The Auditor-General
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Performance Audit

The Administration of Veterans' Health Care

Department of Veterans' Affairs

Australian National Audit Office

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Australian National
Audit Office

Canberra ACT
4 February 2000

Dear Madam President
Dear Mr Speaker

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

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

Yours sincerely

P. J. Barrett
Auditor-General

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

AUDITING FOR AUSTRALIA

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Abbreviations/Glossary

ABS	Australian Bureau of Statistics
AIS	Ad hoc Information System
ANAO	Australian National Audit Office
CCP	Community Care Package
CHUMS	Casemix Hospital Utilisation Monitoring System
DHAC	Department of Health and Aged Care
DMIS	Departmental Management Information System
DOFA	Department of Finance and Administration
DVA	Department of Veterans' Affairs
ESO	Ex-Service Organisation
GP	General Practitioner
HACC	Home and Community Care Program
HCP	Health Care Plan
IT	Information Technology
JCPAA	Joint Committee of Public Accounts and Audit
KRA	Key Result Area
LMO	Local Medical Officer
PM&C	Department of the Prime Minister and Cabinet
PBS	Portfolio Budget Statement
RCCS	Repatriation Comprehensive Care Scheme
RPPS	Repatriation Private Patient Scheme
RPBS	Repatriation Pharmaceutical Benefits Scheme
RRMA	Rural, Remote and Metropolitan Areas Classification. This is the ABS classification of geographic areas.
SEIFA	Socio-economic Index for Areas. This is the ABS index of socio-economic conditions.
SLA	Statistical Local Area
VEA	*Veterans' Entitlements Act 1986*

Summary and Recommendations

Summary

Background

1. For 1999–2000, the Department of Veterans' Affairs (DVA) has a health budget of almost $2.7 billion to give *'eligible veterans, war widows, widowers, and dependants access to health and other care services that promote and maintain self-sufficiency, well-being and quality of life'*[1]. To achieve this objective, the Department is to *'provide access to quality, cost-effective health care and support services'*[2] to entitled persons.

2. The Department provides few health services directly with its own staff. Most services are purchased from, and delivered by, a wide range of individual health care providers and provider organisations. These include general practitioners (also called Local Medical Officers), dentists, medical specialists, hospitals, allied health services and rehabilitation services. In 1999–2000 DVA expects to spend $1.924 billion on hospital and health services of which approximately 25 per cent will be spent on community health services[3].

Audit objective, scope and methodology

3. The audit objective was to form an opinion on the Department of Veterans' Affairs administration of its activities to maintain and enhance the health and independence of veterans and war widows in their homes and in the community.

4. The audit pursued this objective through review of:

- the Department's management of the supply of, and veterans' access to, community health services;
- the implementation of recent major changes in administrative arrangements for purchase of some community health services; and
- the Department's overall approach to planning the implementation and accountability over the broad range of its activities in community health services.

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1 Outcome 2, Portfolio Budget Statements 1999–2000, Department of Veterans' Affairs (Defence Portfolio), Budget Related Paper No. 1.4B, p37.

2 Output Group 2, Portfolio Budget Statements 1999–2000, Department of Veterans' Affairs (Defence Portfolio), Budget Related Paper No. 1.4B, p44.

3 The remainder of the $2.7 billion appropriation will be spent on items such as veterans' pharmaceutical services and veterans' nursing home subsidies.

5. The audit focused on the management of community health services for older veterans since the veteran population is predominantly made up of aged persons. The number of veterans and war widows over 70 years of age in the DVA (health) treatment population was approximately 281 000 in 1999. This is 79 per cent of DVA's treatment population and almost 20 per cent of the Australian population aged 70 years and over.

6. The audit involved three methods of enquiry:

- a review of relevant departmental documents and information, and discussions with departmental officers in the National and state offices;
- interviews with representatives of key stakeholder groups; and
- with the assistance of the Australian Bureau of Statistics, collection and analysis of data on health and aged care from DVA and the Department of Health and Aged Care.

Overall conclusions

7. The overall conclusions are as follows:

- there is a broad degree of satisfaction with the DVA provision of community health services within veterans' communities;
- there are wide regional variations in the take-up of community health services through DVA arrangements. These services include general practitioner services, dental and optical services, community nursing, physiotherapy and podiatry. Variations could be a result of:
  - a lack of available services;
  - different health needs from region to region;
  - veterans accessing health services through other funding arrangements; and/or
  - under or overservicing in some regions;
- there would be considerable benefit from DVA analysis to assess the relative importance of these factors in order to inform strategies to facilitate veterans access to services;
- DVA advises that it has made extensive efforts to address the needs of veterans in rural and remote areas including a number of initiatives included in the Department's rural and remote policy. Notwithstanding these, DVA should explore what can be done to remedy these differences as they affect veterans living in non-remote rural areas and urban and metropolitan areas as well;

- the change process, for new community nursing arrangements in 1998, given its magnitude, was managed well although at the time of audit it was too early to evaluate the outcomes of the changes;
- the Health Care Plans introduced by the Department to assist in the management of complex cases have not been as universally or comprehensively adopted as the Department envisaged. This may indicate that the Department's reliance on General Practitioners (Local Medical Officers) as the coordinators of care may need revision;
- DVA has appropriate administrative mechanisms in place for planning and implementation of its veterans' health care arrangements. The audit does, however, recognise some areas where DVA could enhance its performance in the areas of accountability and performance information. In particular, the Performance Budget Statements should provide, instead of a single indicator for health as a whole, indicators for major health areas such as hospitals, pharmaceuticals and community and allied health.

Key Findings

Regional differences

8. An examination of departmental data, conducted for this audit, found that for each veteran in 1998, nationally, DVA spent an average of $563 in rural and remote regions and $773 in urban and metropolitan regions. Its average expenditure on veterans in rural and remote regions varied from $172 in one region to $608 in another. In urban and metropolitan regions it ranged from $494 in one region to $1123 in another.

9. The ANAO's analysis showed that the least-well-served regions were in the rural areas, (in particular, the more remote), and the better-served areas were in urban and metropolitan areas. These data are relevant for the Department's implementation of its health policy for the veteran community in rural and remote areas. Further the analysis indicated that, in urban and metropolitan regions, veterans' use of DVA funded health services was generally higher in better-off areas than in the socio-economically more disadvantaged areas.

10. DVA does not analyse its expenditure data on a local regional basis, so differences in veterans' access to DVA funded health care cannot be recognised at specific local regional level. In addition, the Department is not in a position to know if local regional differences in service provision reflect under or overservicing. The regional differences in expenditure can be addressed if the Department supplements its state level approach to health care analysis and planning with a regional one.

DVA and health services provided by other agencies

11. DVA has difficulty in comparing its health service provision with related services which older frail veterans might use that are funded, or partially funded, by the Department of Health and Aged Care (DHAC) and state governments. Those services include residential care, community health, and home care services available through the Home and Community Care (HACC) program and Residential Care and Community Care Packages (CCPs). Such comparisons would be important in assessing the extent to which veterans' holistic health care needs are being met. DVA and DHAC should increase coordination of aged care planning so as to ensure that data are available to assess whether veterans are receiving a similar share of HACC and CCP places as other people in the general community.

Health care plans

12. Health Care Plans (HCPs), prepared by general practitioners, were intended by the Department to play a central role in providing quality health care for veterans with complex health needs, including frail elderly veterans. General practitioners had prepared HCPs for only 3177 veterans by 1998–99. The number of veterans receiving the benefits of HCPs was much lower than departmental expectations. DVA is initially addressing the low level of implementation of HCPs by general practitioners through an evaluation.

Community nursing

13. New community nursing arrangements, at the time of the audit, were being bedded down. The changes were seen as being positive by most stakeholder groups consulted by the ANAO, including the service providers—the nursing agencies, and veterans' representative groups.

Administration

14. DVA has management strategies to guide its administration of health care services funding. Nevertheless, National Office comparison of DVA health care services strategies and activities at state office level was difficult to achieve because of differences in those strategies which were not necessarily explained by issues of special significance in particular states.

15. DVA's state offices report to National Office on the efficiency of their transactions processing. DVA does not have common administrative indicators focused on Key Results Areas to measure the relative performance in health administration of state offices.

Performance information

16. DVA did not have performance information relating to the outcomes of the services provided under many of its health provider contracts. Consequently it was unable to prepare performance indicators to monitor the quality of the services it funds. Progress in developing performance measures in the health industry generally is variable. The ANAO acknowledges the complexity of the task.

17. DVA uses surveys of veterans' satisfaction with its services to assess the effectiveness of its health services outputs and outcomes. DVA's health managers recognise the limitations of satisfaction surveys in measuring the quality and timeliness of health services it purchases. The Department is collecting better information than what has been available previously on its health outputs and outcomes to guide its administration.

18. DVA purchases very large amounts of hospital and health services annually. The ANAO has proposed that the Department's performance information for accrual budgeting in 2000–2001 reflect more directly its role as a purchaser, and include information about its effectiveness and efficiency as a purchaser and on the quality and availability of the services.

19. The Department's performance information in the Budget Papers on its $1.9 billion appropriation for hospital and health services meets requirements of the Department of Finance and Administration. Clearer specification of outputs and performance indicators for the large health services expenditures would help Parliamentarians and veterans better understand DVA's use of its budget.

DVA Response

20. ANAO made four recommendations. DVA agreed with all of the recommendations.

Recommendations

Recommendation No.1 Para. 2.60

The ANAO recommends that the Department of Veterans' Affairs:

- investigate the levels of health services received by veterans in different regions;
- develop its data systems to facilitate analyses of local regional differences in use of health services by veterans within states and territories; and
- to the extent that the level of services provided does not match health care needs, develop appropriate strategies to address differences in need for, and provision of, health care services.

DVA: Agreed

Recommendation No.2 Para. 2.85

The ANAO recommends that the Department of Veterans' Affairs work with the Department of Health and Aged Care to establish whether veterans are receiving similar levels of access as other individuals in the community to services provided under DHAC's Home and Community Care program and Community Care Packages.

DVA: Agreed

DHAC: Agreed

Recommendation No.3 Para 4.10

The ANAO recommends that the Department of Veterans' Affairs develop a minimum set of common indicators of performance in health administration for use by all state offices, with the aim of identifying efficient and effective administrative practice.

DVA: Agreed

Recommendation No.4 Para. 4.41

The ANAO recommends that the Department of Veterans' Affairs, in its health outputs for the 2000–2001 Budget,:

- refer to its key role as a purchaser of hospital and health services; and
- include performance indicators which directly measure DVA's output performance, as a health service purchaser, for different major types of health services, in addition to those relating to client satisfaction.

DVA: Agreed

Audit Findings and Conclusions

1. Introduction

This Chapter provides an overview of DVA's role in provision of veterans' health care services and outlines the audit's objective and methodology.

Background to the audit

1.1 The Department of Veterans' Affairs (DVA) is one of the largest purchasers of health care services in Australia. For 1999–2000, the Department has a health budget of almost $2.7 billion to give eligible veterans, war widows, widowers, and dependants access to health and other care services that promote and maintain self-sufficiency, well-being and quality of life.

1.2 Demographic data on the veteran population is outlined in Table 1.1. Veterans and war widows aged 70 years and over made up the majority of the people entitled to veterans' health services (79 per cent of the DVA treatment population in 1999) and made up some 18 per cent of all Australians aged over 70 years. The treatment population is the number of veterans and war widows/widowers entitled to health care under DVA's arrangements.

TABLE 1.1:
The DVA Treatment Population by Age and by Sex, 1999[4]

Age Groups	*Male*		*Female*		*Persons*	
	DVA Treatment Population	*% of Total Australian Population*	*DVA Treatment Population*	*% of Total Australian Population*	*DVA Treatment Population*	*% of Total Australian Population*
under 69	57 062	na	15 995	na	73 057	na
70–74	*41 106*	*14*	*26 946*	*8*	*68 052*	*11*
75–79	*88 125*	*44*	*35 064*	*13*	*123 189*	*26*
80–84	40 663	37	20 845	12	61 508	21
85 & over	15 253	22	13 423	8	28 676	13
Total 70+	***185 147***	***28***	***96 278***	***10***	***281 425***	***18***
Total all ages	**242 209**		**112 273**		**354 482**	
% Treatment Pop'n 70+	***76.5***		***85.8***		***79.4***	

[4] DVA Treatment Population Statistics, March 1999: Australian Demographic Statistics September Quarter 1998 ABS Cat. No. 3101.0.

1.3 The audit had a major focus on the DVA's management of its purchasing of health care services for provision to older veterans and war widows in their own homes or through community care. This emphasis was chosen because of the present preponderance of older people among veterans' ranks and the implications of advanced-age related health problems for the present and the medium term future of DVA health care.

1.4 For other aspects[5] of DVA health provision, the audit had a more limited scope. The audit covered DVA's preparation of appropriate management strategies, implementation guidelines for its own staff and for service providers, and review and accountability mechanisms.

1.5 This audit complements recent ANAO audits of DVA's management of hospital services[6] and the Department of Health and Aged Care's planning of aged care[7].

Overview of DVA's role in provision of veterans' health care

DVA's health care aim

1.6 The Department's aim for health services, as stated in its 1999–2000 Portfolio Budget Statements[8], is that:

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

To achieve this, the Department is to '*provide quality, cost-effective health care and support services*'.[9] The Department provides entitled persons with access to health care services through arrangements with registered health care practitioners and with public and private hospitals.

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5 Including DVA administration of veterans' access to hospital services.

6 Audit Report No. 28 of 1996–97, *Use of Private Hospitals,* Department of Veterans' Affairs Follow-Up Audit, Australian National Audit Office, Canberra, 1997. Audit Report No. 40 of 1997–98, *Purchase of Hospital Services from State Governments,* Australian National Audit Office, Canberra, 1998.

7 Audit Report No. 19 of 1998–99, *The Planning of Aged Care,* Department of Health and Aged Care, Australian National Audit Office, Canberra, 1998.

8 Outcome 2, Portfolio Budget Statements 1999–2000, Department of Veterans' Affairs (Defence Portfolio), Budget Related Paper No. 1.4B, p37.

9 Output Group 2, Portfolio Budget Statements 1999–2000, Department of Veterans' Affairs (Defence Portfolio), Budget Related Paper No. 1.4B, p44.

1.7 DVA's health services complement services available through other government channels, notably from the Department of Health and Aged Care (DHAC) and state governments, including:

- standard Medicare services administered by the Health Insurance Commission;
- residential aged care accommodation and Community Care Packages (CCPs) funded by the DHAC; and
- home care services delivered under the Home and Community Care scheme (HACC). This program is funded jointly by the DHAC and by state and territory governments. While HACC services support the aged in their homes, by providing, for example, home help, they also include some clinical services. Community nursing and allied health services provided in community health centres are examples.

Veterans' entitlement

1.8 The Department has the authority to provide health care services under Part 5 of the *Veterans' Entitlements Act 1986 (VEA).* In general, entitlement for health care stems from determinations on applications from veterans and dependants for benefits, which include service, disability and war widows'/widowers' pensions.

1.9 Entitled veterans and dependants are issued with cards that reflect the level of their coverage. These cards are:

- the Repatriation Health Card for treatment of all medical conditions, commonly known as the Gold Card. This ensures veterans' entitlement to all health care services for disabilities accepted as war related, and entitlement to most services for non-service related disabilities; and
- the Repatriation Health Card for specific medical conditions, commonly known as the White Card. This Card supports veterans' entitlement to health care services for all disabilities accepted as service-related, and entitlement to treatment under the special arrangements for Australian veterans suffering from malignant neoplasia, pulmonary tuberculosis or post traumatic stress disorder.

1.10 Treatment for veterans under the *Veterans' Entitlements Act* can be seen as being of two types: specific treatment for war related injuries; and treatment of the same type as available to the general non-veteran population (but provided under the VEA). In terms of volume of services, the latter is the larger.

1.11 Also, veterans can access the generally available health services through channels used by the general public. These generally available services are provided by DHAC and state governments. To access general health services, veterans are subject to the same eligibility criteria that

apply to other citizens and residents, and the same application and other processes in obtaining access to places that are in short supply. There is incidentally a statistical problem for assessing use of health services by veterans since these non-DVA provided services are not always identifiable as being consumed by veterans.

1.12 A major part of the role of DVA in relation to older veterans is to help them access their general health entitlements. For some health and related services DVA plays only a supplementary role, for example, with HACC services, because DHAC and the state health authorities are primarily responsible for HACC.

1.13 The advantage for older veterans of DVA's assistance is not only for provision of health services required to address war service related medical conditions, but in having their general entitlements provided without either the waiting period or the cost which other individuals might experience.

The range and scale of veteran health services

1.14 DVA's anticipated health expenditure in 1999–2000 of almost $2.7 billion comprises:

- $1102 million on hospital services;
- $520 million on Local Medical Officers and medical specialists;
- $388 million on nursing homes;
- $279 million on pharmaceutical products;
- $198 million on allied health services, including community nursing, dental, optical, physiotherapy, podiatry, and occupational therapy;
- $129 million on other health services, such as rehabilitation and transport; and
- $73 million on the Vietnam Veterans' Counselling Service and on health administration.

Approximately 25 per cent of this budget is spent on purchasing services provided to veterans in the community.

Arrangements for service provision

1.15 Prior to 1992, DVA provided most hospital services, and some allied health services, with its own directly employed staff. In recent years, it has moved away from being a direct provider of health services to being a purchaser of these services from the community and private sectors and from state and territory governments. An audit of aspects of DVA's management of veterans' health care services in the community was timely because of this considerable change.

1.16 The services which the Department still provides directly with its own staff include some of the counselling provided by the Vietnam Veterans' Counselling Service, and, under arrangements that vary from state to state, some of the provision of rehabilitation appliances through the Rehabilitation Appliances Program. The Department also arranges travel for health care purposes.

1.17 The major shift from direct provision of services to the current purchasing model began with the repatriation hospitals which, between 1992 and 1997, were transferred to state governments or sold to the private sector.

1.18 This change has been accompanied by an increased emphasis on services delivered in the community (where the emphasis is on keeping people in their own homes, or at least in their broad community environment). Such a shift is consistent with the Government's emphasis on community care for older persons, recognised more broadly in the community in 1999 as the International Year of Older Persons.

1.19 The Department purchases most services in the community health area from a wide range of individual health care providers and provider organisations under a variety of contractual arrangements. These providers include general practitioners (also called Local Medical Officers), medical specialists, allied health practitioners (including from community nursing, dental and optical services,) and providers of rehabilitation appliances. Where this report refers to DVA's provision of health services it relates to purchase of services through these arrangements.

1.20 DVA health services are funded with uncapped special Parliamentary appropriations that are demand driven. Accordingly, the level of funding is based on the level of demand for, and the cost of the services.

Audit objective, scope and methodology

1.21 The audit objective was to form an opinion on the Department of Veterans' Affairs administration of its activities to maintain and enhance the health and independence of veterans and war widows in their homes and in the community.

1.22 The audit pursued this objective through review of:

- the Department's management of the supply of, and veterans' access to, community health services (Chapter 2);
- the implementation of recent major changes in administrative arrangements for purchase of some community health services (Chapter 3); and

- the Department's overall approach to planning the implementation and accountability of the broad range of its activities in health services (Chapter 4).

1.23 The audit involved three main methods of enquiry:

a) a review of relevant departmental documents and information, and discussions with departmental officers in National and state offices who were involved in veterans' health care;

b) interviews with representatives of key stakeholders, including:
   - representatives of older veterans in Ex-Service Organisations; and
   - aged care service providers, particularly community nursing agencies and general practitioners;

c) the assistance of the Australian Bureau of Statistics (ABS) in a consultancy role to:
   - collate data on DVA funded health services, and data from the Department of Health and Aged Care's Home and Community Care and residential care programs; and
   - analyse the distribution of, and access to, health services at regional and state levels.

1.24 In this report, the terms 'region' and 'regional' are used in the conventional geographic sense of referring to a recognised area of land, which has a certain unity, in this case for management of health services. It provides a way of disaggregating larger areas (in this case the States and Territories) into convenient and more manageable sets of areas. The terms are not used in the more colloquial sense of 'regional Australia' referring to non-metropolitan areas, or the 'bush'.

1.25 Fieldwork was undertaken between March and June 1999 in DVA's National Office, its state offices in NSW, Victoria and Queensland, and in nine case study areas in NSW and Queensland. The ANAO used case studies to obtain information and views from geographically and socio-economically diverse areas including areas considered urban, metropolitan and affluent, metropolitan and not so affluent, rural, older industrial, and retirement areas.

1.26 The audit was conducted in conformity with the ANAO Auditing Standards. It cost $333 000.

2. Older Veterans' Access to DVA's Health Care Services

This Chapter outlines the distribution of, and access to, DVA health services for older veterans in states and territories. It then considers the implications for DVA's planning processes of the significant differences noted between regions in average per capita spending on veterans and in the proportions of veterans accessing services.

Introduction

2.1 Chapter 1 described how DVA purchases on behalf of eligible veterans and their dependants, a broad range of community health services, notably general practitioner (Local Medical Officer—LMO) services, community nursing services, and other allied health services including dental, optical, physiotherapy, podiatry and occupational therapy.

2.2 The ANAO notes that there is a broad degree of satisfaction with the provision of these services within the veteran communities. This is evidenced by DVA's own consumer satisfaction surveys and was confirmed by the ANAO through its discussions with Ex-Service Organisations (ESOs).

2.3 Nonetheless, the ANAO's analysis of the distribution to, and use of, health services by older veterans raises the issue of the comprehensiveness of the coverage of DVA's services for that age group. This is evidenced, in particular, in the considerable differences in extent of service usage between regions within the states, which is described below.

A common level of need for services among veterans but differences in the use of services

2.4 A fundamental question in considering the differences in distribution of veterans' health services is whether and to what extent differences reflect actual differences in need for services. If the health status of older veterans was more or less similar in most areas of Australia, it could be expected that their health care needs would be comparable and the consequent level of provision by DVA of health care should ideally be similar too. However, analysis of DVA's information on its provision of health care for older veterans in the community shows that there are considerable differences in provision of services across different parts of Australia.

2.5 The ANAO asked health professionals and departmental staff at regional and state level about regional variations in veterans' health needs ('regional' as defined in Chapter 1). The aim was to obtain the benefit of informed local opinion on the comparative health status and needs of veterans. Impressions obtained from these discussions suggested that, although there might be minor differences in health needs (see below), these were rarely sufficient to explain the differences in the use of services noted in the analysis. The evidence from this sample, although a small one but reasonably representative, was consistent with the findings of DVA's research, reported in its *Future Needs of Veterans.*[10]

2.6 The discussion in this Chapter has the following lines of reasoning:

- for older veterans, the levels of the health status and consequent health care needs are more or less similar between regions across Australia;
- the distribution of the use of treatment which DVA purchases on behalf of older veterans is uneven, often markedly so, between regions; and
- although DVA management is aware in general terms that there are significant differences in the take up of services between regions, it is not at present in a position to assess the extent and implications of the variations and consequently to mount appropriate strategies, if necessary.

The ANAO's analysis of the distribution of DVA funded health services in the community

2.7 In assessing DVA's management of its provision of health services, the ANAO has used two complementary approaches. The first involved local and detailed enquiry through a case study approach, and the second approach utilised data collection and analysis of DVA and DHAC statistics Australia wide.

2.8 For the case study approach ANAO selected a number of regions broadly representative of the range of geographic and socio-economic conditions in Australia. The nine case study areas included examples of metropolitan, large urban, rural and rural and remote areas, and affluent and economically disadvantaged areas. In each area, ANAO interviewed representatives of important stakeholder groups including ESOs, nursing agencies, LMOs and local DVA staff. These case studies provided some detailed insight into the range of services available to veterans in differing types of areas.

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[10] Department of Veterans' Affairs, *Future Needs of Veterans: Summary of Initial Projections for 1997–2007,* 1999.

2.9 The statistical analysis provided a range of indicators of the distribution and the extent of the utilisation of community health services by veterans. This was achieved by:

- collating information on DVA's and other agencies' funding of health care services for older veterans in the community;
- analysing the distribution of DVA funded services for older veterans; and
- comparing the distribution of DVA's services with DHAC's residential care program and HACC.

2.10 In this Chapter, detailed analysis of veterans' access to services relates, unless otherwise noted, to those veterans holding the gold card entitlements as defined in Chapter 1. The rationale for this is that the gold card holders make up the great majority of users of most types of health services provided by DVA.

2.11 The ANAO employed the ABS to advise on statistical procedure and to assist with processing and analysis of the data.

2.12 The analysis compared the distribution of services to veterans on a geographic basis, using DVA and ABS data for health care regions. Previous ANAO experience, in the audit concerning the planning of aged care by DHAC, had indicated that this type of analysis could provide useful insights into access and equity issues in the provision of health services.

2.13 The health regions used are those defined by state governments (referred to in many states as "planning areas"), and used by the Commonwealth Department of Health and Aged Care (DHAC). The health planning areas (or regions) are the main geographic units used by State Governments for planning and managing the administration of health services within their respective jurisdictions. At the time of the audit there were 72 health regions in Australia varying considerably in area and in population. For example, the Sydney metropolitan area extends into seven regions and NSW as a whole has 17 regions. The health regions are listed as part of the Appendix.

2.14 In the analysis that follows, departmental expenditure on veterans is recorded according to where they live. If veterans received departmentally funded health services in other regions, that expenditure was associated with the regions in which they lived.

2.15 The most important of the data sets used for the audit analysis was the DVA data on treatment provided to veterans through DVA's purchase of services from private and community sector providers. This included the numbers of providers, numbers of older veterans using

services, and numbers of services being supplied, by type of service, and by both provider and recipient location on a postcode and state/territory basis. The health service types included LMOs' consultations, LMOs' health plan preparation (for individual veterans), and community nursing and other allied health services, including dental and optical services, physiotherapy, podiatry and occupational therapy. The comparisons by geographic regions in levels of provision were made in relation to the size of the veteran treatment population aged 70 and over. DVA provided data for each postcode area, which was aggregated into regions.

2.16 In addition, data analysis was undertaken to permit some comparison of health services provided by DVA for veterans with those provided to the general population by DHAC and by state governments, including analysis of:

- DHAC data on residential aged care, including Community Care Packages (CCPs)[11] by statistical local areas, state health regions and state/territory; and
- Home and Community Care (HACC) data, assembled by state government health authorities and made available by DHAC. The data's coverage differed considerably from state to state.

Findings concerning the distribution of DVA's health services for veterans

2.17 The first and major part of the ANAO analysis concentrated on DVA's purchase of services from contracted health care providers. The aim was to form a view on DVA's success in providing services to older veterans in ways appropriate to the needs of the veteran population, notably, to see the extent to which the distribution of services was consistent with a reasonable degree of equity of access in relation to veterans' needs. The initial challenge for the audit was to map the actual distribution of services.

ANAO's indicators of the use of DVA health services by older veterans

2.18 The analysis for this section concentrated on two gauges of the distribution of DVA's health services:

- departmental per capita notional spending on community health services used most frequently, by veterans aged 70 and over, in each health region; and

[11] CCPs are packages of health services tailored to the individual needs of a person in their own home. They are targeted to those older people living in their own homes whose complex care needs are assessed as requiring significant management of service provision.

- the proportions of the veteran treatment population aged 70 and over which, in 1998, received the most frequently used departmentally funded services.

2.19 This package of most frequently used services includes LMO treatment, community nursing and other allied health services, namely dental and optical services (non-specialist), physiotherapy and podiatry. The analysis did not include less frequently used services such as specialist optical and dental treatment, occupational therapy, dietitians and speech pathologists because their costs were relatively minor proportions of departmental health care expenditure. Therefore, departmental spending on health care in the community is slightly larger than the analysis indicates.

2.20 The analysis concentrated on the gold card holders (see Chapter 1 for the distinction between gold and white card entitlements) as these are the major beneficiaries of DVA's health purchases. At the time to which the analysis refers, the proportion of gold card holders in the DVA treatment population of veterans aged 70 and over was 84 per cent, the remaining veterans having the more restricted white card entitlements. In addition, the proportion of services provided to gold card holders was disproportionately higher than to white card holders. For LMO consultations paid for by DVA, 96 per cent were for gold card holders; for other allied health services provided in the community, the gold card holders' share was even larger, between 96.7 and 99.5 per cent.

2.21 The estimated costs of DVA health services per veteran, used in this Chapter, were calculated using not the actual costs but the average cost per service for the state.

2.22 The use of the average cost for the state in this calculation builds into the estimate the assumption that costs in each region in a particular state were the same. Thus the notional estimated average cost allows comparison of the level of provision of services between regions regardless of local variations in cost of supplying the services.

2.23 The results of the analysis showed considerable differences between regions in notional estimated per capita spending on older veterans and in the proportions taking advantage of DVA's services. This has a range of implications, including some for DVA's efforts to target its services in ways appropriate to the needs of veterans, and for the analysis of differences, including possible inequity, in access. In addition, these expenditure trends on older veterans' health care will become more important over the next decade because, as more of Australia's older people will have veterans' entitlements, so the demand for and cost of treatment of veterans by the private health sector will increase

considerably. Table 1.1 at Chapter 1 shows relevant data. The Table indicates that already in 1999, about one in six of Australia's population aged over 80 has a veteran's health card entitlement (respectively, 21 and 13 per cent of the 80–84 and 85–and-over populations). When veterans who, in 1999, are aged 75–79 (respectively, 44 and 13 per cent of the male and female population of 75–79 year-olds) become octogenarians, their increasing frailty is likely to create greater calls on DVA funded services. This temporary surge in need for DVA services is expected to fall away after 2010.

Differences in DVA's spending on older veterans

2.24 The scale of the differences in DVA's spending can be seen by comparing the estimates of its spending by regions. For example, Table 2.1 shows average per capita notional spending on veterans by NSW health areas in 1998. In NSW in that year, DVA's average per capita spending on veterans with gold cards ranged from $485 to more than $1123. NSW is given as an example because that was where much of the audit fieldwork was done, but other states have similar regional expenditure differences. The Appendix shows that the differences between regions across Australia in departmental per capita spending on veterans ranges from $1123 to less than $200.

TABLE 2.1

DVA Capita Notional Expenditure on Community Health Services for Older Veterans, by NSW Region, 1998

Region Name	*DVA Per Veteran Expenditure $*
Central Sydney	*1 123*
Central Coast	*996*
North Sydney	*977*
Northern Rivers	*909*
South East Sydney	*900*
Mid North Coast	*849*
Illawarra	*816*
Hunter	*813*
South West Sydney	*780*
Wentworth	*776*
Southern	*743*
West Sydney	*741*
Greater Murray	*648*
New England	*638*
Macquarie	*615*
Mid Western	*607*
Far West	*485*
New South Wales	***789***

2.25 The Appendix provides statistics on each of the 72 health regions in Australia. The regions are ranked in ascending order of estimated regional average per capita spending on veterans (column 12) for the standard package of services referred to earlier.

2.26 DVA provision of health services (as indicated by estimated spending) is clearly lowest in some extremely remote areas, where lack of providers and the need to overcome great distances between veteran and provider have resulted in extreme difficulty in providing many services. These areas represent special cases for which DVA has developed special programs. However, even in areas where provision of services is not confronted with the enormous distances encountered in rural and remote Australia, the range of differences in spending is still considerable.

The proportions of veterans with access to DVA community health care services

2.27 The proportions of veterans using specific services vary as much by region as does average departmental per capita expenditure. This is evident from the Appendix. The Appendix shows, by regions, the percentage of the gold card veteran treatment population aged 70 years and over for which DVA provided and paid for treatment at least once in 1998. This percentage of veterans having different kinds of treatment is shown in columns 6–11, for LMO consultations, dental services, optical services, community nursing, physiotherapy and podiatry. For most people receiving treatment, this was usually more than once in the year. For several different kinds of health services, the average number of episodes of treatment was between 5–10.

2.28 The differences between regions in veterans' use of most types of service are quite marked. For example, by referring to the Appendix (column 10) on use of physiotherapy services, a comparison can be made between take-up of services between the group of regions with, respectively, the lowest and highest average notional spending (that is between the 0–20 and 81–100 percentiles). The use of physiotherapy services (at least once in the year) in the lowest group varies between region from 0–19 per cent of eligible veterans; in the highest group the take-up varies from 22–39 per cent of eligible veterans.

2.29 In summary, the ANAO noted that there were significant variations between regions throughout Australia in both DVA's average per capita spending on veterans and in veterans' use of DVA's health services. ANAO noted also that DVA cannot identify, analyse and monitor these regional differences readily at present.

The implications of the regional differences in distribution of health services

2.30 DVA notes that it is, for most health services, not a direct supplier but makes services available (by purchasing the services) through its arrangements with contracted providers. This raises the question of the extent of DVA obligation to ensure veterans' access the services made available. On the one hand, it can be argued (as it is by some DVA officers) that veterans have the choice of using services made available through DVA arrangements, using services made available by other agencies, or not using any services. In this interpretation, DVA responsibility is simply to make services available.

2.31 On the other hand, DVA officers frequently spoke to the audit team in terms of their (ie, DVA) having a 'duty of care' for the veterans which would suggest that DVA responsibility extends beyond 'making services available'. This is supported by the inclusion in DVA's key results areas (KRAs) of its aim to improve (among other things) 'the range of, and access to, its services', by DVA's involvement in activity to provide an extensive information service to veterans on health care matters, and its special programs targeting areas where access is a particular challenge (in rural and remote areas).

2.32 It is important to note that veterans are not obliged to use services provided through DVA arrangements and can use services provided to the general public by DHAC and State government agencies. However, the likelihood appears to be that most veterans do use DVA services. The Appendix shows (at column 6) that almost 100 per cent of veterans use LMO (that is, general practitioner) services made available by DVA. In respect of this and other services, there are considerable advantages of saving in time and possibly cost, in using DVA services.

2.33 The following discussion is on the basis that DVA does have an important role in improving access by veterans wherever they live and that for the most part veterans look to DVA arrangements for provision of most of their health care needs.

2.34 The ANAO considers that there could be considerable value in DVA identifying and analysing inter-regional differences in veterans' use of health services. The purpose of this would be to better inform management to allow targeting of the services according to the health needs of veterans. The following discussion seeks to enlarge on the need for more analyses to facilitate planning of the distribution of services.

Remoteness versus centrality

2.35 Comparisons were made between DVA's average per capita spending on veterans and the region's geographic location, that is, whether the regions were urban/metropolitan, non-metro urban (usually with a sizeable rural area included), rural and moderately densely populated, or rural and remote. The predominant geographic characteristic of each health region (based on ABS analysis) is indicated at the Appendix in column 3. As noted above, the Appendix groups regions according to estimated DVA per capita spending. Of the five (quintile) groups in the Appendix the first group is made up of those regions with well below average spending, followed by groups below, around, above and well above average spending.

2.36 The differences between types of region are summarised in Table 2.2. As in Table 2.1, the data are of DVA'S expenditure on veterans according to their regions of residence. That is, if veterans received DVA funded health services in other regions, this expenditure was shown as occurring in their regions of residence.

2.37 The Table demonstrates the extent to which veterans in rural and remote regions have below average service provision (often well below average). Nine rural and remote regions are among the 14 in the 'well-below-average' category. ANAO notes that DVA makes special efforts to remedy the disadvantage of veterans in these regions. The DVA's Health Policy for the Veteran Community in Rural and Remote Areas outlines measures intended to alleviate the effects of remoteness on supply of services.[12]

2.38 Part of the difficulty in providing services is the small number of veterans in these areas. In the 13 regions classified as rural and remote, the total number of gold card veterans aged over 70 years is 2205, less than three per cent of total gold card holders over 70.

2.39 Average funding levels for veterans in (non remote) rural areas are spread across the whole spectrum of levels, with a larger number at average or below-average levels. However, it is noteworthy that the three rural regions 'well above average' in funding might be untypical of most rural areas. They are the Northern Rivers and Mid North Coast regions in NSW and the Sunshine-Caloola region in Queensland, each of which has significant urban seaside retirement areas as well as rural populations.

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[12] Department of Veterans' Affairs, *Health Policy for the Veteran Community in Rural and Remote Areas,* 1996.

2.40 Veterans in metropolitan and large urban areas tend to have an above-average rating. Of the 14 regions in the 'well-above-average' category, 11 are urban or metropolitan. Notable among these are three metropolitan regions in Sydney and two in Brisbane, the large retirement areas in the Gold Coast (South Coast region of Queensland) and around Gosford, north of Sydney (Central Coast in NSW).

TABLE 2.2

DVA Spending on selected Health Services by Region, Australia 1998

Regions	*Number of regions with well below average expenditure*	*Number of regions with below average expenditure*	*Number of regions with around average expenditure*	*Number of regions with above average expenditure*	*Number of regions with well above average expenditure*
Rural and Remote	*9*	*4*	*-*	*-*	*-*
Rural and moderately populated	*4*	*10*	*6*	*5*	*3*
Large urban with rural surrounding area	*1*	*-*	*3*	*2*	*3*
Urban/ Metropolitan	*0*	*1*	*5*	*8*	*8*

Possible explanations of the uneven distribution of services—Demand for and supply of DVA health care services in the community

2.41 The relationship between the proportion of veterans obtaining health care services and their health care needs is not clear to DVA, which does not know if the differences in the rate of provision represent an accurate matching of supply with varying needs in regions, or reflect an over-supply or under-supply of services in different regions.

2.42 In seeking to find possible explanation of the differences between regions, the ANAO explored through its analysis the possible association with other factors, such as any urban-rural and socio-economic differences. Not included in the statistical analysis, but discussed with stakeholders, are other factors that might influence demand for services. These might arise from a range of environmental, occupational and demographic factors. These possible explanations are reviewed below.

Socio-economic status

2.43 If there were a link between lower socio-economic status and lower health status caused by differences in nutrition, housing and lifestyle, higher DVA spending could be associated with veterans' living in areas of lower socio-economic standing (in areas of lesser material well-being and health).

2.44 To test this, the ANAO compared DVA's average per capita notional spending on veterans with an indicator of socio-economic standing of each region. This measure, the ABS indicator of socio-economic disadvantage (SEIFA), uses various measures of socio-economic well-being from the 1996 Census data to produce an index in which Australia, as a whole, has a value of 1000. Areas can thus be measured on the higher side as being of lesser socio-economic disadvantage (ie, better-off or more affluent) and on the lower side as being more disadvantaged (ie, on average poorer with more unemployment, poorer health and housing).

2.45 ABS calculated SEIFA values for each health region using the same postcodes as DVA used for its health data. Most of the regions are contained within the bounds of SEIFA values 900 to 1100. The highest is North Sydney at 1121, and among the lowest are some rural and remote areas at slightly less than 850.

2.46 The Appendix allows SEIFA values (column 4) and DVA regional spending (column 12) to be compared. There seems to be an association between high SEIFA values (that is, comparative absence of socio-economic disadvantage and enjoyment of relatively high levels of material well-being), and higher per capita spending on gold card holders by DVA on health services in the community. This is the opposite to the relationship hypothesised above linking higher DVA health spending with possible great health need in less affluent areas.

2.47 In addition, there appears to be a strong relationship between the socio-economic standing of regions and their geographic type. Urban areas have generally greater levels of affluence and of health care services provided to veterans than rural areas, and, in particular rural and remote areas. Among these influences are the effects of remoteness on the availability of providers.

2.48 However, among metropolitan and large urban areas, distance is a less likely influence. In these cases, it might be expected that higher DVA spending might be associated with greater demand and possibly with greater socio-economic disadvantage. However, even here, higher DVA spending was associated with higher socio-economic status rather than with lower socio-economic status.

Availability of providers

2.49 DVA noted that a major factor explaining the difference in levels of servicing between urban and rural areas is the extreme shortage of health care providers in rural areas. This explanation applies in particular to remote regions where there is in many cases an almost total absence of any health professionals and, for several types of allied health services, in some less remote rural areas. However, the lack of providers seems not to be the only or dominant explanation in other less remote and more densely populated rural areas and in some urban areas with below average take up of services.

Environmental and occupational influences

2.50 Variations in veterans' health care needs could be related to occupational hazards in earlier working life, such as prolonged exposure to bright sunlight in farming areas, or a greater risk of respiratory problems in mining areas. Health professionals with detailed local knowledge pointed to the likelihood of these heightened risks, but confirmed that the risks were not sufficient to explain the scale of the differences in servicing, and were, in fact, more likely to be more prevalent in less-well-serviced areas.

Demographic differences within the older veteran population

2.51 Another factor that might explain the differences in veterans' use of DVA's services between regions is the demographic composition of the older veterans' population. For example, a larger proportion of veterans aged over 85 years could be associated with greater use of services, because this group is more likely to be frail and need more health services. On the other hand, the over-85 group is more likely to be in residential care and to have their needs satisfied by those institutions rather than by DVA.

2.52 The significance of this factor in explaining regional differences in DVA expenditure on older veterans was not analysed in detail in this performance audit. However, it was noted that, in regions where there were unusually high proportions of veterans aged over 85 years, there was also a higher-than-average proportion of people in nursing homes. In addition, the higher proportions of older veterans were generally not sufficient to account for more than a part of the differences in per capita spending in those regions.

Veterans' awareness and acceptance of their entitlements

2.53 Discussions during fieldwork, especially with some ESO representatives, raised the issues of veterans' awareness of their entitlements and possible unwillingness to accept assistance. Both these

factors could help explain why the use of available services is less than DVA management might expect.

2.54 Lack of awareness could arise, especially with an ageing population, because information is often heeded only when it is of immediate use and relevance. Consequently, for a matter such as health entitlements, the messages need to be available regularly so that people, as they become increasingly frail, have the chance to learn what is available for them. The ANAO notes that DVA's publications serve this purpose for those who read them.

2.55 ESO representatives noted that unwillingness to accept DVA's help can arise from a variety of often deeply ingrained attitudes. Individual veterans might express these variously as 'not wanting to bludge', 'not wanting a government handout'. They can be associated with feelings of pride and independence, mixed with stoic determination to put up with discomfort and disability.

2.56 To summarise, variations in departmental spending on veterans in different regions could be linked with:

- difficulty of access to or non-availability of providers;
- differences in the demographic composition of the older veteran population in different regions, which could give rise to greater need;
- interregional differences in the health status of the veterans;
- degrees of socio-economic advantage or disadvantage;
- veterans' lack of awareness of entitlements;
- veterans' use of services made available by other providers; and
- veterans' unwillingness to use DVA's health services.

2.57 The ANAO concluded that:

- veterans in metropolitan regions generally have greater use of services than veterans in non-metropolitan regions;
- DVA does not provide for veterans, in regions of lower socio-economic status, more health services than it does in other regions;
- in metropolitan regions of higher socio-economic status, there seems to be greater DVA expenditure on veterans than in other regions; and
- similar patterns of uneven distribution of and access to DVA services occur in each state.

2.58 ANAO notes that DVA does not know the extent of unevenness in distribution of services within states, nor the relative importance of the above factors in contributing to the uneven distribution nor of the related equity implications. The ANAO's discussions with departmental

staff in state offices indicated that they were aware of some of the possible trends. Notwithstanding, with one exception, there was no systematic attempt to describe and explain the differences in departmental expenditure on veterans in different regions. The exception was in departmental efforts to increase health services for veterans in rural and remote areas. The ANAO notes the 1999–2000 Budget initiatives, which include improvements to services for veterans in rural and remote areas through partnerships with other Commonwealth, state and local agencies to expand services provided at present by DVA.[13]

2.59 The ANAO notes that DVA management is very interested in identifying shortcomings in service provision. However, state office managers are hampered in rectifying unintended differences in departmental provision of services to veterans by a lack of accurate knowledge of the nature and location of and possible explanations for these differences. The ANAO notes that the NSW State Office is adopting a regional approach to health care planning in compiling an inventory of hospital and acute care services. That Office intends to expand its planning to community health operations.

Recommendation No.1

2.60 The ANAO recommends that the Department of Veterans' Affairs:

- investigate the levels of health services received by veterans in different regions;
- develop its data systems to facilitate analyses of local regional differences in use of health services by veterans within states and territories; and
- to the extent that the level of services provided does not match health care needs, develop appropriate strategies to address differences in need for, and provision of, health care services.

DVA response

2.61 *Agreed. DVA has had an active program in recent years aimed at improving service to veterans in rural and remote communities. This has included monitoring service availability by region and contracting community advisers to help veterans access available services. DVA agrees that more can be done in developing its data systems and coordinating the regional analysis of the range of services required by veterans. DVA will also continue to work to address local differences in availability of services, including by contracting visiting services where appropriate, and in*

[13] Department of Veterans' Affairs, 1999 Federal Budget Media Release, May 1999.

liaison with other agencies responsible for the provision of such services (Commonwealth and State). Differences in DVA expenditure between regions will also reflect different levels of reliance on other health services such as Medicare and HACC rather than veteran entitlements, and different population characteristics.

Potential for more effective use by DVA of its information

2.62 Recommendation No.1 proposes some further analysis of the distribution of its services and development of its databases. This section offers suggestions derived from the audit as how DVA might progress this.

2.63 ANAO notes that DVA has a large body of information on veterans' health which it uses in its analysis and planning of health services. At state level this has included the planning of the location of its VAN offices and the analysis of veteran use of health services by the "Rural, Remote and Metropolitan Areas Classification" (RRMA).

2.64 DVA can make comparisons of the provision of its services on a geographic basis at the whole of state level (that is, between states and territories), and within states on the basis of postcodes and of the RRMA classification. Postcodes in themselves are too numerous and small in area for most planning purposes and are usually used as building blocks for other analyses. The RRMA classification provides the broad brush overview, totaling data for, respectively, all the postcodes characterised as metropolitan, large urban, rural (non-remote) and rural and remote in a single figure. It does not, as currently used, distinguish between different local geographic regions within a state. ANAO suggests that DVA, utilise for an analysis of the use of its services by veterans, the state health regions.

2.65 In addition, DVA has difficulty in making comparison of its own service provision with services provided through HACC and CCPs on a geographic basis. Use of the state health regions by DVA would facilitate comparison with DHAC residential care and HACC services. ANAO suggests that DVA and DHAC should consider the potential benefits of further coordination of aged care planning through this type of analysis.

2.66 DVA's information on the geographic distribution of services is stored on the basis of postcode areas, from which base it is processed to serve the needs of inquiries by departmental staff. In this, DVA differs from both ABS and DHAC which store data on the basis of statistical

local areas (SLAs), one of the major units for ABS' storage of census data. This complicates comparison of DVA and DHAC health statistics at the local and regional levels. The ANAO and ABS noted that some caution was needed in compiling statistics for analysis. The relationship between postcodes and SLAs is not one-to-one, and boundaries of groups of postcodes do not always match SLA boundaries. In reconciling the different bases in the present audit analysis, a concordance between the 1996 SLAs and postcode regions was used which assigned the postcode data to an SLA based on a proportion of the postcode within the SLA.

2.67 The three data sets available for analysis in the audit, and which ANAO suggests DVA make greater use of, each vary considerably in their technical design and in their reliability and utility. This is of relevance to the extent to which DVA can be expected to invest effort in their use.

2.68 The DHAC data on residential care is the most reliable and comprehensive of the data sets. It has been collected for more than a decade and its method of collection has been refined by DHAC regularly. Its usefulness to DVA is in showing what residential health care facilities might be available to veterans in specific areas in addition to DVA's own services. This is of importance especially for frail older veterans. DHAC's data on Community Care Packages is of particular interest to DVA because these packages enable veterans to be cared for in the community.

2.69 There are considerable limitations on HACC data. Until relatively recently, information on HACC services was available only on a local basis, and only in the last few years has DHAC had available to it the data to assemble a more comprehensive database. As yet, the most up-to-date data supplied by DHAC to the ANAO is not fully comprehensive or comparable between the states. ANAO notes that DHAC is, during 1999–2000, developing a minimum data set which should provide a much more useful planning base than is available now.

2.70 It follows that at present DVA offices in the states may not have an accurate picture of HACC provision in their areas. HACC services are important to veterans because, although DVA is able to provide for their health needs, it has limited ability to provide for their home help needs, so they must rely for this on access to HACC services.

2.71 However, ANAO notes that with the expected improvements in the HACC data noted above, and with the use of relevant and up-to-date statistical concordances between the data sets, it should be possible for DVA to make more effective use of the available information.

DVA funded health services, and services for the aged funded by DHAC and state government health authorities

2.72 DVA's approach to care for older veterans in the community embraces a holistic approach to health care, concentrating on the needs of the individual veteran. An important element in maintaining the health and independence of veterans is home care, both the veterans' needs for these services and the type and availability of such services. However, DVA's own community health services that it makes available for veterans focus on health issues and largely exclude home care. These services, where provided by government agencies, are provided primarily through the HACC program. For these other services, veterans rely on their entitlements as members of the general public. DVA has a strong interest but little direct control over these programs which are provided by DHAC and by State Government agencies.

2.73 In the broad context of ageing, care provided by federal and state government agencies consists of several programs aimed at arresting the decline from a state of 'wellness' and independence, through increasing frailty and lessening independence, to incapacity and (for some) total dependence. Table 2.3 illustrates the approximate links between health status of individual older people, available types of intervention, and programs that supply it. That is, the Table illustrates the Commonwealth and state government funded health care services for which older veterans are eligible.

2.74 As noted above, HACC services are important to veterans and their dependants because they are their main sources of government sponsored home care. For the greater part, since HACC services concentrate on home care and related non-medical services, they generally do not duplicate DVA's services or DHAC's residential services. The main exception is in community nursing where DHAC, state governments and DVA provide services either directly or indirectly.

2.75 In addition, as noted in Table 1.1 at Chapter 1, veterans are becoming a larger proportion of the older population and will remain so for the next decade or more, so there are advantages for DVA and DHAC in exploring ways to strengthen their cooperation.

TABLE 2.3

Commonwealth and State Funded Health Care Services for Older Veterans in Relation to their Health Status

HEALTH STATUS	*INTERVENTION*	*PROGRAM*
Well and independent	*Promotion of healthy lifestyles*	*DVA's 'Never Too Late!'* [14]
Low level of frailty	*Mainly home help and some health care*	*HACC*[15]*. Veterans also access DVA's health services and DVA's HomeFront* [16]
Moderate frailty	*More comprehensive home help and health care*	*HACC. DHAC's low level (hostel) residential care or Community Care Packages. Veterans also access DVA's health services and some respite care*
High level of frailty and considerable loss of independence	*Nursing care, comprehensive home help; support for carers*	*DHAC's high and low level residential care or Community Care Packages, and HACC. Veterans also access DVA's health services and respite care*
High level of frailty and dependence	*Intensive nursing care and supervision*	*DHAC's high level residential care*

2.76 The ANAO noted in fieldwork that DVA's offices, especially at state office level, liaise intensively at present at operational level. However, in those states visited, it seemed that DVA has a less well developed coordination and planning relationship with state government health authorities. This is one area in which DVA and other health authorities could profit from greater cooperation.

Observations on the distribution of HACC and residential care services

2.77 In an earlier performance audit in DHAC on the Planning of Aged Care[17], the ANAO noted that there were inequities in the distribution of and access to residential aged care facilities. For this present audit, these differences and some gauges of HACC funding were analysed and compared with DVA's own provision of health services, discussed above. The information had considerable comparability problems, and, therefore, it should be considered exploratory rather than definitive. Nonetheless, it suggested some potentially significant similarities and differences in

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[14] A DVA preventive health initiative to increase the veteran community's participation in sport and recreation activities adapted to meet their needs.

[15] HACC is jointly funded by the Commonwealth and the State and territory governments

[16] A DVA aged care accident and falls prevention strategy with a focus on maintaining a safe living environment in veterans' homes. It is operated by Worldcare Pty Ltd on behalf of DVA.

[17] Audit Report No. 19 of 1998–99, *The Planning of Aged Care* Department of Health and Aged Care, Australian National Audit Office, Canberra, 1998.

the distribution of care under the various programs of the two departments.

2.78 The analysis suggested that DVA's services and DHAC's residential care services paralleled each other in being better provided in metropolitan and large urban regions and less so in rural areas. The distribution of HACC's services was more diverse, and seemed to be provided in small town and rural areas at a higher per capita level than in larger urban areas.

2.79 Although the data were limited, a cautious conclusion was that differences in the regional provision of DHAC funded residential care services seemed to be similar to differences in DVA's funding of health services in regions. That is, both DVA and DHAC offered few services in some areas, and relatively more in similar other areas.

2.80 Although HACC and DVA's services together might amount in theory to a comprehensive service, one concentrating on home care and the other on health care, that is not always so in practice. Many regions seem to have below-average levels of one or both types of service. In addition, greater than average level of home care does not substitute, in a health care sense, for a lack of DVA's nursing services. HACC and DVA's health services do not substitute for each other in the field because they have different functions.

2.81 DVA and DHAC, in respect of HACC, do not use formal and objective measures of estimated need for their services on a regional level. Nor does either Department set targets at regional level for the allocation of funds and services. In contrast, DHAC's residential care has a target of providing 100 aged care places for every 1000 persons aged 70 years and over.

2.82 A comprehensive and adequate provision of both health and home care is a necessary management objective. However, DVA can only manage its own arrangements and of necessity must rely on cooperation with other government providers to ensure that its client group's needs are catered for properly.

2.83 Few quantitative data are available to DVA to conclude whether veterans receive a fair share of HACC places. Anecdotal evidence collected in fieldwork was conflicting. One opinion is that veterans are often omitted from programs by HACC providers on the basis that, having veteran status, they have access to alternative DVA services. Another opinion is that although this might have occurred in the past, it is no longer the case and veterans do not suffer from this kind of discrimination.

2.84 DHAC advised

that the DVA funding for Home and Community Services was "rolled in" to the Commonwealth contribution to HACC when the program commenced in 1985. At that time it was agreed that the criteria for providing HACC services to veterans would be the same as for the total program.

DHAC also advised

that to determine a "fair share" for veterans, comparable data would need to be collected for both veterans and non-veterans for those receiving HACC funded services and those who were not. Such data would have to include information on such factors as degree of disability, living arrangements, income levels, availability of informal support, age and sex and any other factors that influence HACC use.

Recommendation No.2

2.85 The ANAO recommends that the Department of Veterans' Affairs work with the Department of Health and Aged Care to establish whether veterans are receiving similar levels of access as other individuals in the community to services provided under DHAC's Home and Community Care program and Community Care Packages.

DVA response

2.86 *Agreed. DVA is according a high priority to improving veteran access to HACC and CCP services. DVA has recently contracted a research study to better gauge veteran usage of community care services and to inform DVA input to local community care liaison forums.*

DHAC response

2.87 *Agreed. DHAC are happy to work with DVA to help investigate this issue but note it would be a resource intensive exercise.*

3. DVA in the Community

This Chapter includes comments on operational aspects of DVA's provision of health services to older veterans in the community, in particular services provided by Local Medical Officers, community nursing and other allied health service providers.

3.1 In 1998–99 DVA's expenditure on veterans' health services in the community was approximately $658 million. This is shown in Table 3.1.

TABLE 3.1

DVA's Expenditure on Health Services in the Community in 1998–99

Components/Areas of DVA Health Care	*$m*
LMO/Specialist services	*305.3*
LMO consultations	*108.9*
LMO case management	*0.4*
Community nursing	*39.7*
Physiotherapy	*24.8*
Podiatry	*23.1*
Optical supplies	*10.1*
Optical services	*3.8*
Dental	*55.2*
Specialist consultations	*82.0*
Other Allied Health Professionals	*4.6*
Total	***657.9*** [18]

3.2 The ANAO consulted a number of stakeholders in three states to obtain an understanding of how they saw the various health services functioning and how these could be improved, in particular services provided by:

- Local Medical Officers (LMO's), as care coordinators and usually as the first point of contact for veterans with health problems; and
- community nursing agencies, which provide professional health care in veterans' homes.

[18] The figures above are for providers of health treatment services. DVA also expended $51 million for rehabilitation appliances and $36 million for repatriation transport.

3.3 The ANAO met stakeholders in each of the nine case study areas, including general practitioners' representatives (usually the Divisions of General Practice), one or more community nursing providers, Ex-Service Organisation representatives and, where available, local DVA staff at Veterans' Affairs Network offices.

3.4 The overall finding was that DVA was managing the provision (ie, through its purchaser provider arrangements with contracted providers) of these health services well, in an environment where many factors were outside its control. DVA actively sought out and took action to deal with emerging problems. Although the discussions with stakeholders highlighted some concerns, a number of DVA activities were addressing them. Nonetheless, this Chapter suggests some improvements in departmental administration of provision of health services to veterans in the community.

Care coordination

3.5 In organising the distribution of health care services to veterans in the community, DVA gives a central and major role to the LMO as care coordinator. There are about 14 000 general practitioners registered with DVA as LMOs, which is about 95 per cent of the general practitioners in Australia. DVA's payments for veterans' consultations of LMOs in 1998–99 amounted to $108.9 million. LMOs were also paid a share of the $305.3 million in 1998–99 attributed to LMO and Medical Specialist services. DVA did not have data on what proportion of this $305.3 million was spent on LMOs' services.[19]

3.6 Care coordination involves providing the central focus of holistic care and linking and mobilising different professional health services for individual veterans. For the general population the care coordinator, if there is one, is usually the GP or the health professional most involved with the patient. DVA advised the ANAO that research confirms there is a spectrum of coordination activity required by elderly persons, and while DVA does have a focus on the LMO, the Department strongly supports the need for professional health groups to work together.

3.7 In DVA's current system, care coordination or case management occurs generally at an informal level. DVA advised the ANAO that it was considering extending health interventions beyond treatment and the informal coordination of care to more formal case management approaches. This would go beyond the limits of administering the Health

[19] DVA does not disaggregate this expenditure of $305.3 million as it accounts for its expenditure by the type of service funded, rather than by the provider group which renders that service.

Care Plans, which are discussed below. With the support of the Divisions of General Practice, DVA is investigating (on a local geographic area basis) the level of veterans' need for additional support, including geriatric assessment, case management and an increase in the level of HACC services. Phase 2 of that project will evaluate the formal provision of case management in two Divisions of General Practice. DVA has yet to decide which provider groups will have the case manager role in that trial.

3.8 The ANAO noted from discussions with LMOs that many were keen on their role as care coordinators and saw it as an important professional function. They seemed to fulfil this role to a great extent for both veterans and the general population.

3.9 However, the effectiveness of the LMO as a care coordinator was questioned by several groups of stakeholders. The ANAO's observation from discussions with stakeholders is that, although LMOs as coordinators of care are logical first choices, this role works well primarily for general practitioners who have a special interest in older patients. The DVA model in which LMOs are coordinators of care does not work as well for some other general practitioners. Comments made to the ANAO on the effectiveness of LMOs in the care coordination role included:

- many LMOs are seen as not being dedicated to the concerns of aged people to the extent envisaged by DVA because they either do not have enough time or have major competing health care interests in their practices;
- some LMOs are seen to be reactive rather than active promoters of health care. A preference for a reactive role might diminish their effectiveness as health care coordinators;
- some interviewees emphasised that LMOs had a critical role in medical / clinical concerns, that is, they needed to be involved but not necessarily as the main coordinator;
- community nurses also have a major role and interest. Proponents noted that community nurses could fulfil all or some parts of the care coordinator function more effectively, economically and with greater community insight than LMOs. That is because, it was claimed, community nurses have more effective community links and patient empathy, and regard case management as their role already. This viewpoint was shared not only by community nurses but by a significant proportion of other stakeholders consulted by the ANAO;
- some LMOs thought they were ideally situated to make decisions about planning and needs, but an independent care coordinator could

do the administration, for example, of Health Care Plans. Some health professionals put the view that an effective unit could be a number of LMOs working with a manager as coordinator in larger GP practices; and

- community nurse groups suggested that DVA explore a larger community nursing role and greater diversity of practical arrangements.

3.10 In summary, the general view of the groups and individuals consulted was that the existing system, with the LMO as care coordinator, was not working effectively to cover all older veterans who could benefit from more comprehensive care arrangements. In seeking to improve performance in the present model, the ANAO suggests that DVA introduce some flexibility into current arrangements. For instance, there may be merit, for cases where an LMO has not accepted the role of health care coordinator, in considering involving a coordinator other than a general practitioner, such as a community nurse. The ANAO notes that this proposal might have training implications to ensure that other health professionals who become involved have the requisite skills.

Health Care Plans

3.11 A key element in DVA's approach to care coordination is the Health Care Plan (HCP), the aim of which is to enable LMOs to coordinate, formally and effectively, preventive measures and treatments by all of a veteran's care providers. HCPs are intended to be a major initiative, with the potential to improve the quality of veterans' lives by slowing the rate of deterioration of their health as they age.

3.12 HCPs were introduced by DVA in 1996 and their implementation has been uneven. In 1998–99 DVA paid LMOs a total of $360 000 to prepare Health Care Plans for veterans, an average cost per veteran of about $110[20].

3.13 DVA's management of HCPs is evolving. The initial target group (the frail aged with the highest treatment costs) was shown to be inappropriate, as noted below, and HCPs are now for patients over 70 who have complex needs. Less than one per cent of the treatment population aged 70 years and over have HCPs, whereas the Department's initial estimates were that about 10 per cent of veterans could benefit significantly from them. DVA is currently evaluating HCPs for veterans.

[20] Departmental source

3.14 The ANAO's consultations with stakeholders demonstrated clearly that use of HCPs varied greatly with the interest of the LMO. From discussions with GPs, it seems that in some cases the dominant criterion for having an HCP is not the 'need' of or usefulness to the veteran but the interest of the LMO. This observation was similar to that made for care coordination, discussed earlier. Essentially in many cases HCPs are provider initiated.

3.15 This is not surprising since there is a divergence of opinion among LMOs about the relevance of HCPs. Some LMOs said there was no need for the formal plan because this kind of coordination was integral to the LMO's normal professional practice in caring for patients. Others noted that HCPs helped make their health care more systematic, and that through HCPs the Department paid them a reasonable fee for what they were doing already. LMOs receive $110 for each Health Care Plan they prepare, in addition to the standard Medicare fee.

3.16 Some Divisions of General Practice considered that the low incidence of HCPs was caused partly by the Department's inadequate promotion when they were introduced. The Department's launching of its HCP proposal was directed at high cost, heavy users of departmentally funded services. These were predominantly people in advanced stages of illness and unlikely to benefit from HCPs.

3.17 Impediments noted by LMOs to their greater use of HCPs included:

- HCPs address preventive care, so that LMOs whose approach is mainly to react on the basis of current complaints will need to change the focus of their care to be more forward looking;
- some LMOs do not have many veterans as patients. This results in LMOs spending much time understanding HCPs for a relatively small number of patients, when they could treat more patients if they did not have to complete time consuming HCPs;
- some LMOs might have higher priority professional and developmental concerns relating to major needs of the local community, such as an interest in maternal and child health; and
- a number of LMOs noted reluctance on the part of veterans to be involved in HCPs, because of either lack of personal interest in them or worries that their pensions might be affected by their involvement.

3.18 A continuing theme in discussions with stakeholders was the need for DVA to educate both LMOs and veterans themselves about the benefits of HCPs.

3.19 LMOs who had used HCPs said DVA's form for HCPs was satisfactory, providing a suitable format without requiring superfluous detail, although there could be advantages in having the form available electronically. On the adequacy of the fee paid for producing the HCP, LMOs had varying views, but it did not arise as a major reason for not adopting HCPs; limited availability of time seemed to be the main obstacle.

3.20 DVA advised that it is has commissioned a three year trial that is looking at alternative assessment and coordination practices. The essence of the trial is a supplementation of LMO's knowledge of client need by non-medical personnel. This complements the LMO focus of HCPs.

3.21 The ANAO notes DHAC's 1999–2000 Budget initiative to introduce, for people over 75, voluntary health assessments concentrating on prevention and better management of chronic illness. DVA advised that it made its experience of Health Care Plans available to DHAC, and that a DVA staff member was part of a key Health working party overseeing the implementation of DHAC's Budget initiative.

3.22 DVA advised that the current departmental evaluation of HCPs was trying also to determine whether the perceived benefits of HCPs could be demonstrated.

Community nursing reforms

3.23 A major management initiative by DVA in recent years has been its effort to reform and improve nursing care for veterans in the community. Before the reforms there were significant differences between states in service patterns and average costs, which indicated to DVA the potential for improved levels of service. To get better value for money and a more consistent achievement of high professional standards, DVA set about a major overhaul in 1996 of its community nursing arrangements.

3.24 The new community nursing arrangements came into effect on 4 May 1998. During the period of the audit these reforms were in the 'bedding down' process. It was too early to form a view on the success of the reforms and quantitative data were few at the time of the audit. However, the ANAO was able to gather observations on the processes of the introduction of the reforms from perceptions of health professionals involved (particularly from a selection of community nursing providers and ESO representatives).

The extent of the change

3.25 DVA implemented purchasing and contractual arrangements using a set of guidelines that emphasised appropriate quality care, best practice and a concentration on patient's health outcomes. These arrangements replaced the previous fee for service basis.

3.26 DVA has about 300 contracted community nursing agencies delivering services to veterans. This is a significant reduction from the 2200 providers (many sole providers) under the previous arrangements. Expenditure for DVA's community nursing services in 1998–99 was $39.7 million. For 1999–2000, DVA has estimated its likely expenditure at $42.6 million.

3.27 The new community nursing system has a number of major components designed to achieve best practice care and equitable access. These components include greater client focus, maintenance of agreed professional standards, in a framework of probity and accountability.

3.28 DVA aims to achieve this via:

- an assessment of individual veterans' health status and associated care needs over time;
- a classification system that makes providers responsible for determining appropriate levels of service linked with a casemix based fee schedule;
- flexibility to allow for exceptional cases outside the fee schedule, these fees based on the individual clinical care needs of the veteran;
- health outcome measures and clinical pathways linked with the classification system (clinical pathways are discussed below);
- quality control reinforced by client feedback mechanisms and evaluation strategies;
- monitoring via a community nursing minimum data set;
- best practice information for clinical care; and
- accountability to be reinforced by a mixture of accreditation and random audits by an independent organisation.

Impact of the reforms

3.29 The ANAO inquiries in this audit were made nine months after the introduction of the reforms. By this time, the outcome of the community nursing reforms was widely accepted, providers considering the outcome professionally satisfying. This positive reception by the majority of providers indicated a level of success by DVA's management in designing and planning the introduction of the new system.

3.30 In addition, the ANAO noted that in consultations with stakeholders there were few significant complaints by veterans' representatives about any changes in the level of services or disruption of services to veterans, during or after the reform process. This observation is supported by the low volume (about 1.6 per cent) of ministerial correspondence on veterans' health matters related to

community nursing over the period of change. Given the extent of the changes and the potential for service disruption, the relatively smooth implementation of the community nursing reforms was an achievement for both DVA and the providers.

The change process

3.31 Although comment on the eventual impact was positive, there were some stakeholder criticisms of the change process. It is not easy to gauge how justified these criticisms were. Given the extent of the change, some friction between contracting parties is to be expected and it would be unusual if there had been no complaints. In addition, it may be observed that, in a commercial environment, the cost of readjustment to purchasers' changing needs is part of the business risk. ANAO noted that DVA is not indifferent to the criticisms and that substantial DVA review activity is occurring, and more planned, to deal with these matters.

3.32 The matters raised by community nursing providers consulted by the ANAO included:

- DVA did not appear to recognise or appreciate the extent of the cost in time and resources to adapt providers' systems to DVA's new requirements. Examples quoted included the time needed to train staff in DVA's arrangements, and the costs associated with changes in providers' computer systems;
- some providers were concerned about the adequacy of payments. However, ANAO noted that DVA had anticipated that there would be 'teething problems' and made an initial commitment to the industry to undertake an early review to obtain industry counterpart commitment. This review was occurring at the time of the audit;
- there was some concern about the number of clients they were referring to DVA for consideration as exceptional cases[21] and the increased workload this imposed on them. The large number of exceptional cases suggests that there is a problem in the client classification system. DVA is examining these concerns by reviewing the exceptional case process; and
- the DVA contract requirement that providers are to establish clinical pathways[22] was a source of some provider complaint. Although

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[21] Exceptional cases are instances where a nursing agency assesses a veteran's nursing care requirements to be greater, and therefore more costly, than DVA allows for in its client classification system. The client classification system advises agencies of the level of funding, via a fee schedule, for veterans with similar conditions.

[22] Clinical pathways are tools used to define the sequencing and timing of the therapy services and day to day activities of medical, nursing and allied health team members to maximise the quality of care and better utilise resources.

comment on their use was favourable, there was substantial concern about their development. Providers acknowledged their contractual responsibilities to develop clinical pathways. Simultaneously, however, DVA had been developing clinical pathways to be made available to providers at no cost for providers' use. Some providers noted DVA had not clarified with them their intention to develop these pathways and these providers had inadvertently, and at some expense, duplicated DVA work.

3.33 Some persisting causes of provider dissatisfaction (at the time of the audit) included DVA's tardiness in fulfilling some obligations of the new system:

- DVA had yet to honour an undertaking to provide an electronic means for community nursing providers' reporting to DVA; and
- DVA had not advised providers of the purpose for which it would use providers' data and whether the data could be used by providers as a management tool. The ANAO's understanding is that the data, among other things, is to help in the design of a Community Nursing Minimum Data Set being devised by DVA[23].

3.34 The ANAO considers that these perceptions point to communication difficulties that should be addressed.

3.35 Most providers commented that the guidance material provided by DVA on the new community nursing system was comprehensive and generally user friendly. It required careful reading because of the complexity of the services and the treatments veterans needed. Several suggested that DVA could provide more assistance to community nursing providers by producing a quick reference guide on most frequently used sections of the guidance material.

Evaluation of reform process

3.36 The ANAO notes that DVA has scheduled an evaluation of the community nursing reform process for 1999–2000. Given the complexity of the implementation process and its possible use as a model for more reform of allied health services, the ANAO supports the Department's evaluation.

Monitoring community nursing performance

3.37 At the time of the ANAO's fieldwork, the new contractual arrangements for community nursing were in the process of being introduced and bedded down. The ANAO considers that the current

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[23] This data set is a sub set of DHAC's Community Nursing Minimum Data Set Australia.

DVA community nursing arrangements have a sound management basis for monitoring contracts. The standards DVA expects contractors to meet are specified in contracts, and there are clear fee schedules and guidelines. The following controls are specified in the contract:

- a regular program of audits against contract requirements. Random audits are to be scheduled for accredited providers, and yearly for others;
- penalties for inappropriate servicing (overservicing, underservicing and fraud); and
- monitoring of payments by matching service data with provider and beneficiary data.

3.38 At the conclusion of the ANAO's fieldwork, the community nursing arrangements had been in place for 12 months, and, in accordance with the new system, DVA had recently begun a round of auditing of providers' activities in providing services.

4. Aspects of Administration and Reporting

This Chapter comments on selected aspects of DVA's administration of its health services in the community.

4.1 The ANAO found that, overall, DVA has a firm basis for its administration of veterans' health care arrangements. The audit did identify a few areas where DVA could enhance its performance. The main areas noted are outlined below.

Directions, Key Results Areas and state offices

4.2 The audit reviewed the different aspects of the administrative arrangements in terms of their presence or absence. Limitations of time and resources precluded a detailed evaluation of the relevance or effectiveness of particular arrangements, except in the case of community care health services covered in Chapters 2 and 3.

4.3 In general, DVA has clear directions for its health programs in the community. Some of these are prescriptive strategies that are reflected in decisions of the Repatriation Commission, in the Treatment Principles, or in the Repatriation Private Patient Principles. An example of a prescriptive strategy is that health services in the community health area are to be rendered by providers working in a contractual arrangement with DVA.

4.4 The Corporate Plan specifies Key Results Areas (KRAs) for administration, and the broad activities intended to achieve DVA's corporate outcomes. Two KRAs relevant to health services in the community are:

- quality service to the veteran community; and
- partnership with providers.

4.5 DVA defines the main objectives relevant to health under these two broad KRAs are:

- improving the range, accessibility, quality, timeliness and coordination of the services DVA provides to veterans or arranges on their behalf;
- optimising DVA's position as a competitive purchaser in the marketplace;
- monitoring standards of service delivery; and
- managing and developing productive contractual relationships.

4.6 DVA's state offices develop strategies for achieving each KRA and formalise them in their annual business plans. This is because health services are delivered by providers in the states, and DVA's state offices are responsible for ensuring that administrative arrangements for service delivery are working well.

4.7 The three state plans surveyed by the ANAO exhibited considerable differences, as shown by the following examples:

- two state offices had service delivery strategies concentrating on the needs of Vietnam and younger veterans and the third did not;
- one state office had a strategy for streamlining processes to improve veterans' access to health services; another listed an activity that would result in streamlining, but under a wider strategy; and the third listed a related but narrow goal.

4.8 These state office documents serve the purposes of each state office. They demonstrate also that DVA managers in the states have discretion in how they structure their activities. However, because of differences in the strategies reflected in these plans, there is no ready vehicle to ensure that national directions and KRAs could be advanced consistently for health administration. The differences in the strategies also complicate DVA's comparison of relative performance in health administration of each state against the KRAs, and consequently the identification and promulgation of best practice in program administration. The ANAO suggests that DVA identify a core of approaches common to all state offices to achieve national consistency in addressing corporate KRAs.

4.9 DVA would benefit from a set of common indicators to compare the performance in health administration of state offices. The monitoring of performance against such yardsticks could point to examples of best practice in the organisation and to areas where there might be shortcomings to overcome, and advance the national nature of DVA's activities.

Recommendation No.3

4.10 The ANAO recommends that the Department of Veterans' Affairs develop a minimum set of common indicators of performance in health administration for use by all state offices, with the aim of identifying efficient and effective administrative practice.

DVA response

4.11 *Agreed. The recent introduction of accrual and outcome budgeting provides an enhanced framework for identifying unit costs of delivery and administrative overheads.*

4.12 The ANAO notes that the Department's Health Care and Services Division in the National Office did not have a business plan for 1998–99. However, it did have other planning mechanisms in place, and is exploring options for developing a formal plan.

Guidelines

4.13 DVA has a wide range of formal guidance mechanisms for staff and health providers. For providers, DVA has service standard information in its contracts and associated provider guidelines, which regulates service provision. The provider guidelines are an important link between purchaser and provider in defining the type and quality of service required. For staff, this material includes an electronic reference copy of the Treatment Principles, the Administrative Handbook (Treatment) and National Office instructions to state offices.

4.14 The majority of users surveyed by the ANAO regarded the guidelines as informative and of good quality. However, the ANAO notes that this guidance material was not always current. For example:

- no progress had been made towards redeveloping the *Notes for Specialists* to provide more specific information about the Repatriation Commission's requirements in respect of specific medical specialist groups. The Department had expected this to be achieved by December 1998; and
- the electronic version of the Treatment Principles used by staff had not been revised to incorporate amendments relating to community nursing. The amendments had come into effect on 1 May 1998.

4.15 To ensure that staff have accurate information for making management decisions, to reduce the risk of wrong decisions and so that providers have current information and instructions, the ANAO suggests that DVA maintain the currency of its guidance material.

Communication with veterans

4.16 DVA has a broad range of communication mechanisms through which it liaises with stakeholders. This includes publications such as the *Vetaffairs* quarterly newspaper sent to all eligible cardholders and the six monthly journal *Veterans' Health* for health providers. It also includes consultative bodies such as the National Treatment Monitoring

Committee (composed of ESO representatives), the GP-based Local Medical Officer Advisory Committee and other forums with ESOs, such as the Aged Care Round Table. DVA's Veterans' Affairs Network is also a significant point of contact for veterans, providers and other stakeholders.

4.17 DVA recognises the difficulty of accurately targeting readers of information about departmental services, since veterans usually appreciate information on a specific topic only at the time they need it. As a result, DVA relies on LMOs to inform veterans during medical consultations about the health services they need at the time they need them. The ANAO notes that this expectation is not always met, but acknowledges that DVA is taking reasonable steps to communicate with this provider group.

Quality, cost-effectiveness and monitoring

4.18 In DVA's output reporting structure, one goal is to *'provide quality, cost-effective health care and support services'*.[24] This goal emphasises the importance to DVA of the quality of veterans' health care.

4.19 The main ways in which DVA pursues the quality of veterans' health care are:

- requiring providers to meet minimum professional standards, and including where appropriate, encouraging providers to have professional accreditation;
- expecting that health care providers will uphold their professional standards of care. DVA relies heavily on the standards, quality assurance practices and professionalism of the various health professional associations. These standards are included in DVA's contracts;
- monitoring the care provided to veterans; and
- a policy of LMO coordination of care.

4.20 DVA monitors the appropriateness of health care proposed by health practitioners through its prior approval and care plan processes. Prior approval processes are based on providers' approaching DVA for approval to provide particular services and, in this approval process, the Department uses the expertise of its specialist advisers in each state office. These advisers review requests for prior approval and make recommendations to the Department.

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[24] Output Group 2, Portfolio Budget Statements 1999–2000, Department of Veterans' Affairs (Defence Portfolio), Budget Related Paper No. 1.4B, p44.

4.21 At the time of audit, DVA was planning to move away from the prior approval model to one based on the inclusion, in contracts with providers, of specific quality guidelines and measures including clinical pathways, outcome measures, benchmarks and best practice. According to DVA, future arrangements might also involve audits of providers' records. As a step toward this, DVA is working to develop clinical pathways for community nursing services and health outcome measures for allied health services generally. Chapter 3 describes DVA's clinical pathways for community nursing.

4.22 As described in Chapter 3, health care is coordinated by the veteran's LMO, to whom other practitioners provide information on the veteran's health. Health professionals are required to do this as part of their contractual arrangements with DVA. LMOs receive copies of care plans completed by a number of allied health professional groups, outlining the treatment regime and levels of treatments proposed as well as the intended and achieved results, and are revised during the year as required. For specific veterans who have complex conditions, LMOs also complete Health Care Plans, discussed in Chapter 3.

4.23 In reference to DVA's understanding of the cost-effectiveness of its health services in the community ANAO considers DVA should take its current analysis further.

4.24 DVA seeks to maximise its health services purchasing power for the delivery of services to veterans. Current initiatives that demonstrate this include competitive tendering for private hospital services in Victoria, and initiatives to replace the current prior approval arrangements with more timely and less resource intensive administrative arrangements.

4.25 The challenge for DVA in its analysis of the cost-effectiveness of its arrangements will lie in developing and applying a definition of cost-effectiveness, specifying clearly the outputs it expects from its purchases, and developing a fuller understanding of the links between its outputs and the qualitative outcomes achieved by services that it provides directly or indirectly. DVA is planning to use benchmarking processes to facilitate comparisons with similar health services. The ANAO supports this intention.

4.26 DVA did not have performance information on the results of the services provided under many of its health provider contracts, so it has a limited capacity to prepare performance indicators against which it could monitor the quality of the services it funds. Progress in developing performance measures in the health industry generally varies and the ANAO acknowledges the complexity of the task.

4.27 Because of the difficulty of developing outcome measures, DVA monitors the provision of the health services it funds mainly by systems based on approval and payment data, and as the Department follows up queries or complaints. DVA also monitors its performance in managing contracts for health services.

4.28 Current monitoring systems do not include data on services provided to the veteran community by programs managed by other agencies, such as state departments of health and DHAC. ANAO notes that data from these sources may currently be inadequate for DVA monitoring purposes but that the coverage and quality of available data is being continually upgraded.

4.29 As discussed in Chapter 2, the ANAO is aware that at least one state office is trying to fill this gap to get a better understanding of veterans' total health care needs and to identify where there might be shortfalls. To aid planning, management and coordination, the ANAO suggests that DVA supplement its existing data with data from other Commonwealth and state government agencies that fund health services to veterans, where and when this is available.

4.30 DVA has a program of reviews of health care arrangements. Two recent departmental reviews were of the Repatriation Private Patient Scheme and the Repatriation Comprehensive Care Scheme. Another major review—called the Health Review—was, at the time of audit, in progress. An evaluation of health care planning will also be completed during the year and, as mentioned in Chapter 3, the Department is reviewing key aspects of its funding of community nursing for veterans.

Performance Information

4.31 The 1999–2000 Portfolio Budget Statements (PBS) include $1.9 billion for veterans' hospitals and health services. The output is called '*arrangements for delivery of services*'. The price of this output is $52.7 million. The treatment population was 354 000 and from this the average per capita administrative cost was calculated as $149. The ANAO notes that the performance information in the PBS correctly represent the information required by DOFA for accrual budgeting. However, in the ANAO's view, disclosure could be enhanced.

4.32 The 1999–2000 PBS includes as performance information, veteran satisfaction with the choices they have and the quality of the care they receive. The performance information is collected from surveys of veterans. These surveys are important sources of data for the Department. The target is a high percentage of cardholders who report satisfaction with the standard of health care received through DVA arrangements.

4.33 DVA acknowledged that there were limitations in using these surveys as a measure of performance for all health services provided under DVA arrangements. The ANAO notes that the following factors will impact on the quality of the data collected:

- anecdotal evidence from some DVA staff in state offices suggested that it was common for veterans to express anxiety about the possible reduction of health benefits offered by the Department. Therefore, surveys would be expected to show a high level of veteran satisfaction with departmental services;
- since services are provided by health professionals in the community, private and other government sectors, veterans' dissatisfaction normally would be expressed in the first instance to those providers, and then not necessarily to the Department;
- movements in any measure of satisfaction across the entire veteran population would tend to be small unless there were special circumstances. It would be very difficult to gauge the significance of small movements in an index of veteran satisfaction with the quality of departmental health care, especially because factors outside the Department's control may lead to movements in the index;
- in addition, respondents' perceptions of unrelated matters can influence their responses to specific questions. DVA advised that these unrelated issues could include respondents' perceived need for continuation of the care about which comment is provided. As a result their impressions were not always concerned with the outcome or effectiveness of the treatment provided; and
- in general, DVA did not ask questions about veterans' satisfaction with particular groups of health care services, such as those by allied health practitioners.[25] DVA used the results of its veterans satisfaction surveys in a direct way only in the activity areas, such as hospitals, about which its surveys asked specific questions.

4.34 ANAO suggests that a broader range of performance information is necessary to provide a more accurate measure of departmental performance.

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[25] In regard to other departmental survey data on veterans, much of the material in a 1998 report (*Australian Veterans and War Widow—Their Lives and Needs*), based on a 1997–98 survey commissioned by the Department was descriptive rather than evaluative. Another 1998 departmental report was based on the results of a 1997 survey of entitled veterans, war widows and their carers. That report did include some questions on health care issues. However, its main purpose was to revise 1992 data on clients and their carers.

4.35 A second issue is the utility of heavy departmental reliance on the one measure for its large $1.9 billion expenditure on relevant health services. DVA has a holistic approach to specifying its health outcomes. From that perspective, it is only necessary to state in a one line appropriation that it has $1.9 billion for hospital and health services. Consequently, the price of the administrative output it reports is the price of providing hospital and health services for all DVA card holders.

4.36 However, although hospital and health services are both concerned primarily with the health of veterans, there are differences between these types of services, especially in their delivery mechanisms. For example, the Department purchases hospital services from a relatively small number of state governments and private hospitals and those services tend to be comparatively high cost items. In contrast, the Department purchases community health services from a relatively much larger number of small non-hospital health care providers which are small businesses. Where there are significant differences in the nature of purchasing, in the cost of hospital and health services, and in the nature of the hospital and health services industry sectors, there are sufficient reasons for the Department to increase its disclosure of its use of the $1.9 billion appropriation.

4.37 The very high level of aggregation in a single line appropriation of $1.9 billion, with the same outputs and outcomes summarising all its diverse components, makes it difficult for the Department to demonstrate its success in providing for the hospital and health care of veterans and their dependants. The absence of separate objectives or outputs for the hospital and health service sectors clouds the nature of the financial relationship between these two sectors, so it is not possible, for example, to determine whether the Department expects its expenditure on health care, including preventive care, to affect the rate of growth of its expenditure on hospital care. Such a financial relationship can be expressed in health output or outcomes terms. The Department should consider presenting the PBS in a way that better informs Parliament of the performance of key elements of the program. It could do this, for instance, through separation of its objectives for hospital and non-hospital care, and ideally through further subdividing its objectives for different components of care in the community.

4.38 The 2000–2001 PBS will report whether the Department used all its 1999–2000 appropriation of $1.9 billion for hospital and health services. That will be the clearest information the Parliament and stakeholders will receive in 2000–2001 about the use of $1.9 billion, because, for the reasons stated above, it will be difficult to interpret performance information reported in that year on any high level of veteran satisfaction the Department might measure.

4.39 The text of the 1999–2000 PBS refers to the Department's approach to competitive tendering and contracting for its services, informing readers that the Department provides no services directly under the relevant Budget output. The Department is one of the largest purchasers of health services in Australia. The planned 1999–2000 output does not reflect the PBS' textual explanation that the greatest proportion of the $1.9 billion will be used to purchase hospital and health services.

4.40 The Department has a great deal of data about veterans' health, giving it the capacity to determine whether, for instance, its investment in health services is increasing or decreasing its expenditure on hospital services. The Department's creation of a new management information system (called DMIS), to include most departmental data on its clientele's health services, is departmental recognition of the importance of creating even more understanding of use of its resources to assist veterans.

Recommendation No.4

4.41 The ANAO recommends that the Department of Veterans' Affairs, in its health outputs for the 2000–2001 Budget,:

- refer to its key role as a purchaser of hospital and health services; and
- include performance indicators which directly measure DVA's output performance, as a health service purchaser, for different major types of health services, in addition to those relating to client satisfaction.

DVA response

4.42 *Agreed. DVA has customarily reported on levels of usage of health services by type of service and veteran satisfaction with services. Information can be presented on DVA's effectiveness as a health purchaser.*

Canberra ACT
4 February 2000

P. J. Barrett
Auditor-General

Appendix

Appendix 1

DVA's Services for Veterans aged 70 Years and Over, 1998.

					Older Veterans (including War Widows) Receiving Services, as a percentage of the DVA Treatment Population						
State	*Region Name*	*RRMA Classification (a)*	*1996 Index of Relative Socio-Economic Disadvantage (SEIFA) (b)*	*DVA Treatment Population 70 + Gold Card only*	*LMO Consultations (c)* %	*Dental Services* %	*Optical Services* %	*Community Nursing* %	*Physio-therapy* %	*Podiatry* %	*Average Per Capita Spending (d) (e)* $
(Col 1)	**(Col 2)**	**(Col 3)**	**(Col 4)**	**(Col 5)**	**(Col 6)**	**(Col 7)**	**(Col 8)**	**(Col 9)**	**(Col 10)**	**(Col 11)**	**(Col 12)**
0 - 20th Percentile											
WA	Pilbara	Remote	995	22	73	18	14	0	5	0	172
NT	East Arneham	Remote	817	7	71	14	0	0	0	0	186
NT	Barkly	Remote	846	4	50	0	0	0	0	0	196
WA	Midlands	Rural	981	376	89	14	2	0	7	3	293
WA	Goldfields	Remote	980	248	81	17	27	0	5	11	315
QLD	North West	Remote	940	99	89	6	11	14	4	0	330
NT	Katherine	Remote	892	13	100	8	23	0	0	0	439
SA	Whyalla, Flinders & Far North	Remote	924	229	97	18	49	3	10	7	452
WA	Mid West	Remote	961	493	99	29	34	0	13	17	460
SA	South East	Rural	977	813	87	27	43	4	18	31	464
SA	Mid North	Rural	928	421	99	29	46	0	11	4	465
NSW	Far West	Remote	914	702	81	25	23	8	6	4	485
NT	Darwin	Large Urban	1001	201	100	43	26	0	19	16	494
SA	Eyre Peninsula	Rural	964	371	96	28	46	0	16	2	503
Average—1st Quintile											**375**

					Older Veterans (including War Widows) Receiving Services, as a percentage of the DVA Treatment Population						
State	*Region Name*	*RRMA Classification (a)*	*1996 Index of Relative Socio-Economic Disadvantage (SEIFA) (b)*	*DVA Treatment Population 70 + Gold Card only*	*LMO Consultations (c)* %	*Dental Services* %	*Optical Services* %	*Community Nursing* %	*Physio-therapy* %	*Podiatry* %	*Average Per Capita Spending (d) (e)* $
(Col 1)	**(Col 2)**	**(Col 3)**	**(Col 4)**	**(Col 5)**	**(Col 6)**	**(Col 7)**	**(Col 8)**	**(Col 9)**	**(Col 10)**	**(Col 11)**	**(Col 12)**
21st - 40th Percentile											
QLD	Central West	Remote	969	89	96	6	0	0	0	0	504
SA	Yorke, Lower North & Barossa	Rural	969	1143	100	22	30	1	13	13	512
WA	Great Southern	Rural	988	612	99	30	24	0	12	26	535
NT	Alice Springs	Remote	947	44	100	20	36	0	18	30	570
WA	South West	Rural	965	2155	100	35	32	0	18	27	578
QLD	South West	Remote	960	233	94	18	18	7	10	0	580
SA	Riverland	Rural	948	489	100	31	39	7	20	23	585
VIC	Gippsland	Rural	984	3220	100	23	46	11	14	36	587
NSW	Mid Western	Rural	982	1981	100	28	25	2	12	31	607
SA	Metro North	Capital	956	1407	90	32	39	0	17	54	608
WA	Kimberley	Remote	913	22	100	59	23	0	32	0	608
TAS	North Western	Rural	945	1673	100	18	43	15	11	39	609
SA	Hills, Mallee & Southern	Rural	984	1424	100	29	33	7	18	33	614
NSW	Macquarie	Rural	962	1186	100	29	42	8	13	31	615
QLD	Fitzroy	Rural	972	1590	100	36	35	12	18	16	622
Average—2nd Quintile											**582**

					Older Veterans (including War Widows) Receiving Services, as a percentage of the DVA Treatment Population						
State	*Region Name*	*RRMA Classification (a)*	*1996 Index of Relative Socio-Economic Disadvantage (SEIFA) (b)*	*DVA Treatment Population 70 + Gold Card only*	*LMO Consultations (c)* %	*Dental Services* %	*Optical Services* %	*Community Nursing* %	*Physio-therapy* %	*Podiatry* %	*Average Per Capita Spending (d) (e)* $
(Col 1)	**(Col 2)**	**(Col 3)**	**(Col 4)**	**(Col 5)**	**(Col 6)**	**(Col 7)**	**(Col 8)**	**(Col 9)**	**(Col 10)**	**(Col 11)**	**(Col 12)**
41st - 60th Percentile											
VIC	Loddon Mallee	Rural	993	4092	100	23	29	12	16	40	626
VIC	Barwon-South Western	Large Urban	996	5249	100	26	30	12	21	34	635
QLD	West Moreton	Lge Urban	961	1372	100	27	19	12	20	31	636
NSW	New England	Rural	978	2737	100	34	19	9	14	29	638
QLD	Northern	Lge Urban	981	1762	100	37	36	11	19	24	647
NSW	Greater Murray	Rural	993	3682	99	29	37	9	15	29	648
VIC	Hume	Rural	997	3934	100	21	40	13	15	35	649
QLD	Logan River Valley	Capital	970	1298	99	34	31	13	18	11	651
VIC	Northern Metro	Capital	994	6503	100	23	22	1	21	39	654
WA	Metro East	Capital	1010	3001	100	36	27	0	17	40	661
SA	Metro South	Capital	1017	4897	99	42	34	0	19	39	662
VIC	Western Metro	Capital	979	3692	97	40	38	2	14	54	672
QLD	Mackay	Rural	984	932	100	25	49	11	23	19	695
VIC	Grampians	Rural	995	2942	100	20	30	15	17	37	704
Average—3rd Quintile											**656**

					Older Veterans (including War Widows) Receiving Services, as a percentage of the DVA Treatment Population						
State	*Region Name*	*RRMA Classification (a)*	*1996 Index of Relative Socio-Economic Disadvantage (SEIFA) (b)*	*DVA Treatment Population 70 + Gold Card only*	*LMO Consultations (c)* %	*Dental Services* %	*Optical Services* %	*Community Nursing* %	*Physio-therapy* %	*Podiatry* %	*Average Per Capita Spending (d) (e)* $
(Col 1)	**(Col 2)**	**(Col 3)**	**(Col 4)**	**(Col 5)**	**(Col 6)**	**(Col 7)**	**(Col 8)**	**(Col 9)**	**(Col 10)**	**(Col 11)**	**(Col 12)**
61st - 80th Percentile											
TAS	Northern	Rural	966	2606	100	19	41	18	16	38	705
QLD	Wide Bay Burnett	Rural	925	2934	100	34	32	10	22	24	713
QLD	Darling Downs	Rural	981	2661	100	32	34	11	22	30	720
VIC	Eastern Metro	Capital	1075	10089	100	35	23	1	20	50	721
SA	Metro West	Capital	943	3625	97	37	24	10	16	38	721
QLD	Caboolture	Capital	985	3588	100	39	40	9	26	18	727
WA	Metro South	Capital	1004	4767	100	45	46	0	19	47	728
QLD	Far North	Rural	978	1628	100	36	33	12	19	21	728
NSW	West Sydney	Capital	1004	5105	98	31	16	4	18	41	741
NSW	Southern	Rural	1004	2565	100	38	35	9	15	28	743
TAS	Southern	Lge Urban	992	4206	100	26	44	17	22	48	768
NSW	Wentworth	Capital	1030	2146	100	36	18	1	18	39	776
NSW	South West Sydney	Capital	959	5462	100	31	22	4	15	43	780
WA	Metro North	Capital	1042	4899	99	46	17	32	19	42	803
NSW	Hunter	Lge Urban	972	6815	100	34	23	11	21	37	813
Average—4th Quintile											**746**

					Older Veterans (including War Widows) Receiving Services, as a percentage of the DVA Treatment Population						
State	*Region Name*	*RRMA Classification (a)*	*1996 Index of Relative Socio-Economic Disadvantage (SEIFA) (b)*	*DVA Treatment Population 70 + Gold Card only*	*LMO Consultations (c)* %	*Dental Services* %	*Optical Services* %	*Community Nursing* %	*Physio-therapy* %	*Podiatry* %	*Average Per Capita Spending (d) (e)* $
(Col 1)	**(Col 2)**	**(Col 3)**	**(Col 4)**	**(Col 5)**	**(Col 6)**	**(Col 7)**	**(Col 8)**	**(Col 9)**	**(Col 10)**	**(Col 11)**	**(Col 12)**
81st - 100th Percentile											
NSW	Illawarra	Lge Urban	973	3942	100	38	41	12	24	41	816
QLD	Brisbane South	Capital	1014	5796	100	43	23	10	22	48	821
ACT	Australian Capital Territory	Large Urban	1091	1780	100	48	23	11	33	52	826
VIC	Southern Metro	Capital	1026	13808	100	35	25	18	26	46	829
NSW	Mid North Coast	Rural	947	5918	100	40	46	12	27	36	849
QLD	Brisbane North	Capital	1050	7959	100	50	27	10	27	42	858
QLD	Sunshine Caloola	Rural	967	4126	100	48	40	9	31	35	886
SA	Metro East	Capital	1039	3897	100	61	45	22	25	57	895
NSW	Sth East Syd	Capital	1058	8901	100	46	21	4	26	52	900
NSW	Northern River	Rural	957	5646	100	41	39	15	23	38	909
NSW	North Sydney	Capital	1121	10917	100	53	15	4	29	49	977
NSW	Central Coast	Capital	983	6873	100	40	29	13	26	51	996
QLD	South Coast	Lge Urban	988	5439	100	50	47	11	39	43	1012
NSW	Central Sydney	Capital	1003	4593	100	48	20	38	25	53	1123
Average—5th Quintile											**907**
Average											**653**

(a) ABS Rural, Remote and Metropolitan Areas Classification —Large Urban areas include large urban centres and often with extensive rural areas as well.
(b) Source: 1996 Census of Population and Housing Socio-Economic Indexes for Areas Cat. no. 2039.0
(c) The percentage refers to the percentage of older veterans holding the gold card who made use of DVA purchased LMO consultation services in 1998. A similar interpretation can be made of the percentages in columns 7 to 11.
(d) Source: DVA cost of services—Community Health Section DVA data for year ending September 1998
(e) Source: Average cost per head calculated by ABS-ANAO.

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