence also informed the ANAO that:

In order to maintain the readiness and capability of the ADF, the ADF health care system provides levels of preventative health, health promotion, medical, dental, mental health and psychology, physiotherapy and rehabilitation services that are not generally available to the broader community under the Australian public and private health systems. Within the ADF health care

¹⁵³ Governments around the world have accepted that, because of the need to ensure that their armed forces are available to be deployed on operational duties at short notice, it is reasonable that members of the armed forces are entitled to a standard of health care that will maximise their health readiness. Members of the armed forces are also more likely to sustain injuries than most members of the community because of the high level of physical activity and involvement in operations. This means that armed forces members are generally entitled to a higher standard of health care than most members of the community can expect.

¹⁵⁴ There are two types of Pharmaceutical Benefits Scheme (PBS) beneficiaries—general patients who hold a Medicare card and concessional patients who hold both a Medicare card and a specified Centrelink or Department of Veterans' Affairs concession card. Under the PBS, the maximum cost for a pharmaceutical benefit item at a pharmacy is \$33.30 for general patients and \$5.40 for concessional patients, plus any applicable special patient contribution, brand premium or therapeutic group premium. Under a Safety Net scheme, general patients who have reached the safety net threshold may receive pharmaceutical benefits at the concessional rate, plus any applicable special patient contribution, brand premium or therapeutic group premium.

¹⁵⁵ However members are required to pay 50 per cent of the levy in respect of any dependants.

system, there are a significant number of health personnel who do not deliver day-to-day garrison clinical health support, but who provide the clinical and administrative support required on operations and exercises ... ADF deployable health staff not only provide primary health support but also provide the first aid and evacuation capability (similar to paramedics in the Australian community), the resuscitation capability (similar to an Accident and Emergency Department), the diagnostic capability (X-ray and pathology) and the surgical and in-patient capability. These increased roles, together with a requirement to provide the same level of health care to non-deployed ADF members, mean that the ADF health workforce is significantly larger than that required to provide routine day-to-day primary health care but importantly the cost of maintaining this capability is included in the overall cost of ADF health care. In addition to the requirement to provide health care and support to deployments, there is a continuing requirement to maintain the same level [of] garrison health care to non-deployed ADF members. This increases the numbers of non-uniformed health providers required to provide day-to-day healthcare.¹⁵⁶

4.38 Reflecting this higher health care requirement, the ANAO estimates that the ratio of health care practitioners per capita in the ADF garrison is around four times higher for primary care practitioners and eleven times higher for dental practitioners¹⁵⁷ than is the case in the wider community. However, the number of nurses per capita in the ADF garrison is marginally less than that of the Australian community (even counting ADF Medics as nursing equivalents), possibly reflecting lower acuity of care demands of the ADF garrison.

¹⁵⁶ Defence advice, 9 April 2010.

¹⁵⁷ The ANAO primary care estimates are based on analysis of Defence data and *AIHW Medical Labour Force Survey, 2007*. The Australian community figure used by the ANAO includes, but is not limited to, general practitioners. The ADF garrison figure includes contracted civilian general practitioners and ADF Medical Officers (doctors and non-doctors) providing direct garrison support. The ADF figure also includes ADF Medical Officers attached to the single Services some of whom augment garrison health services.

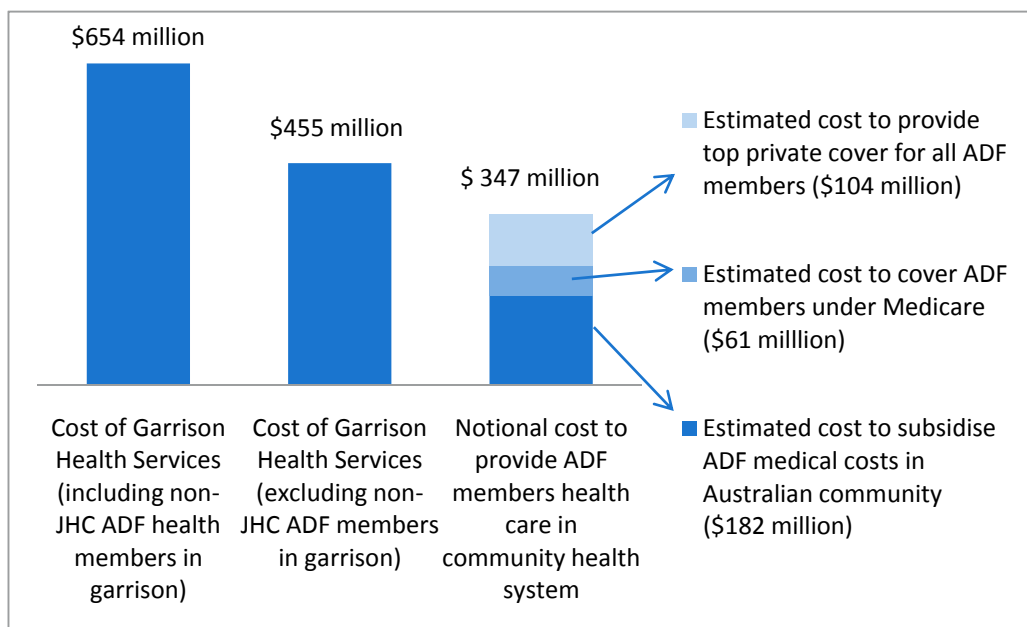
The estimates of dental practitioners are based on ANAO analysis of Defence data (January 2010), and *AIHW Dentist Labour Force Survey, 2005*. The Defence dental personnel data include dentists, dental specialists, therapists, prosthetists, hygienists, and dental assistants. They exclude practitioners providing services in respect of approximately \$7.7 million (or about 25 per cent of total expenditure on dental) spent by JHC in 2008–09 on dental services provided on a fee-for-service basis. Garrison ADF personnel includes those providing full-time dental care. These personnel are augmented by other ADF dental personnel on a part-time basis.

The 2008–09 total ADF dependency of 55 068, used in the ADF calculation, was discounted by six per cent in the Garrison calculations to take account of deployments of ADF personnel.

4.39 Figure 4.6 compares the notional cost to government of subsidising the cost of providing ADF members with health care through the same mechanisms used in the wider community and the estimated actual cost of the health services provided to them under the current model. It assumes that Defence would pay the cost of the Medicare levy on behalf of ADF members as well as provide private top health cover, and that the government would be required to increase other health funding, such as grants to the states for hospital funding, by an amount per ADF member equal to the average of its current funding for members of the civilian community. In as far as Garrison Health Services can be regarded to be as efficient as the health care that is provided to the general community, this comparison illustrates the 'extra' level of service that is now provided to ADF members above community standards.

Figure 4.6

Costs of Garrison Health Services versus notional costs to provide ADF members health care in the community health system, 2008–09



Source: ANAO analysis.¹⁵⁸

4.40 Figure 4.6 indicates that, to maintain the ADF at a ready state under current ADF policies and practices, the Government paid an estimated premium of between around \$100 million and \$300 million in 2008–09. These estimates assume a theoretical situation in which ADF members would be

¹⁵⁸ Theoretical Medicare costs are calculated by applying a 1.5 per cent surcharge to the 2007–08 salaries and allowances expense for the 70 per cent of ADF personnel without dependants and a 0.75 per cent surcharge to salaries and allowances expense for that year for the 30 per cent ADF personnel contributing to Medicare for dependants as estimated by the ABS. Australian Bureau of Statistics, *3228.0.55.001 Population Estimates: Concepts, Sources and Methods, 2009* [Internet]. ABS, Canberra 2009, available from <<http://www.abs.gov.au/ausstats/abs@.nsf/Products/4CFC810D86D6B8B6CA2575D2001ABFE1?opendocument>> [accessed 10 November 2009].

Theoretical private health care costs are calculated by taking an average cost of top singles private hospital and extras health cover (assuming no age loading) and multiplying this by the number of ADF members. The theoretical cost to Government to subsidise ADF members in the community health system is calculated by multiplying the total Government subsidy per capita in Australia (which includes the costs of the Department of Health and Ageing, the Department of Veterans' Affairs, state and local government expenditures and premium rebates) uplifted by health inflation to a 2008–09 equivalent, by the estimated total ADF garrison dependency. See Australian Institute of Health and Welfare, *Health Expenditure Australia 2007–08*, AIHW, Canberra, 2007, Table A3: Total health expenditure, current prices, by area of expenditure and source of funds.

required to make a contribution to some elements of their health care, which would be a reduction in their conditions of service from the current position.

Management of the cost of Defence health services in Australia

Monitoring and reporting on the overall cost of health services

4.41 Given the need to realise savings in the health budget as part of the Defence Strategic Reform Program, it is important that Defence monitors the overall cost of Garrison Health Services (and other health support provided by JHC), and not just that part of the Garrison Health Services budget that is managed by JHC. That Defence does not systematically and periodically calculate the total costs of its health services makes it difficult for the department to make well informed decisions on the continued viability of particular services and to determine whether savings in one area are resulting in substantially increased costs in other areas.

4.42 Monitoring and reporting the total cost of Garrison Health Services would both improve the financial transparency of Defence's health operations and provide a better framework for management decisions on Defence health service delivery. However, this would require Defence to establish mechanisms to collate and monitor Garrison Health Services costs, such as arranging for the single Services (for augmented support), the DSG (for facilities) and DMO (for health materiel) to provide JHC with information concerning their garrison health costs to JHC. Reasonable estimates of Garrison Health Services could be developed on the basis of a consistently applied methodology, pending the development of more systematically determined costs. The ANAO considers financial transparency of Defence's health operations would be improved by the establishment of such mechanisms. Once collected, Defence could also consider publishing them to complement the employee health benefit expenses the department currently reports in its annual reports, which only comprise part of the cost of Garrison Health Services (chiefly costs related to Contracted Health Professionals).

Recommendation No.4

4.43 To provide a better framework for effective management decisions on Defence health service delivery, and to improve financial transparency of Defence's health operations, the ANAO recommends that Defence establish mechanisms to collate and monitor the total cost of Garrison Health Services and other JHC activities.

Defence response

4.44 *Agreed with qualification:*

Defence agrees that it will be able to achieve a better framework to improve financial transparency when the e-health system (JeHDI) is implemented.

However, to establish mechanisms to collate and monitor the total cost of Garrison Health Services and other JHC activities would necessitate far broader changes to the Defence budgeting process, including major changes to all Groups within Defence. In 2009, Pappas McKinsey on behalf of Defence undertook an "Audit of the Defence Budget". Defence is currently implementing these changes in line with the SRP (Strategic Reform Program). Pappas McKinsey did not identify this as a deficiency, nor recommend such a shift in process.

4.45 ANAO Comment: The implementation of the ANAO's recommendation should not necessitate changes to Defence's budgeting arrangements but rather would require Defence to establish mechanisms to ensure that the single Services (for augmented support¹⁵⁹), the DSG (for facilities) and the DMO (for health materiel) collect and provide to JHC the necessary data to allow it to collate and monitor total Garrison Health Services costs. Reasonable estimates of total annual Garrison Health Services costs could be developed on the basis of a consistently applied methodology, pending the development of more systematically determined costs, particularly since, as part of the Regional Level Agreements, JHC and the Services will be required to agree on the levels of augmented contributions that each Service will make to the provision of Garrison Health Services.

¹⁵⁹ That is, augmentation of the delivery of Garrison Health Services by ADF health personnel in garrison but not posted to JHC.

Major drivers of cost of health services

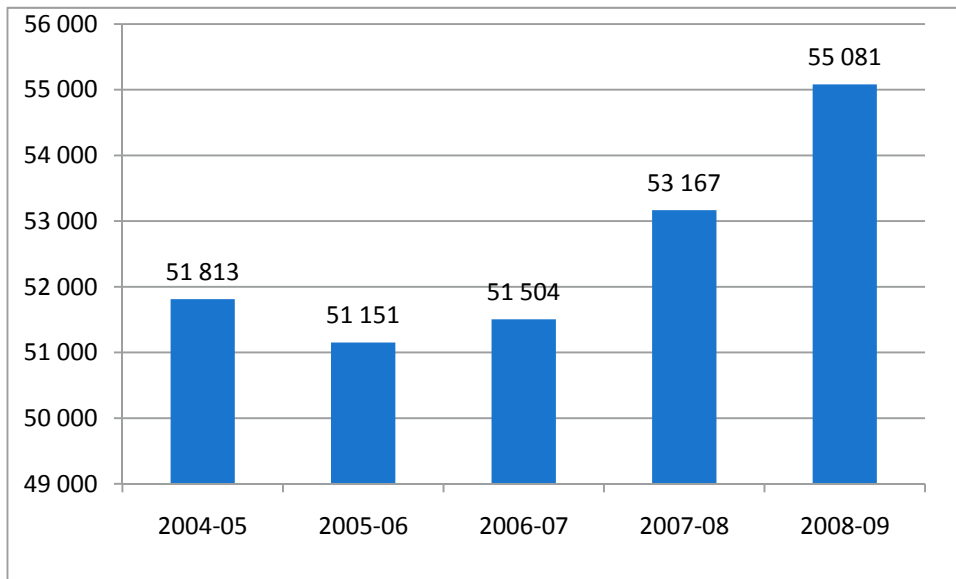
Demand drivers

Size of the dependency

4.46 The major demand driver of Defence health services costs is the size of the ADF dependency (that is, the number of ADF personnel who require health support in garrison). This dependency roughly equates to the total number of funded ADF personnel. There have been significant increases in the size of the ADF in recent years (see Figure 4.7, which shows that the average funded strength of the ADF increased from 51 813 in 2004–05 to 55 081 in 2008–09). The numbers of ADF members can be expected therefore to be a major contributor to increases in the cost of Garrison Health Services.

Figure 4.7

ADF permanent force average funded strength, 2004–05 to 2008–09



Source: Defence annual reports.

Impact of military operations

4.47 Since the 1997 ANAO audit of ADF Health Services, and the subsequent follow-up audit of 2001, the ADF's level of operational activity has increased substantially. Over that time, the ADF has, compared to earlier periods, deployed relatively large numbers of personnel to operations overseas including to Afghanistan, Iraq, the Solomon Islands, East Timor and Indonesia

(in a humanitarian role following the 2004 Indian Ocean earthquake and tsunami).

4.48 The increased operational tempo of the ADF has had two major effects on Defence health services. First, as significant numbers of ADF health personnel have been involved in these operations, it has reduced the ability of Defence to commit ADF health personnel to providing Garrison Health Services. Second, due to increasing levels of injuries and sickness sustained by ADF members on deployment or in training for deployment, it has increased the health care requirements of these ADF members on their return to garrison.

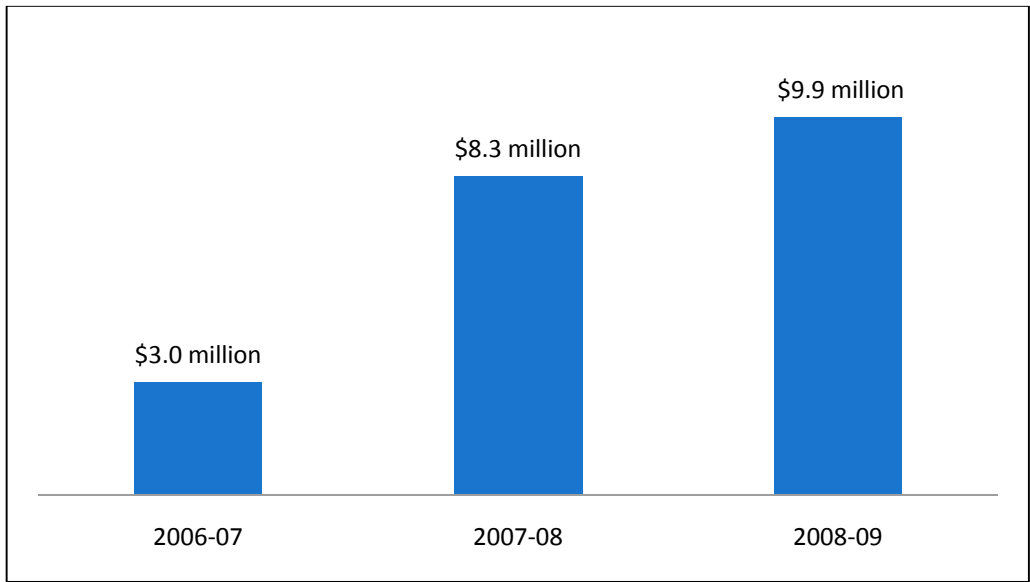
4.49 The cost of the decreased involvement of ADF health personnel in the provision of Garrison Health Services is difficult to quantify because Defence's systems currently do not support the identification of the extent to which ADF health personnel attached to the single Services are augmenting Garrison Health Services provided by JHC.

4.50 It is also difficult to quantify the cost of the injuries and sickness sustained by ADF members on deployment or during preparation for deployment due to the increased operational tempo of the military. However, it is possible, to some extent at least, to gauge the impact of operations on ADF members' health and the consequent costs through an examination of the ADF Rehabilitation Program.

4.51 The ADF Rehabilitation Program commenced in 2006. It was developed by Defence to ensure that ADF members receive fast rehabilitation assessments and coordinated management of injury or illness sustained on deployment. The aim of the program is to maximise Defence's capability through returning injured or ill members as quickly as possible to military duty, or if this is not possible, to the civilian environment. The cost of the program since its introduction is shown in Figure 4.8. These program costs relate primarily to case assessment and management activities. They do not include expenses incurred in the treatments required for rehabilitation, and so they do not reflect the total cost to Defence of rehabilitating its members post deployment. They do, however, indicate the scale of the impact of recent deployment activity on the Garrison Health Services dependency.

Figure 4.8

Costs of ADF Rehabilitation Program (\$ million)



Source: JHC.

Supply drivers

Increasing cost of health services in the community

4.52 Increased health costs in the general community also impact on the costs of Defence health. However, while health costs in Australia from 2004–05 to 2008–09 grew at an average of around eight per cent annually¹⁶⁰, the average annual increase in expenditure administered by JHC and its predecessors over this period was about 13 per cent.

Reduced involvement of military medical personnel

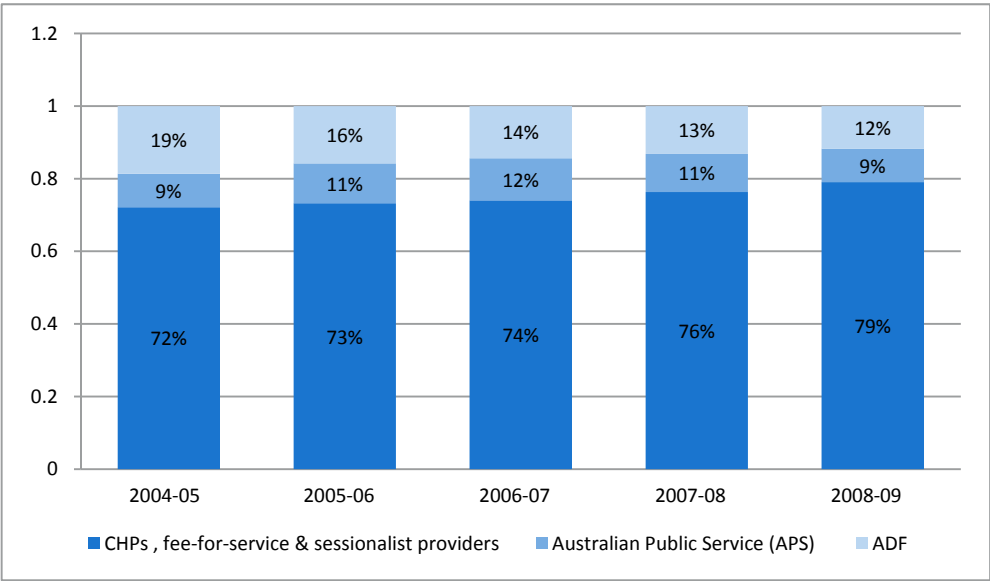
4.53 JHC currently has financial and administrative control of only around a quarter of medically qualified ADF staff in garrison. The proportion of JHC total employee costs (and of its predecessor organisation the former Defence Health Services Division) represented by military employees has steadily declined from around 19 per cent in 2004–05 to around 12 per cent in 2008–09, as shown in Figure 4.9. Over the same period, the cost of Contracted Health

¹⁶⁰ Australian Institute of Health and Welfare Health expenditure Australia 2005–06 *Total health expenditure, current and constant prices (a), and annual growth rates, 1995–96 to 2005–06.*

Professionals, fee-for-service and sessionalist providers has risen from around 72 per cent to 79 per cent of total employee costs. The proportion of total employee costs represented by JHC (and by the former Defence Health Services Division) APS staff has remained relatively stable at between nine and 12 per cent.

Figure 4.9

Proportion of JHC and former Defence Health Services Division employment costs related to Contracted Health Professionals, fee-for-service and sessionalist providers, APS staff and ADF staff



Source: ANAO analysis.

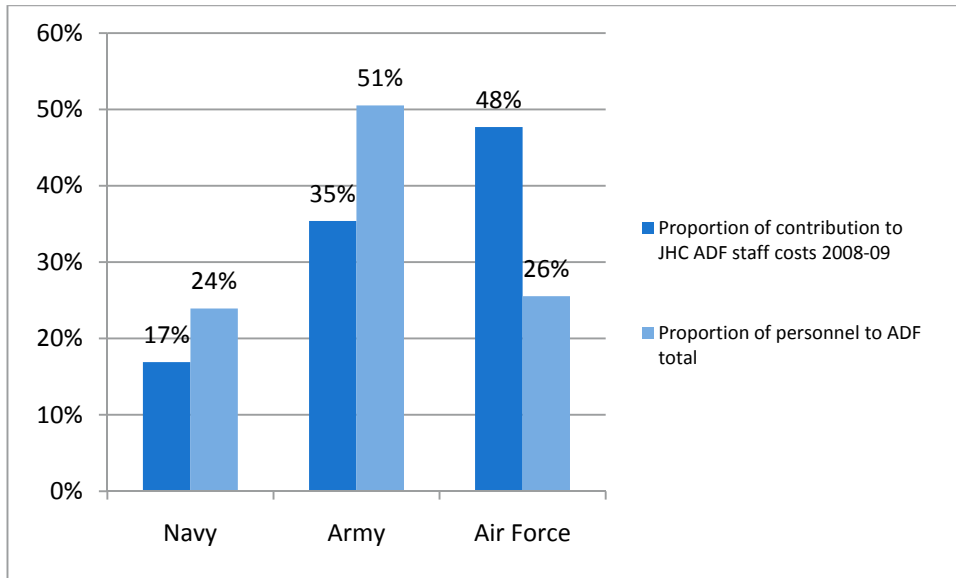
4.54 As noted in paragraph 4.47, the high operational tempo of the ADF in recent years has directly impacted on the numbers of ADF health personnel available to provide Garrison Health Services, as ADF health personnel are increasingly being deployed on operations or required to perform other operational support roles. This has meant that the ADF’s requirement for Contracted Health Professionals to provide Garrison Health Services has increased.

4.55 The ANAO estimates that there are on average around 2100 ADF health personnel in garrison at any one time, but that only around 550 of these

are posted to JHC positions.¹⁶¹ Figure 4.10 shows the proportion of JHC's ADF personnel contributed by each of the single Services. It indicates that Army and Navy currently contribute considerably less personnel resources to JHC than Air Force in proportion to the respective sizes of their forces.

Figure 4.10

Contribution of ADF personnel costs to JHC by single Services



Source: ANAO analysis.

4.56 While ADF health personnel who are not attached to JHC may still be providing Garrison Health Services, as discussed in paragraph 4.28, it is difficult to ascertain the degree to which this is so, since this information is currently not collected.

4.57 There is a high risk that purchased health professional services costs will increase more rapidly than other Garrison Health Services costs, if the ability of the single Services to augment Garrison Health Services is further reduced (because of the difficulties in recruiting sufficient ADF health personnel and continuing high levels of operational deployments).

¹⁶¹ As at 4 October 2009, there were 2382 ADF health personnel. These include undergraduates, trainees, health personnel who are on deployment and others who are not working in garrison. Adjusting for these, it is estimated that around 2100 health personnel would be in garrison.

Accordingly, to assist in reducing reliance on these contractor resources, it is important that Defence maximise the use of ADF health personnel in garrison to provide Garrison Health Services, to the extent possible consistent with operational requirements and the requirement for such personnel to gain experience in acute settings to ready them for deployment.

4.58 The SLAs that JHC has signed with the single Services provide that the degree to which the Services will provide augmentation of JHC provision of Garrison Health Services by non-JHC medical personnel in Regions is to be determined on a Region by Region basis in the RLAs (see paragraphs 2.31–2.37 in Chapter 2). Where a Service does not provide the level of support agreed under the relevant RLA, the agreement will require that Service to either provide financial supplementation to JHC to cover the cost of providing the agreed support not provided by the Service or elect to accept a lesser standard of health support.

4.59 The level at which medically qualified ADF members who are not operationally deployed can, should and do augment Garrison Health Services is an issue that is pivotal to the RLA negotiation process. The higher the level of augmentation that a unit is able to provide from within its current ADF health personnel resources, the greater will be JHC's ability to contain future cost increases in an environment where Defence is striving to meet demanding savings targets under the SRP. There is a risk for JHC that units will not meet their commitment to augment Garrison Health Services and that it will have difficulty in either finding replacement Contracted Health Professionals in a timely way or that units will argue that financial supplementation for JHC to engage replacement Contracted Health Professionals is not required.

4.60 However, an alternative approach that could be simpler and provide more certainty would be for JHC:

- to be fully funded to provide Garrison Health Services; and
- then to pay the single Services for the level of augmentation of Garrison Health Services actually provided by their ADF health personnel, with the estimated revenues flowing back to each Service from JHC (based on the agreed levels of augmentation set out in the RLAs) being included in the Services' budget estimates.

4.61 This would provide a stronger financial incentive for the Services to provide the agreed level of resources, and even further supplement this agreed amount where they have the capacity to do so and enable accurate accounting

of ADF expenditure on Garrison Health Services and on Operational Health Support.¹⁶² While the ANAO recognises that this approach would represent a departure from Defence's current budget allocation practice, it is an approach that could be considered when negotiating future SLAs.

4.62 Separately, as another part of its reform agenda, JHC is considering the feasibility of introducing an 'integrated workforce' in which it would convert Contracted Health Professional, sessionalist and fee-for-service positions to APS positions. An external consultant estimated in October 2009 that Defence could realise savings of \$35.7 million through this strategy and a further \$56.9 million by using physician assistants and nurse practitioners to perform some work currently done by general practitioners.¹⁶³

Regulation of service levels

4.63 The level of health services provided to ADF members by JHC under the SLAs with the Services is determined in accordance with established health policy directives.¹⁶⁴ As noted in Chapter 1, under these directives, the level of health care provided to ADF members is that which is: 'deemed necessary by the Chief of the Defence Force'.¹⁶⁵ While the level of health care provided to the general community under Medicare is used as a guiding principle in determining the *basic* level of health care to which ADF members are entitled, Defence health policy recognises that the health services provided to ADF members will usually exceed this level of care so that the ADF requirement for members to meet and maintain operational readiness can be satisfied.

4.64 The medical and dental treatments that are available at no cost to ADF members are determined by exception. Defence health policy is effectively

¹⁶² Defence informed the ANAO that ADF health resources are generally less costly than Contracted Health Professionals. Accordingly, there would be advantages in having financial incentives for the Services to exceed the agreed level of augmentation, where they have the capacity to do so, provided that this can be done in a way that will allow JHC to fund these incentive through savings in Contracted Health Provider numbers.

¹⁶³ Access Economics, *Specialist health economic input in support of the Strategic Reform Program*, pp. 39–42.

¹⁶⁴ See Appendix 1 to Annex B of *Service Level Agreements 1/09 Garrison Health Support* (Navy, Army and RAAF) Schedule of Services for Garrison Health. These schedules refer to services as detailed in Health Directive 919 *Guidelines on Australian Defence Forces Access to Health Support* dated (current issue is dated 23 June 2009). Health Directive 919 in turn refers to Defence Instruction (General) Pers 16–1 *Health Care of Defence Force Personnel* dated 8 May 2002.

¹⁶⁵ Defence Instruction (General) Pers 16–1 *Health Care of Defence Force Personnel* Dated 8 May 2002, paragraph 4.

framed such that members are entitled to any treatment with the exception of those excluded or limited by Defence health policy on the grounds that they do not improve operational readiness:

DGDHS [now Commander Joint Health (CJHLTH)] will, from time to time, issue policy which may exclude or limit the provision of certain medical or dental treatment on the grounds that such treatment is contra-indicated or unnecessary for operational readiness ...¹⁶⁶

4.65 There are a number of Health Directives which effectively limit the level of health services that are provided to ADF members.¹⁶⁷ However, there are several other Health Directives (and Defence Instructions which relate to the provision of health services) that significantly increase the costs of providing health services to ADF members.¹⁶⁸ In respect of this latter category of health policies, there are aspects where Defence could consider more cost effective solutions. The incorrect implementation of some Defence health policies may also unnecessarily increase health care costs.¹⁶⁹

4.66 In the context of the Strategic Reform Program, as Defence seeks to control the costs of the health care it provides to its members, more cost effective ways of satisfying the Department's health policy goals will need to be pursued. In this context, there would be benefit in Defence reviewing all

¹⁶⁶ *ibid.*

¹⁶⁷ Recent examples are: Health Directive 919 *Guidelines on Australian Defence Forces Access to Health Support*, 23 June 2009), which effectively introduced a waiting list for members to receive elective surgery and specialist treatments; and Health Directive 231, *Plastic Surgery*, 30 March 2009 which outlines the circumstances under which a member is entitled, as a condition of service, to cosmetic or non-cosmetic plastic surgery.

¹⁶⁸ In this audit, the ANAO noted a number of examples of ADF policies that entitle ADF members to health services which may not be greatly increasing the operational readiness of the ADF and which may unnecessarily increase costs. For example, the ADF generally observes a policy that members living on base or living alone in the community generally recuperate from illness as inpatients (normally at a base medical facility, or at a civilian facility if inpatient beds are not available on base). However, in many locations the cost of treating living-in members with minor illnesses as in-patients would exceed the cost of providing a community nursing type service for members recuperating from illness on-base. Similarly, bowel cancer screening rates in the ADF exceed community standards while not greatly increasing operational readiness of the ADF. Health Directive 242 provides that bowel cancer screening be carried out every year for ADF members from 50 years of age. However, community standards are for these to be conducted every two years. See: *Access Economics Specialist health economic input in support of the Strategic Reform Program*, 26 October 2009.

¹⁶⁹ Health Directive 404 *Indications for Removal of Third Molars in the Australian Defence Force*, 7 November 1994 outlines ADF policy in relation to the removal of wisdom teeth. However, Defence has identified that some dentists were incorrectly interpreting the policy and removing wisdom teeth, although there may not have been a need to do so at the time. Defence has taken action to correct this.

health policies to ensure that they are cost effective and justified in terms of contributing to the operational readiness of ADF members.

Health assessments

4.67 Defence health personnel conduct a large number of health assessments of ADF members, including annual health assessments.¹⁷⁰ Defence's policy of conducting annual health assessments of all ADF members¹⁷¹ commits the ADF to providing a service that exceeds community entitlements under Medicare with, arguably, a negligible impact on the operational readiness of its forces. This is because health conditions that would preclude an ADF member's readiness for deployment are likely to be first identified outside the annual health assessment process or are likely to be identified during separate pre-deployment health checks.

4.68 JHC has recently reviewed the policy related to ADF health assessments.¹⁷² The review's report proposed that a new health assessment framework be introduced. Under this framework, annual health assessments would be replaced with annual individual readiness medical and dental checks, for which ADF members would be asked to complete online health readiness questionnaire. These would then be reviewed by the member's health facility and the member's medical employment classification would be updated in PMKeyS, Defence's personnel information system.

4.69 However, given the primary reliance on pre-deployment health checks, fitness checks that ADF members complete and the general age profile of the ADF population, Defence could consider adopting a risk-based approach in preference to annual individual readiness medical and dental assessments. For instance, annual health checks may only be deemed necessary if a

¹⁷⁰ The following scheduled health assessments of ADF members are conducted:

- annual health assessments (AHAs);
- comprehensive preventive health examinations (CPHEs), performed every 5 years;
- pre-deployment health checks;
- a further pre-embarkation medical check 14 days before departure; and
- post-deployment health checks.

¹⁷¹ Contained in Defence Instruction (General) Pers 16–18 - *Australian Defence Force Policy for the Health Promotion Program*, 27 September 2001.

¹⁷² Discussion Paper – ADF Health Assessment (HD 242) Review, 3 July 2008.

commanding officer has a concern about a member's fitness or an ADF member is older than a medically established threshold.

Recommendation No.5

4.70 The ANAO recommends that Defence:

- (a) evaluate the current level of health services provided to ADF members under ADF health policies. Where such policies provide for a level of health services that exceeds community standards, Defence should ensure that they are cost effective and justified, including in improving the operational readiness of ADF members; and
- (b) consider the merits of adopting a risk-based approach in preference to annual individual readiness medical and dental checks.

Defence response

4.71 *Agreed.* Defence is currently revising the two health policies that underpin this recommendation to ensure Defence provides a level of health care that meets our operational, clinical and budgetary requirements.

Administrative processes and non-patient tasks

4.72 The ANAO observed that a great deal of staff effort in the Defence health facilities visited during fieldwork for this audit was spent on administrative processes. The 2006 COSC Cost Review used rate of effort data to construct a cost model that sought to quantify staff administrative effort.¹⁷³ It found that, on average, 50 per cent of all staff time—Contracted Health Professionals, APS and ADF—was spent performing administrative tasks.¹⁷⁴

4.73 Staff at Defence health facilities visited during fieldwork informed the ANAO of their view that greater effort is spent on administrative tasks by health professionals in the ADF compared with those in the wider community. Reasons advanced for this included the fact that ADF health professionals must work within a system consisting of the health services of the three single Services as well as JHC and because Defence facilities have to work with

¹⁷³ These data were extracted from the HealthKEYS and MIMI electronic patient records systems that are examined in Chapter 5.

¹⁷⁴ Cogent Business Solutions Pty Ltd, Conduct of a Study into the Health Care Costs in the Defence Health Service – April 2006, p. 6.

different health information systems, none of which are as efficient as those in use in community health services. The final report on a replacement e-health solution for JHC in 2009 noted that there were over 200 health forms used in the ADF, indicating inconsistent and duplicated clinical and administrative processes that result from the multiple health systems involved.¹⁷⁵

4.74 The rate at which health professionals working for the ADF see patients is one indication of the extent to which they are occupied on non-clinical tasks. The Greater Sydney Northern New South Wales (GSNNSW) Area Health Service used data that it considers adequately reflect Medical Officer (MO) activity rates to show that, within the Area Health Service, civilian MOs, on average, saw less than 12 patients per day, well below the 30 or more consultations per day that might be typical of a general practitioner in the wider community.¹⁷⁶

4.75 Defence may be able to realise efficiencies by examining opportunities to reduce the administrative burden of health staff by arranging for some of these tasks to be undertaken by administrative support staff, where possible. In the longer term, the ANAO would expect that the proposed new e-health system (see Chapter 5) would provide the opportunity to realise further efficiencies, as some tasks will then be able to be performed efficiently during consultations, while reducing the need subsequently to make a separate record of the outcome of the consultation.

Recommendation No.6

4.76 The ANAO recommends that JHC examine the scope to achieve efficiencies through reducing the administrative burden of health personnel by reallocating administrative tasks to administrative support staff, where possible.

¹⁷⁵ Commonwealth of Australia, RDPE, *Task T29 e-Health Final Report Part 1 Executive Summary*, Doc. No. T29-04-07-01, v. 1.0, 20/7/2009, p. 10.

¹⁷⁶ Area Health Service management in the Greater Sydney Northern New South Wales (GSNNSW) considered that 15 to 20 consultations to be a reasonable target for DHS Medical Officers. In comparison, a GP in the wider community might normally conduct 30 standard 15 minute consultations in a 7.5 hour day. The Area Health Service determined its target based on this standard, but allowed for longer appointments for medicals and extra time to complete directed non-patient tasks (such as completing rehabilitation referrals and engaging the chain of command about their members). It also took into consideration that there is also no funding for contract staff to work unplanned overtime. Whereas, in non-ADF general practice the doctor might work beyond their finishing time this is not supported by the Area Health Service.

Defence response

4.77 *Agreed.* Defence is currently undertaking a review of the Garrison workforce which will provide information on the correct workforce mix. This along with the development of the e-Health system (JeHDI) and the updating of policies will reduce the administrative burden on health staff.

5. Health Information Systems

This chapter reviews the health information systems currently being used by Defence and assesses the efforts being made by JHC to improve them.

Introduction

5.1 To support the delivery and management of patient care, JHC needs:

- ready access to patient records; and
- good management information that will help it to analyse and plan health support needs.

5.2 Defence has implemented various computerised electronic health information systems (e-health information systems or eHIS) over the past 20 years, in an attempt to support better health care delivery in the ADF. These include:

- patient records information management systems; and
- other systems that support the management of such things as pharmaceuticals and health surveillance reporting.

5.3 Because of perceived inadequacies with Defence's patient records systems, including problems with their development, Defence now plans to develop a replacement patient records system.

Defence's current health information systems

5.4 There are two main e-health patient records information management systems currently in use in Defence. These are:

- the Medical Information Management Index (MIMI) system; and
- Health Key Solution (HeathKEYS).

5.5 Other e-health patient records information management systems are more specific or are not used widely. Some corporate systems also provide health information. These systems are summarised at Figure 5.1.

Figure 5.1

Other Defence e-Health systems and corporate systems with health information

Other e-Health systems
The Electronic Psychology Record and Information System (EPRIS) records psychology tests and other psychological support that are provided to ADF members. This system was originally developed to support psychological assessment of potential recruits to the Defence Forces, but has recently been redeveloped by JHC staff as a broadly based psychological assessment and support management tool and contains an ADF member's psychological assessment record. However, not all ADF psychology units have yet adopted the system.
The Micro-Imaging RAAF Medical Electronic Records (MIRMER) system is used to scan and make electronic copies of Air Force members' medical records.
PILS – the Pharmaceutical Integrated Logistics System manages the dispensing and stocks of pharmaceuticals by health facility pharmacies.
Epi-Track is a MS Access database, for health surveillance reporting in the ADF.
DEARS is a Disease Reporting System that provides information about what diseases are prevalent in each country around the world.
Corporate systems with health information
Occupational health and safety information is available through the Occupational Health & Safety Management Information System (OHSMIS).
Information on completed annual and pre- and post-deployment health assessments is available through Defence's personnel system, Personnel Management Key Solution (PMKeyS).

Source: ANAO analysis.

5.6 Notwithstanding the considerable efforts that Defence has made over the past 20 years, there is still no single patient records management system in use in Defence, and so Defence medical personnel continue to rely primarily on paper-based patient records. This is inefficient because:

- the medical records of Defence personnel have to be transferred with the ADF member when that person transfers from one location to another;
- the electronic records that a health facility uses may then have to be updated based on the paper records;
- copies of the paper records (the 'Central Medical Record') have to be kept by Defence in centralised storage at the ADF Health Records Office; and
- consistent data are not available for analysis of patient presentations (outpatients, health assessments etc) across health facilities and morbidity rates for particular health conditions.

5.7 Recognising the inadequacy of its e-health patient records systems Defence has decided, as part of the current reform of its health services, to develop a new e-health patient records system, to be called the Joint e-health Data Information (JeHDI) system.

Inadequacies of Defence's current e-health patient records systems

Medical Information Management Index (MIMI)

5.8 MIMI was developed by Navy personnel using a Microsoft Access database to support the management of hospital inpatients and medical centre outpatients and assist in obtaining external accreditation of the Balmoral Naval Hospital. Because MIMI is relatively easy to use and because it was developed to meet specific ADF needs, it is used by the majority of Defence's health facilities. However, it:

- is facility-based, which means that patient records are only accessible to that facility and are not readily transferrable to other facilities;¹⁷⁷
- has no appointments functionality;
- has no interface capability with PMKeyS, which means that health data about ADF members' individual readiness have to be recorded manually in PMKeyS;
- contains separate indexes for Medical and Dental;
- has limited built-in statistical reporting functionality (reports are service-related for the individual health facility);
- is not capable of being developed into a modern e-health management system; and
- because it is a locally developed solution, does not comply with Defence's IT architecture and is not a solution that will be supported by Defence's Chief Information Officer Group (CIOG).

¹⁷⁷ The facility-based nature of the system means that neighbouring facilities (such as the Duntroon and Russell health centres in the ACT) each have their own patient records systems and so ADF members who attend both facilities have separate records at each of those facilities. An exception is Area Greater Sydney/Northern NSW, which has redeveloped the data base and placed it on a central server to enable it to serve all health facilities in that Area.

HealthKEYS

5.9 HealthKEYS was proposed in 1999 as Defence's replacement e-health system. It is based on a commercial off-the-shelf (COTS) product.¹⁷⁸ It was expected to provide:

- practice and clinical management systems and a health information management system;
- relevant Defence personnel with accurate information on individual health readiness and deployability;
- senior health managers with relevant health information;
- accurate cost information for management and reporting purposes to higher Defence organisation and other authorities;
- the ADF with information to develop and assess preventative health strategies; and
- a platform for development of deployed health requirements.¹⁷⁹

5.10 HealthKEYS has experienced major problems in its development and implementation. Users of the system interviewed by the ANAO complained that the system is slow (with lengthy delays in moving between screens), 'clunky' (meaning that users have to navigate awkwardly between different screens in order to enter patient data) and not user-friendly, particularly compared with systems in common use in civilian medical practices. Similar criticisms have been made over the course of the system's implementation and this has led to poor take-up of it. While Defence has endeavoured to address user criticisms, the problems remain.

5.11 Potential problems with Defence's proposed implementation of HealthKEYS were evident from the start of the system's implementation, and were highlighted in the ANAO's 2000–01 follow-up audit, as follows:

Defence Information Systems Group (DISG) has indicated some concerns about the project, particularly that its operating/support costs had been understated and that the system architecture proposed by the project office (a decentralised architecture) was at odds with that increasingly being adopted

¹⁷⁸ The IBA MaxCare product.

¹⁷⁹ Robson Huntley & Associates, *HealthKEYS Status Review*, July 2006, p. 7.

across Defence (that is, a centralised architecture). The HealthKEYS project office considered that the latter architecture would result in unacceptable down-load times for patient records and adversely affect user acceptance of the system. The ANAO understands that DISG and the project office have now agreed to undertake the system trial using a centralised architecture and assess its performance.¹⁸⁰

5.12 These comments reflected the fact that HealthKEYS is a local area network (LAN) based application which should have been deployed on distributed servers, rather than on the Defence wide area network (WAN).

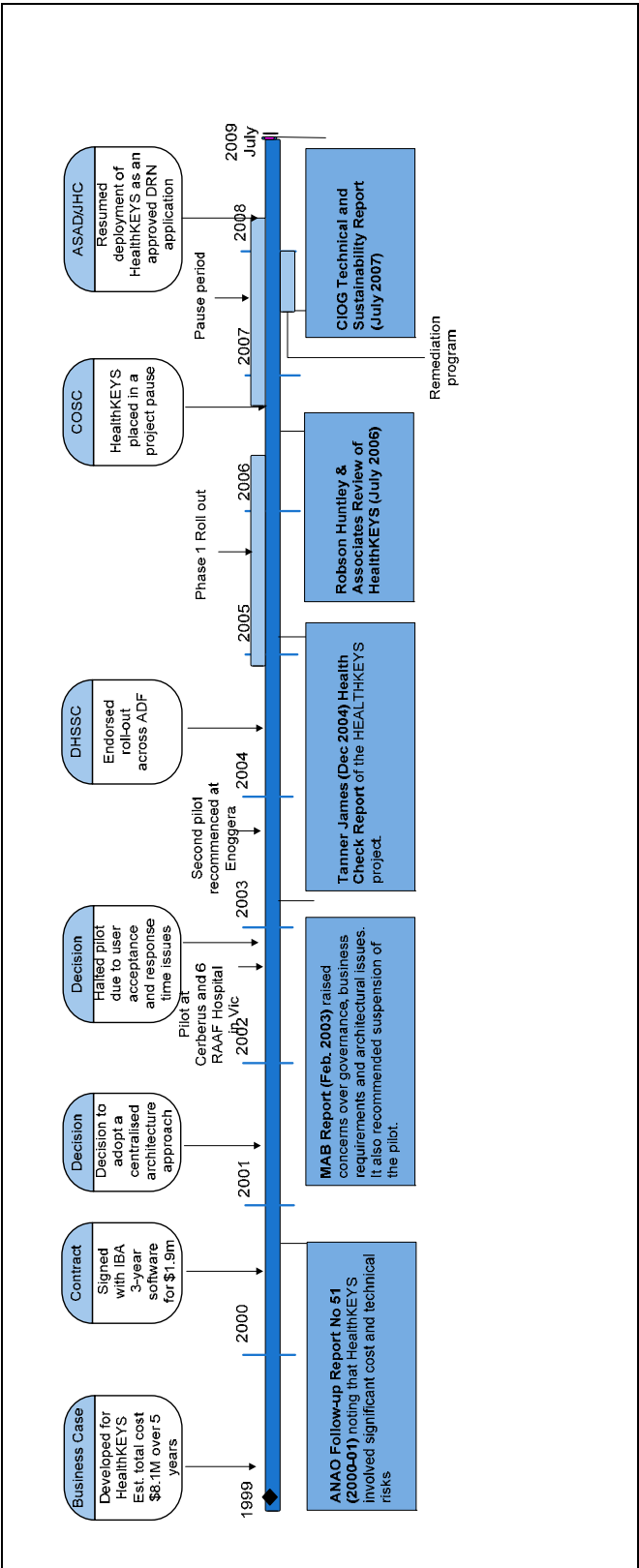
Development of HealthKEYS

5.13 Figure 5.2 lists the key events, reviews and decisions associated with the development and implementation of HealthKEYS from its inception in 1999 until July 2009 in chronological order. The difficulties experienced in the development of HealthKEYS are summarised in the chronology at Figure 5.3.

¹⁸⁰ ANAO Audit Report No.51 2000–01, op. cit., p. 79.

Figure 5.2

Chronology of development of HealthKEYS



Note: MAB refers to Management Audit Branch in Defence.

Source: ANAO analysis.

ANAO Audit Report No.49 2009-10
Defence's Management of Health Services to
Australian Defence Force Personnel in Australia

Figure 5.3**Chronology of the development and roll out of HealthKEYS**

Date	Chronology of HealthKEYS
October 2002	<p>A trial of HealthKEYS was conducted at HMAS Cerberus and six RAAF hospitals in Victoria, but the pilot was halted by the end of 2002 due to a number of user acceptance issues including slow response times across the Defence Restricted Network (DRN). Halting the pilot was recommended in Defence's Management Audit Branch's (MAB) audit report No. 02/036. It further recommended that the Project Board and DISG resolve the architectural issues for HealthKEYS and that the product be comprehensively tested in a controlled environment to overcome identified problems.</p> <p>In September 2003, the HealthKeys project team raised concerns over the expansion of MIMI as more modules were being integrated into the core functionality and the product was growing in direct competition with HealthKEYS.¹⁸¹</p>
June 2004	<p>The Defence Health Services Steering Committee endorsed the rollout of HealthKEYS across the ADF. Phase 1 implementation consisted of practice and financial management functionality with some clinical management functionality brought forward from phase 2 as a result of user feedback.</p>
July 2004 to June 2006	<p>HealthKEYS was rolled out to around a third of the planned phase 1 sites and an independent review of HealthKEYS' project management was conducted in December 2004.</p> <p>The rollout to Stirling in WA, SA and remaining units across the ADF was put on hold pending the outcomes of a further review of the project—the Robson Huntley Review.</p> <p>The Robson Huntley review recommended that:</p> <ul style="list-style-type: none"> the HealthKEYS project be paused until the end of 2006. During this time, only maintenance support to those sites that agreed to remain connected and operational, and essential development as agreed by the CIOG; HealthKEYS be subjected to a formal project approval and a new business case in order to lift the project pause; the complete HealthKEYS project team be moved to the CIOG so that the project could be managed in accordance with structured enterprise systems management; Head Defence Personnel Executive (HDPE), in consultation with Head Defence Health Services (HDHS) and the Services, undertake a strategic review of HealthKEYS objectives to align its scope within the context of likely future corporate personnel management information requirements; CIOG, in consultation with HDPE, initiate a review of HealthKEYS

¹⁸¹ Minutes of the Extraordinary Meeting of the HealthKEYS Project Board on 10 September 2003.

Date	Chronology of HealthKEYS
	<p>infrastructure and sustainability; and</p> <ul style="list-style-type: none"> • HDPE, in consultation with HDHS and CIOG, further investigate the functionality and relationships of the various e-health applications operating in Defence.¹⁸² <p>While the pause was in place, HealthKEYS continued to be maintained at existing sites and only limited development was conducted, until a new project mandate and business case could be raised.</p> <p>The new business case was predicated on the findings of two reviews:</p> <ul style="list-style-type: none"> • an Infrastructure and Sustainability Review conducted by Defence Personnel Executive (DPE) and CIOG to determine the technical viability and sustainability of HealthKEYS within the Defence Information Environment; and • a Business Architecture Review conducted by DHSD and CIOG to investigate the functions and relationships of other e-health applications.¹⁸³
July 2007	<p>The CIOG presented the HealthKEYS Technical and Sustainability report, which recommended that:</p> <ul style="list-style-type: none"> • a replacement product capable of delivering the required e-health functionality be sought as the MaxCare software product would not be sustainable in the longer term within DIE; • in order to assist in improved system performance, primary recommendations from Citrix and Oracle specialist reports be implemented within the three month-period; and • consequent to the Citrix and Oracle report recommendations being implemented, and an assessment of the actual performance improvements, a decision be made regarding the continued roll-out of HealthKEYS Phase one.
July to December 2007	<p>A technical remediation program was carried out and systems performance improvements were made. As a result, HealthKEYS stakeholders agreed that the improvements in system performance were sufficient to justify the continued rollout of HealthKEYS Phase 1.¹⁸⁴</p>

¹⁸² Robson Huntley & Associates – HealthKEYS Status Review, July 2006, pp. 21–22.

¹⁸³ DHSD/2006/1177742/1 minute on status of HealthKEYS, 7 March 2007.

¹⁸⁴ Update on COSC Outstanding Action Item – Agendum 43/06 – HealthKEYS Status and Future, 8 January 2008.

Date	Chronology of HealthKEYS
September 2008	The continued deployment of HealthKEYS resumed. This continued deployment simply meant providing access to HealthKEYS by any new users. There was no longer a plan to roll out HealthKEYS to all remaining sites, since a decision had by then been made to develop a replacement system (the new JeHDI). ¹⁸⁵ Some sites in WA took up HealthKEYS in 2009, but have quickly reverted to the use of MIMI, as performance was poor. ¹⁸⁶

Source: ANAO analysis.

5.14 In the ANAO's view, there have been a number of major issues that were not adequately dealt with in the development of the system. These are listed at Figure 5.4.

Figure 5.4

Issues not adequately dealt with in the development of HealthKEYS

Business Case
<ul style="list-style-type: none"> The IBA MaxCare product was assessed as meeting then Defence Health Services Branch management requirements during Health Systems Redevelopment Project (HSRP) trials in 1996. However, after the cancellation of the HSRP in 1997 and with the passage of time between the completion of these trials and the decision to proceed with HealthKEYS in October 1999, the ANAO considers that there would have been benefit in Defence revisiting, prior to the HealthKEYS project being approved, the product's continued suitability and availability, its likely acceptance by users and its continued 'fit' with Defence's health service business requirements. It would also have been useful to conduct a review at this point of the suitability within the Defence Information Environment (DIE of the technical requirements of the system). Defence later discovered that IBA no longer intended to support the product commercially and that there were problems with its suitability in the DIE.¹⁸⁷
Change Management
<ul style="list-style-type: none"> There were no robust communications and change management strategies to shape customer expectations and inform users of what the project was expected to deliver.¹⁸⁸ This needed to include changes in work practices.

¹⁸⁵ Minute by the Acting Assistant Secretary, Applications Development dated September 2008.

¹⁸⁶ The HealthKEYS Support Team accepts that HealthKEYS does experience slow response times in WA, but notes that WA also experiences communication difficulties with other corporate systems (PMKeyS, Roman) in WA (although these other systems have less onerous data entry requirements when compared to the clinical modules of HealthKEYS).

¹⁸⁷ ANAO Audit Report No.51 2000–01 *Australian Defence Force Health Services Follow-up Audit*, paragraph 6.11, noted that the HealthKEYS Project Office had raised concerns that Defence's centralised information architecture would result in unacceptable download times and adversely affect user acceptance of the system. The ANAO noted that, having regard to the significant cost and technical risks involved, Defence would need to monitor the project carefully.

¹⁸⁸ *ibid.*

Project management

- It should have been clear to Defence after the difficulties experienced in the trials that HealthKEYS was not going to operate successfully in the Defence Information Environment. Sound project management methodology would suggest that, at this point, it would have been prudent for Defence to have considered whether the project could be restructured to enable it to operate in a decentralised environment or cancelled, and new business requirements developed.
- The Defence internal audit report produced by the Management Audit Branch (MAB) indicated that there was inadequate senior level oversight of the project.
- It would also have been desirable if there had been a better understanding and articulation of the roles and responsibilities of the then Health Services Division (HSD) and Information Services Division (ISD), and in particular HSD's role as business owner and ISD's role as developer/operator of the system.
- There was a lack of post-implementation/roll-out reviews of HealthKEYS (although there was the early MAB review). This meant that opportunities for lessons to be drawn during the course of the project may not have been fully realised.

Business processes

- Staff interviewed by the ANAO, who were working in Defence health centres and Regimental Aid Posts (Medics, Registered Nurses and Medical Officers) visited during fieldwork for this audit, noted that clerical work such as completing forms formed a substantial part of their work. Furthermore, HealthKEYS did not seem to streamline the work, but rather added to their workload due to the large number of screens to be navigated around and completed. It was clear that HealthKEYS does not reflect existing health delivery business processes. Rather, it has been superimposed over the top of a previous manual process, without the opportunity being taken to garner potential efficiencies from the workflow in the system.¹⁸⁹

Source: ANAO analysis.

5.15 It is important that these issues are addressed adequately in the development of the replacement electronic health information management system, JeHDI.

The development of JeHDI

Scoping a system model

5.16 In September 2008, Rapid Prototyping, Development and Evaluation (RPDE) which is a collaborative organisation formed by Defence and Industry of Australia in 2004¹⁹⁰, was tasked to investigate what commercial off-the-shelf

¹⁸⁹ Robson Huntley & Associates – HealthKEYS Status Review, July 2006, p. 11.

¹⁹⁰ RPDE is an organisation formed by Defence and Industry of Australia in 2004 to support Defence and Industry to work collaboratively. RPDE Operations are governed by a 'Board' comprising representatives from Defence and Industry. Its aim is to accelerate the introduction of innovative Network Centric Warfare solutions into ADF Warfighter organisations. RPDE is funded from the Defence Capability Program. Source: RPDE Flyer, March 2008.

(COTS) technologies were available to implement an initial e-health system for the ADF that would provide:

- a clinical management system, as a real-time interface between the health provider and service member which can be used in both the deployed and non-deployed environments; and
- aggregated clinical, financial and epidemiology data that interfaces with current financial and personnel management systems.

5.17 RPDE carried out a 'proof-of-concept' exercise. As a result of the Discovery and Capability Analysis Phases of this exercise, RDPE confirmed that a number of mature and immediately available COTS software products could be integrated to form the basis of an eHIS.¹⁹¹ The proposed solution for the eHIS has since been endorsed by three Defence senior committees.¹⁹²

5.18 As part of the capability analysis, a study was conducted into the current state of data and messaging health standards in Australia. These are administered by the National eHealth Transition Authority (NeHTA), although they still have to be finalised. The ANAO was advised by the RPDE Team that it had worked closely with NeHTA officials during the proof-of-concept process to ensure that any new Defence eHIS work aligns with NeHTA's and other recognised standards. This is important in enabling information to be exchanged with external systems or networks, such as those in hospitals. The recently released report of the National Hospitals and Health Reform Commission has also recommended that a person-controlled electronic health record should be introduced for every Australian.¹⁹³ JeHDI will therefore need to communicate with any national health record system.

5.19 A review of the Defence ICT infrastructure required to support planned health information systems management was carried out by RPDE. The RPDE team found that the most effective solution would be for the eHIS to be located in the Defence Online Service Domain (DOSD). This would ensure access to users both inside and outside the Defence Restricted Network (DRN). In-principle endorsement of this architectural solution was given by the Defence

¹⁹¹ This solution could potentially also integrate some existing Defence systems, such as EPRIS.

¹⁹² The Defence Committee, the Workforce and Financial Management Committee and the Defence ICT Committee all of which are chaired by the Secretary and the Chief of the Defence Force.

¹⁹³ National Hospitals and Health Reform Commission, *A Healthier Future for All Australians*, Final Report, June 2009.

Chief Technology Officer, although the selection of different solution components will be considered as part of product procurement.

Implementing the new system

5.20 Table 5.1 shows that Defence has identified four stages for the development of the JeHDI project.

Table 5.1

JeHDI Project Stages 1–4

Project	1 December 2009 to 31 December 2013
Stage 1 - Planning and Design	1 December 2009–18 January 2010
Stage 2 - Prototype	4 January 2010–31 August 2010
Stage 3 - Pilot	1 October 2010–31 May 2011
Stage 4 - Controlled Implementation and Enhancements	1 July 2011–31 December 2013

Source: JeHDI Project Plan, v1.0.

5.21 Stage 1 has been completed and included:

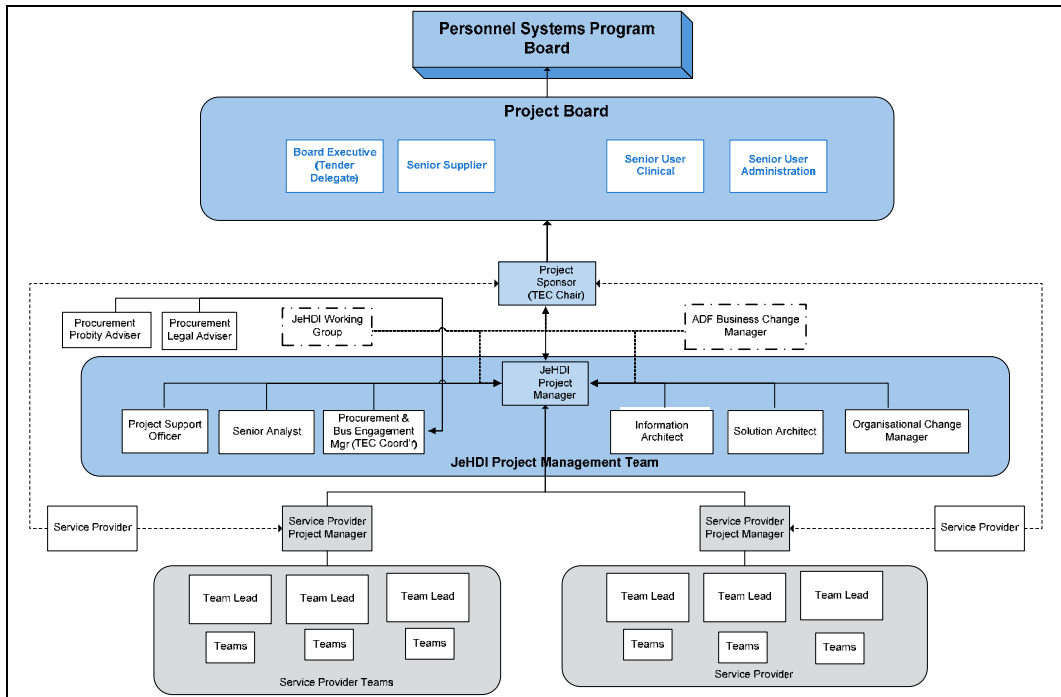
- the engagement of a project manager and establishment of the Project Management Team;
- establishing governance structures for the management of JeHDI within the Personnel Information domain, including organisational structure and responsibilities for the JeHDI Project Board (JPB), the JeHDI Working Group (WG), the JeHDI Project Management Team (JPMT) and other key roles;
- delivery of a number of key products including the project plan, procurement strategy, risk management plan, stage plans and quality management plan;
- commencement of the tendering process for service providers; and
- stakeholder engagement both internally and externally.

5.22 Stage 2 has commenced with the publication of a Request for Tender on 19 February 2010 for service provider(s) to design, build and implement JeHDI. Service provider(s) have been asked to tender for all services associated with JEHDI's implementation, including supply and integration of the relevant COTS products and the hosting of the solution. The successful tenderer is expected to be announced in July 2010.

5.23 The project management structure for JeDHI is shown at Figure 5.5.

Figure 5.5

Project management structure for JeDHI



Source: JeDHI Project Plan, v1.0.

5.24 A Project Board has been established to provide direction for and oversight of the project. It, in turn, is responsible to the Personnel Systems Program Board (PSPB), which provides strategic level control and oversight of the health information system.¹⁹⁴ Its roles and responsibilities are laid out in the PSPB Governance Arrangements and include:

- providing Senior Executive governance over the Personnel System Program;
- providing strategic guidance and direction on health information systems;
- identifying and allocating program and project resources; and
- monitoring and reviewing the progress of a program and its projects.

¹⁹⁴ JeDHI Governance Roles and Responsibilities v1.0 – Accepted by JPB on 21 January 2010.

5.25 The Deputy Secretary Personnel Systems Programs is the designated Business Enterprise Owner of JeHDI.

5.26 The JeDHI project board has three formal members:

- Project Executive: Commander Joint Health Command (CJHLTH), who is accountable to the Deputy Secretary Personnel Systems Programs and the PSPB for the project;
- Senior User, Clinical: Director Defence Clinical Services; and
- Senior Supplier Administration: Director General Policy and Plans, CIOG.

5.27 In addition, the PSPB may be represented on the project board, as necessary, to represent PSPB's priorities and objectives including the application of standards and interoperability with other personnel systems; identify PSP funding priorities for the JeHDI project; and facilitate access to funding of JeHDI activities that meet PSPB priorities.

5.28 PSPB oversight of the project could be enhanced by ensuring that its representative is a formal member of the project board. Given the size and complexity of the JeDHI project, PSPB oversight of the project could be further enhanced by appointing an independent assurer, who would report to it on the project's progress, management of key risks, project deviations, adequacy to which user needs will be met and quality standards. Without this independent assurance, the PSPB will be primarily reliant on reports provided by the project manager.

5.29 The Manager of JHC Project Management Office has been appointed as JeHDI Project Sponsor as well as the Chair of the Tender Evaluation Committee. The Project Sponsor may act as Board Executive in the absence of the Chair, the CJHLTH.

5.30 There will also be a JeHDI working group that will analyse, prioritise and develop potential business solutions to issues which may require changes to JeHDI business processes and functionality and act as a coordinator and communicate with stakeholder business areas.

5.31 The total development cost has been estimated at \$19 million from December 2009 to December 2011, with the overall cost estimated at \$25 million. According to the Project Plan, all costs associated with JeHDI development in 2009–10, 2010–11 and 2011–12 will be met from within JHC's existing funding. However, funding for full deployment in the garrison environment after 2011–12 would require money to be redirected from SRP

JHC reforms and SRP ICT remediation funds.¹⁹⁵ The budgets for stages 3 and 4 will be reviewed on completion of the tender evaluation of potential system suppliers.

5.32 The ANAO has been advised that the JeHDI project will be managed using the Stage-Gate approach.¹⁹⁶ There are a number of 'critical success factors' that should be considered when developing the Stage-Gate process implementation including ensuring:

- sufficient and appropriate resources availability;
- well-defined and communicated key roles and responsibilities, particularly those of the Stage-Gate Committee;
- clear and transparent criteria for project evaluation; and
- effective change management.

5.33 There may be benefit in including an independent assurer role in the JeHDI project to complement the Stage-Gate approach, as one of the principles of this approach is that there should be expert independent reviews of each stage.



Ian McPhee
Auditor-General

Canberra ACT
24 June 2010

¹⁹⁵ JeHDI Project Plan v1.0, p. 24.

¹⁹⁶ The Stage-Gate process was developed by Drs R.G. Cooper & S.G Edgett. The Stage-Gate approach introduces a critical review process to a project at several points along the project lifecycle. Sponsors and/or project managers are expected to justify with gatekeepers or decision-makers, and request authorisation for funding for subsequent stages.

Appendices

Appendix 1: Defence Health Personnel

Group	ADF		Total	APS		CHPs	Total	Total
	JHC	Other		JHC	JHC		JHC	Defence
Administrative staff	123	31	154	302	31	456	487	
Dental assistant	57	84	141	7	78	142	226	
Dental hygienist	2	3	5	-	20	22	25	
Dental technician	3	19	22	-	17	20	39	
Dentist	35	28	63	-	72	107	135	
Dietician	-	-	-	-	7	7	7	
Environmental health officer	22	22	44	-	-	22	44	
Exercise therapist	-	-	-	-	4	4	4	
Laboratory technician	13	12	25	-	-	13	25	
Medical officer	67	62	129	-	148	215	277	
Pathology	4	6	10	9	-	13	19	
Pharmacist	15	12	27	9	33	57	69	
Pharmacy assistant	-	-	-	1	4	5	5	
Physiotherapist	-	-	-	27	69	96	96	
Podiatrist	-	-	-	-	6	6	6	
Preventative medicine	1	39	40	-	-	1	40	
Psychology officer	25	43	68	24	5	54	97	
Radiographer	5	6	11	-	6	11	17	
Rehabilitation coordinator	-	-	-	21	-	21	21	
Registered nurse Div 1	85	183	268	3	167	255	438	
Registered nurse Div 2/enrolled nurse/medic	185	765	950	-	119	304	1069	
Technician operating theatre	-	14	14	-	-	-	14	
Therapeutical officer	2	9	11	-	-	2	11	
Trainee	13	387	400	-	-	13	400	
Totals	657	1725	2282	403	786	1846	3571	

Note: Includes all ADF health personnel providing health support, including those on deployment.

Source: JHC.

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