

The Auditor-General  
Audit Report No.51 2000–2001  
Performance Audit

# **Australian Defence Force Health Services Follow-up Audit**

**Department of Defence**

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Canberra ACT  
15 June 2001

Dear Madam President  
Dear Mr Speaker

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

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



Ian McPhee  
Acting Auditor-General

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

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**Audit Manager**

Scott Haig

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# Abbreviations

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ADF	Australian Defence Force
ANAO	Australian National Audit Office
CDPs	Central Dispensing Points
CSP	Commercial Support Program
DCP	Directorate of Clinical Policy
DEFMIS	Defence Financial Management Information System
DEPHADS	Defence Pharmacy Dispensing and Stock Management System
DGDHS	Director General Defence Health Service
DHS	Defence Health Service
DHSB	Defence Health Service Branch
DPE	Defence Personnel Executive
H&HP	health and human performance
HDPE	Head, Defence Personnel Executive
HealthKEYS	Health Key Solution
JCPAA	Joint Committee of Public Accounts and Audit
JHSA	Joint Health Support Agency
JP 2060	Joint Project 2060 ADF Deployable Health Capability
KPI	Key Performance Indicator
OSGADF	Office of the Surgeon General Australian Defence Force
PMKEYS	Personnel Management Key Solution
ROMAN	Resource and Output Management and Accounting Network
SGADF	Surgeon General Australian Defence Force





# **Summary and Recommendations**



# Summary

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## Background

1. The Australian National Audit Office (ANAO) has followed up its 1997 performance audit report on Australian Defence Force (ADF) health services (Audit Report No.34 1996-97 *Australian Defence Force Health Services*). ADF health services have two main aims: to maintain military personnel at required standards of health and fitness; and to provide deployable medical services in support of military operations.
2. The 1997 audit focused on the first of these two aims, that is, the delivery of non-operational health services to entitled ADF members. It found that the ADF provided high quality health services to its members, with a strong emphasis on prevention; health service administrative structures were complex and fragmented and led to inefficiencies and inequities in the provision of health services; costs associated with ADF health care were significant; and there was considerable scope for Defence to improve the efficiency and effectiveness of service delivery.
3. The audit report made 19 recommendations to improve the efficiency and administrative effectiveness of ADF health services. Defence agreed to all but one of the recommendations, noting that this recommendation would require a comprehensive study before a response could be given. The report was reviewed in 1998 by the Joint Committee of Public Accounts and Audit (JCPAA). The Committee was supportive of the audit report and made recommendations consistent with the ANAO's conclusions.
4. ADF health services have been re-organised since the original audit was conducted. A jointly staffed and integrated Defence Health Service (DHS) has been created under the Defence Personnel Executive. It consists of the Defence Health Service Branch (DHSB), the Joint Health Support Agency (JHSA) and 12 Area Health Services. Health support to ADF operations is still provided by health units under the direct command and control of the ADF's environmental commands.
5. The objective of the follow-up audit was to assess Defence's implementation of recommendations made in the original audit report and their effectiveness in improving ADF health services. In view of the number of recommendations made in the original audit report and by the JCPAA, this report does not make further recommendations but identifies where recommendations have not been fully implemented and where further action is required.

## Conclusion

6. Defence has made progress in fully, or partially, implementing all of the ANAO's recommendations and these actions have improved the efficiency and effectiveness of ADF health services. There has been commendable work in establishing a health and human performance research committee; developing a corporate planning framework; reviewing the potential for cost recovery; forming health specialist consultative groups; reviewing the dental service workforce structure; developing common standards and processes; and preparing an ADF Health Status Report. The ANAO also supports initiatives and developmental work in progress in the following areas: customer/supplier agreements between the JHSA and the Services for non-operational health delivery; guidance on establishing strategic health alliances with civilian health facilities; a more flexible career structure for medical officers; and long-term strategies to reduce injuries and illness in the ADF.

7. Although there has been substantial organisational change in ADF health services and shortages in uniformed health personnel still persist, implementation of the ANAO's recommendations has been slow. Many of the recommendations have only been partially implemented and considerable work remains to be done. In particular, up-to-date information on the cost of providing health services is still not readily available, and this is impairing effective management decision-making. Full implementation of many of the outstanding recommendations relies on the introduction of a suitable ADF-wide health information system, the outcomes of the national rationalisation and market testing program and the outcomes of the Defence's review of ADF deployable health capability. Defence should give priority to the completion of these tasks in the interests of greater efficiency and effectiveness.

8. Progress is needed in the following areas: developing further strategic alliances; completing a review of pathology services; reviewing the usage and availability of therapeutic substances; devolving responsibility for costs associated with compensable injuries and illness to sub-program managers; and improving command and control arrangements associated with delivery of non-operational health services.

# Key Findings

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9. Set out below are the ANAO's key findings from its follow-up audit in relation to each of the original recommendations. (Priority recommendations are marked with an asterisk.) The original recommendations are detailed in the relevant chapters. Unless it is explicitly indicated that the recommendation has been addressed, implementation action is considered to be still in progress.

## **Policy, Resourcing and Corporate Planning (Chapter 2)**

### *Recommendation No.1\**

- Defence has not yet established the minimum level of health service resources essential to support military operational requirements, but is reviewing its requirement. Defence is progressively assessing the scope for achieving efficiencies in the provision of non-operational health services through a program of rationalisation and market testing, but progress in doing so has been slow. A significant amount of work has been undertaken in developing rationalisation studies and market testing documentation but rationalisation recommendations have not yet been implemented and a preferred tenderer has not been selected to provide health services to any Defence regions.

### *Recommendation No.2*

- Defence has assessed the merits and implications of a member contribution to the cost of any health services additional to those required for the maintenance of individual readiness or that are outside the ADF's duty of care to its members. It has done this through a review of its instruction on the provision of health care to ADF members (currently in draft form). Under the proposed arrangements members would be required to pay fully or partly for the costs associated with any health services that were unnecessary for operational readiness. This addresses the concerns that originally prompted the recommendation.

### *Recommendation No.3\**

- Defence has given the development of common health standards and processes priority and therefore has addressed this recommendation. However, scope remains for further development of common standards and processes, particularly in the areas of health policy, documentation, training and standards of care.

#### *Recommendation No.4*

- Defence has consulted relevant parties when developing health policy and, in most cases, has taken account of cost implications of new health policy. Policy development guidance could more explicitly note the requirement for cost/funding implications for all new policies to be identified and documented. Defence has substantially implemented the recommendation.

#### *Recommendation No.5\**

- The Defence Health Service has developed a strategic plan that provides a framework for development of business plans for all its subordinate organisations. However, it lacks the necessary systems to monitor and report adequately the plan's key performance indicators (KPIs). Some of the KPIs and goals included in the plan need to be made clearer to aid in their measurement and the linkages between the plans outcomes, goals and KPIs need tightening. Defence had made progress in implementing the recommendation but further work is needed to secure the improvements in performance that are available.

### **Organisation and Staffing (Chapter 3)**

#### *Recommendation No.6\**

- Action to address this recommendation has been slow. Establishment of the DHSB and JHSA partially implemented the recommendation. However, full command and control of all health resources has not been transferred to the DHS as Defence considered such an arrangement to be inconsistent with the overall command and control paradigm in the ADF. The ANAO notes that determined efforts need to be made to address command and control issues associated with the JHSA's effective operation.
- Defence is developing customer/supplier agreements between the JHSA and the three Services for delivery of non-operational health services. Control of financial resources relating to the payment of external service providers has been transferred to the JHSA.

#### *Recommendation No.7*

- As recommended, Defence has examined the medical officer career structure and is developing a new structure which incorporates employment of specialist medical officers, career streaming and some scope for promotions for general practice clinicians. The cost of the new structure has not been assessed. Progress on the recommendation has been slow but the proposed salary and career structures, if implemented, should provide greater flexibility, improve operational

effectiveness and assist in the recruitment and retention of medical officers.

#### *Recommendation No.8*

- A committee had been established to oversee the general program of health and human performance research in Defence and determine priorities for allocating resources to this research. Although progress has been slow in establishing the committee, the ANAO considers that action taken by Defence addresses this recommendation.

### **Facilities Planning and Utilisation (Chapter 4)**

#### *Recommendation No.9\**

- Despite serious data deficiencies, Defence is costing ADF hospitals and medical centres as part of its regionally-based rationalisation and market testing program. Although costing information was not in a format that allows the cost of ADF in-patient beds to be compared with that of civilian facilities, Defence rationalisation studies completed so far confirm that there is considerable inefficiency in the delivery of in-patient services. The recommendations of these studies have not been agreed or implemented. Although slow to do so, Defence is now addressing the recommendation.

#### *Recommendation No.10\**

- There have been impediments to developing strategic alliances to give ADF health personnel experience in emergency treatment of wounds and injuries. However, it could reasonably have been expected that suitable alliances, similar to that established by Army with Liverpool Hospital in 1998, would have been in place by now. To assist ADF health units in establishing strategic alliances, Defence is developing general guidance. Progress in relation to the recommendation has been slow and further work is needed.

#### *Recommendation No.11\**

- Although it has taken some time to do so, Defence has examined the costs and benefits of contracting out or centralising pathology services. A review of pathology services in the ADF found that current pathology service delivery arrangements are inefficient and recommended that pathology services be outsourced. The ANAO considers that, to complete the implementation of this recommendation, a review of ADF deployable pathology capability should be undertaken and its findings, and those of the earlier review, used to develop an ADF-wide pathology services delivery model.

## **Financial Administration (Chapter 5)**

### *Recommendation No.12\**

- Defence still does not maintain up-to-date information on the full costs of providing health services and this continues to impair effective management decision-making. Baseline costings of the delivery of health services in Victoria and Southern NSW/ACT have proved difficult and time consuming to develop, due to the lack of cost and activity data. Information systems are being developed to improve Defence's ability to monitor and control costs associated with the Defence Health Service. Primary among these is a system called HealthKEYS.

### *Recommendation No.13*

- Defence has examined the health services provided by the ADF to civilians and found that there was limited scope for cost recovery, primarily due to the infrequent and emergency nature of most of the health services provided to them. Defence has also developed an instruction on the recovery of health costs associated with treatment provided to an ADF member at Commonwealth expense, where that member has an enforceable claim for damages against a third party. The instruction has assisted in a greater recovery of ADF health costs from third parties. Defence has addressed this recommendation.

## **Health Information Systems (Chapter 6)**

### *Recommendation No.14\**

- The Health Systems Redevelopment Project, an information system that was planned to address ADF's health management information needs, was cancelled in 1997. A new system, HealthKEYS, is being developed with out-patient, dental and financial management sub-systems. It is expected to cost in excess of \$15 million but only \$2.7 million has been approved so far. In response to technical and cost risks associated with the project, Defence has established a HealthKEYS Project Board. The system is to be tested at three lead sites in May 2001. Phase 1 of the project is expected to be completed in 2002–2003. Once fully implemented, the system should address many of the health management information deficiencies identified by the original audit.

## **Occupational Health and Safety (Chapter 7)**

### *Recommendation No.15\**

- Defence has given greater attention to epidemiological research on injuries and illnesses through a number of initiatives, including the



development of an ADF Health Status Report and a proposed joint surveillance unit.

- Short-term strategies to reduce injuries and illness in the ADF have been limited to reducing injuries among recruits, but short-term strategies with wider application to the ADF population could have been developed based on existing studies. Three long-term strategies have been developed by Defence on injury prevention, cardiovascular health and mental health.
- Defence is still unable to identify all costs associated with compensable injuries and illness but is making progress towards this goal through the development of HealthKEYS and its linkage with DEFCARE. Budget responsibility for all costs associated with compensable injuries and illness has not been devolved to relevant sub-program managers as recommended by the ANAO.

## **Dental Services (Chapter 8)**

### *Recommendation No.16\**

- Defence has not reviewed in detail ADF dental service work practices and standards of care. It will do this as part of a quality assurance program in 2001. Defence has reviewed the number of dental personnel and proposed a more cost-effective workforce structure involving a mixture of civilian and uniformed dental staff. The proposed structure has only in-principle support from the Services and is therefore yet to be implemented.

## **Health Materiel (Chapter 9)**

### *Recommendation No.17\**

- The Therapeutic Advisory Working Party has not been reactivated and there has been no comprehensive review of the availability and usage of therapeutic substances. A preliminary review of therapeutic substances found that, before a thorough review could be conducted, members' health care entitlements needed to be clearly defined. Defence is still unable to monitor centrally the prescribing and dispensing patterns of its medical practitioners and pharmacists but the introduction of HealthKEYS and a new pharmacy management information system should improve this situation.

### *Recommendation No.18*

- Arrangements for dispensing and issuing pharmaceuticals have been reviewed and policies have been issued, as recommended. A new pharmacy management information system is also being introduced which should enhance Defence's ability to monitor the issuing and dispensing of pharmaceuticals.

- Defence considers the current number of pharmacists in the ADF to be the minimum needed to support the ADF safely but there is scope to civilianise a number of uniformed positions. There are also indications that the requirement for uniformed pharmacists may be better met on a single-Service basis.

#### *Recommendation No.19*

- The prime vendor is keeping appropriate quantities of ADF preferred brands of pharmaceutical supplies in stock. Logistics and health staff are minimising the risk of more expensive items being supplied as alternatives to generic brand items by providing monthly updates of the pharmaceutical standing offer list to Central Dispensing Points and by reviewing monthly reports from the prime vendor. The prime vendor contract has been amended to improve performance and minimise costs. Defence has addressed this recommendation.

## **Response to the report**

10. Defence agreed with the thrust of this report. It acknowledged that a number of recommendations remained outstanding but considered that they were dependent, in one form or another, upon the completion of two major long-term projects (HealthKEYS and Joint Project 2060 *ADF Deployable Health Capability*) and the completion of the Commercial Support Program.

# **Audit Findings and Conclusions**



# 1. Introduction

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*This chapter provides an overview of the original audit, its subsequent review by the Joint Committee of Public Accounts and Audit in 1998 and the organisational changes to ADF health services that have occurred since the original audit. It also sets out the audit objective and methodology.*

## The 1997 audit

**1.1** The ANAO has carried out a follow-up audit of a 1997 performance audit report on Australian Defence Force (ADF) Health Services.<sup>1</sup> The objective of the 1997 audit was to assess the efficiency and administrative effectiveness of Defence's<sup>2</sup> provision of health services to full-time members of the ADF. Its scope included the following issues: health care policy; strategic planning; resource management; the delivery of health care; the operation of and planning for major health facilities; health care management information systems; occupational health and safety; and health materiel.

**1.2** The primary focus of the 1997 audit was on the peacetime support activities of ADF health services as this area consumed most of the resources expended. It was acknowledged, however, that the primary purpose for maintaining this peacetime capability was to ensure the availability of well trained and equipped health personnel to support operational deployments. The original audit found that:

- ADF health services provided high quality health services to its members with a strong emphasis on preventative health care;
- the ADF health service had demonstrated the ability to provide effective health support to military operations;
- health service administrative structures were complex and fragmented and led to inefficiencies and inequities in the allocation of health services, and that a more effective management of health services could be achieved if these structures were rationalised and placed under centralised command and control;
- the costs associated with ADF health care were significant and there was considerable scope for Defence to improve the efficiency and effectiveness of service delivery; and

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<sup>1</sup> Audit Report No.34 1996-97 *Australian Defence Force Health Services* (May 1997).

<sup>2</sup> 'Defence' comprises the Department of Defence and the ADF (Navy, Army and Air Force).

- there was a need to develop common ADF policy, improve corporate planning and to attend to under-used health facilities, inadequate financial and health information systems and the high costs associated with ADF workplace injuries and illnesses.

1.3 The original report conservatively estimated the total cost of operating ADF health services to be about \$400 million a year. This represented an average cost per member of \$6800 a year.

1.4 The original report made 19 recommendations. Defence agreed to all but one (No.2), noting that this recommendation would require a comprehensive study before a response could be given. The recommendations are set out throughout this follow-up report. Those recommendations considered to be priority recommendations by the original report are identified with an asterisk.

## Review by Joint Committee of Public Accounts and Audit

1.5 The audit report was reviewed by the Joint Committee of Public Accounts and Audit (JCPAA), which reported on its review in 1998.<sup>3</sup> Defence gave evidence to the JCPAA review and commented, *inter alia*:

*At the time of this ANAO audit there were a number of reviews into health services being conducted within the ADF. This report from ANAO has taken cognisance of those reviews and added new perspectives that were not contained in the reviews under way. I would like to say from the outset that in that context this report provided by the ANAO has been most useful to the ADF and Defence as a whole. ...*

*The recommendations of the report were, in the main, agreed to by Defence and have been reflected in the Defence Efficiency Review. Many of the measures necessary have been set in train and are occurring at the moment at an extremely fast pace. One of the major recommendations—that is, the formation of a Defence Health Service—has been effected.<sup>4</sup>*

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<sup>3</sup> Joint Committee of Public Accounts and Audit, *Review of Auditor-General's Reports 1996-97, Fourth Quarter, Report 359* (March 1998). Public hearing was held 25 July 1997.

<sup>4</sup> Appendix VI, Transcript of evidence, Major General Peter Dunn, Head, Defence Personnel Executive, PA 4.

1.6 The JCPAA was supportive of the audit report. In its review the JCPAA expressed concern about the audit findings and made recommendations in support of the ANAO's conclusions.<sup>5</sup> These recommendations are referred to in relevant sections of this report.

## Changes since 1997

### *Defence Health Service Branch*

1.7 As a result of the ANAO's original audit and the Defence Efficiency Review (which began when the audit was nearing completion), there have been major organisational changes to ADF health services.<sup>6</sup> The Office of the Surgeon General ADF (OSGADF) has been restructured and renamed the Defence Health Service Branch (DHSB). The DHSB is headed by the Surgeon General Australian Defence Force (a 'two-star' Reserve member of the ADF), and three single-Service Assistant Surgeon Generals ('one-star' Reservists). The Director General Defence Health Service, a full-time appointment, is responsible for managing the day-to-day activities of the DHSB. DHSB develops strategic health policy, provides strategic level health advice and exercises technical<sup>7</sup> and financial control over ADF health units.

1.8 The previous eight health directorates have been merged into four directorates of the DHSB. The Directorates are Health Resources, Preventative Health, Health Capability and Development and Clinical Policy. In addition to the four directors, three specialist adviser positions have been established in the areas of nursing, dental and psychology. The responsibilities of the Surgeon General ADF and DHSB staff are outlined in Appendix 1.

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<sup>5</sup> Defence responses to the JCPAA's recommendations are in *Finance Minute: JCPAA Report 359, Review of Auditor-General's Reports 1996-97 Fourth Quarter (11 November 1998)*.

<sup>6</sup> The ANAO provided advice to Defence Efficiency Review staff and made the preliminary findings and conclusions from the audit report available to Defence in January 1997.

<sup>7</sup> Technical control is the specialised or professional guidance and direction exercised by an authority in technical or professional matters.

## *Joint Health Support Agency*

**1.9** A single, joint, integrated organisation called the Joint Health Support Agency (JHSA), which is subordinate to the DHSB, was established in January 1998. It was established to achieve efficiencies in the delivery of health care in the National Support Area (NSA)<sup>8</sup> by avoiding duplication of effort and achieving economies of scale. The JHSA was formed from the single-Service health support elements in Navy Support Command, Army Logistic Command and Air Force Training Command. The role of the JHSA is to coordinate the provision of health services to entitled members in the National Support Area through 12 Area Health Services (AHS).

**1.10** The Defence Health Service (DHS) is part of the Defence Personnel Executive (DPE). It consists of the DHSB, the JHSA and Area Health Services. Health support to ADF operations is provided by health units under the direct command and control of the environmental commands (Land Command, Air Command and Maritime Command). However, these units remain under the technical control of the DHSB. The key DHS deliverables are the provision of health care to ensure that, from the health perspective, ADF members are adequately prepared for operations and that deployable elements of the DHS are prepared for deployment in support of military operations.

**1.11** The number of full-time health personnel in the ADF has fallen since the original audit was conducted. Between November 1996 and May 2000 the number of full-time health officers fell by 91, from 786 to 695. In the same period, the number of full-time 'other ranks' health personnel fell by 334, from 1790 to 1456.<sup>9</sup>

## **The follow-up audit**

**1.12** The follow-up audit process reinforces the ANAO's commitment to improving public administration and accountability through monitoring the implementation of performance audit report recommendations where they have retained their relevance. Improved performance is clearly forgone if implementation has not occurred or if it has been partially or unnecessarily delayed. Given the JCPAA's interest in the original report, the number and significance of recommendations agreed and the period that has elapsed since the original audit (which began in 1996), it was

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<sup>8</sup> The National Support Area is that part of the Australian continent which provides the personnel, resources (civil and military) and materials required to raise, train, mobilise, deploy and sustain forces.

<sup>9</sup> *Defence Health Service Annual Report 1999-2000*, Annex C, December 2000.



considered timely to undertake a follow-up audit of the original audit report.

**1.13** The objective of the follow-up audit was to assess Defence's implementation of recommendations made in the original audit report and their effectiveness in improving ADF health services. Recommendations in the original audit report therefore served as the criteria in assessing Defence's performance. Audit methodology involved discussions with key health personnel and a review of relevant files, documents, reports and meeting minutes maintained by Defence.

**1.14** Most of the audit fieldwork, conducted over the period October to December 2000, was undertaken at Defence in Canberra. The ANAO also held discussions in Sydney with Senior Health Officers in the ADF's environmental commands. Audit issues were discussed with Defence throughout the audit. Discussion papers consolidating the ANAO's findings on each recommendation were provided to Defence in March 2001 and the proposed report was provided to Defence in April 2001 for comment. In responding to the proposed report Defence agreed with its thrust and concluded that:

*In general terms the follow-up audit proposed report represents a positive outcome for the Defence Health Service and reflects progress in most areas, particularly in the last 18 months and given the limited resources available. Although a number of recommendations remain outstanding, they are dependent, in one form or another, on completion of the two major long-term projects, HealthKEYS<sup>10</sup> and JP 2060 and the completion of the Commercial Support Program (which is itself dependent in part on HealthKEYS). Consideration is also being given by Defence to increasing the resources available to the DHS Commercial Support Directorate.*

**1.15** The follow-up audit was conducted in conformance with ANAO Auditing Standards and cost \$159 000. This report has eight other chapters. The report structure follows that of the original audit report.

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<sup>10</sup> Health Key Solution

## 2. Policy, Resourcing and Corporate Planning

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*This chapter discusses Defence's implementation of Recommendation Nos 1, 2, 3, 4 and 5 of the original audit. These concerned the minimum level of health resources essential to meet operational requirements, scope for achieving economies in the provision of non-operational health services, implications of a member contribution for some health services, common health standards and processes, development of health policy and corporate planning arrangements.*

### Provision of non-operational support

#### Findings of the original audit—Recommendation No.1

**2.1** The original audit found that most day-to-day ADF health care resource usage was associated with non-operational support and that, in view of the high costs associated with it, the costs and benefits of other health care delivery options should be evaluated. A key issue was whether the existing level of health service resources was essential to meet operational requirements. Once the appropriate level had been determined, it would then be feasible to examine more efficient options for delivery of non-operational health care. Such an examination could consider whether the range of services and facilities was essential or could be rationalised and whether services could be provided through more economical means.

#### 1997 Recommendation No.1\*

The ANAO recommends that Defence establish the minimum level of health service resources essential to meet military operational requirements and then assess the scope for achieving economies in the provision of non-operational services through other means such as rationalisation or commercial support.

Defence response: Agree.

#### Findings of the follow-up audit

##### ***Minimum level of operational health resources***

**2.2** Defence is reviewing its operationally deployable health assets. The review, Joint Project 2060 *ADF Deployable Health Capability* (JP 2060), seeks to identify and develop capabilities required to prevent, treat and evacuate casualties in joint operations in the defence of Australia.

**2.3** The Project's initial study was completed in December 1998. It found that the current deployable health force structure had been largely developed on a single-Service basis to support maritime, land and air operations and that *'much of the current [health] force structure was hollow capability lacking preparedness, staffing, equipment, personnel skills and flexibility needed to effectively support ADF operations.'*<sup>11</sup> The study concluded that the health tasks in support of maritime, land and air operations were common to the three Services and recommended a jointly-staffed health force structure based on common capability elements, effectively integrated with the national civil health infrastructure.

**2.4** The initial study report was endorsed by the Service Chiefs in March 1999. As part of the study, an indicative force structure for ADF deployable health support was developed. It includes a broad estimate of the numbers and types of capability elements that may be required and an assessment of the way capability elements should be grouped to ensure efficient and effective support of ADF operations.

**2.5** It was agreed in October 2000 that JP 2060 would proceed in several phases. Subject to Defence Executive agreement, more detailed studies on selected areas of the deployable health capability, including the force structure, are to commence in 2001. JP 2060 outcomes will determine the minimum level of health resources essential to meet military operational requirements (the first part of the ANAO's Recommendation No.1).

### ***Rationalisation and market testing of ADF health services***

**2.6** Although the minimum level of health resources essential to support deployed forces has not yet been established, Defence, by means of rationalisation and market testing, is progressively seeking economies in the provision of non-operational health services. The approach adopted has been to divide the National Support Area (see paragraph 1.9) into eight regional projects. The projects, in proposed order of completion, are Victoria; ACT/Southern NSW; Sydney and Surrounding Areas; Queensland; Northern Territory; Western Australia; South Australia and Tasmania. Consultants have been engaged to assist with rationalisation studies, statements of requirement and requests for tender. The regional approach and order of projects is broadly based on the ADF's Area Health Service jurisdictions, with precedence given to the regions with major groupings of ADF personnel and relatively high levels of expenditure on health services.

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<sup>11</sup> JP 2060 ADF Medical Capability Study, Initial Study Report, DHSB, 20 November 1998.

2.7 The services to be market tested are primary health care services; dental services; specialist out-patient services; accident and emergency services; in-patient medical and surgical services; allied health services (for example, physiotherapy and optometry); diagnostic services (for example, pathology and radiology); military health administration and health support to military activities. Defence recognises that, due to the immature nature of the health services market in Australia, potential contractors may have difficulty providing all the health services required by the ADF.

2.8 The ANAO understands that any ADF health personnel displaced by market testing would be posted to fill vacancies elsewhere in the National Support Area. Those health support functions considered inappropriate for market testing, either because of special military skill requirements or the hazardous nature of duties, have not been market tested. These activities (for example, medical support to field training exercises) will remain a Defence responsibility.

### *Victoria Project*

2.9 The first region to be reviewed and market tested by Defence was Victoria, which comprises health facilities at seven Defence establishments.<sup>12</sup> In response to an industry-wide invitation to register interest, expressions of interest were received from 28 organisations seeking to provide all services to all sites, all services to particular sites or particular services to all sites. These were short-listed to five as a result of Defence's preference to contract with a firm able to provide all services to all sites. Before release of the formal Request For Tender (RFT) in September 2000, three of the short-listed firms withdrew their interest in the project. Accordingly, only two firms were issued with RFT documentation.<sup>13</sup> It is unlikely that a contractor would be on site in Victoria providing the full range of services before January 2002. [Defence advised the ANAO in May 2001 that the evaluation of tenders for the market testing of ADF health services in Victoria is expected to be completed before the end of June 2001.]

2.10 Rationalisation proceeded separately. A consultant was engaged in September 1999 to review ADF health services in Victoria and report on possible areas for rationalisation. The consultant's report, known as

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<sup>12</sup> HMAS *Cerberus*, Defence Force Health Centre Melbourne, Simpson Barracks Watsonia, RAAF Williams, Puckapunyal, RAAF East Sale and Albury/Wodonga.

<sup>13</sup> At the time of audit fieldwork there existed a substantial risk that one or both firms may withdraw from the tendering process.

the Hoult report,<sup>14</sup> identified four main areas with potential for rationalisation: on-base in-patient facilities; primary health care; policy and practice on dental fitness; and dental laboratories.

**2.11** The Hoult report was useful in identifying areas warranting further review. Accordingly, it was decided to conduct another, more detailed review. Known as the Victorian Rationalisation Study,<sup>15</sup> it was completed in November 2000. It provided rationalisation options and recommendations for consideration by Defence Health Service authorities. The study report estimated that the baseline cost of providing ADF health services in Victoria was \$28 million in 1998–99 and that savings ranging from \$2.6 million to \$4.6 million (9 to 16 per cent) were possible. Its main conclusions were as follows:

- the cost of specialist out-patient services, on and off-base, could be reduced if bases acted in concert to concentrate their purchasing power to negotiate more cost-effective contract and sessional arrangements;
- in-patient facilities were grossly under-utilised and the majority of medical bed-days were occupied by persons requiring low dependency care. Due to the proximity of ADF facilities in Victoria to private or public hospitals, all ADF in-patient facilities in the region could be closed but an in-house facility with up to nine beds for the care of low dependency self-care patients should be retained at bases;
- the need to maintain dedicated accident and emergency vehicles and staff at some bases, in the event that in-patient acute care and surgical services ceased to be provided on-base, was questionable;
- there was over capacity in provision of pathology services, medical imaging and pharmacy services;
- medical health administration could be rationalised; and
- in-house dental laboratories should be rationalised and policy on dental fitness standards studied, having regard to costs.

**2.12** The study stated that *'it is obvious to even a casual observer that there is at present substantial under-utilisation of the facilities. Under-utilisation to an extent that could cause embarrassment to Defence were it to become public knowledge.'*<sup>16</sup>

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<sup>14</sup> *Report to the DGDHS on Business Process Re-engineering options within the Victorian region*, Hoult Consulting Pty Ltd (January 2000).

<sup>15</sup> *ADF Health Services in Victoria, Rationalisation Study—Final Report*, 20 November 2000.

<sup>16</sup> *ibid.*, p. 88.

2.13 The study report recommended that implementation of agreed recommendations begin as soon as possible, *'say from early 2001'*. It stated that, should its recommendations be accepted, top priority be given to: improving health services ahead of market testing (unifying the management of ADF health services in Victoria under a single Area Health Service); reducing on-base in-patient medical and surgical services; and reducing on-base diagnostic services (for example, closure of pathology laboratories). These recommendations are yet to be implemented.

### *ACT/Southern NSW Project*

2.14 At the time of the follow-up audit, three firms able to provide *'all services to all locations'* had been short-listed for this region and the statement of requirement (SOR) was being developed.<sup>17</sup> The RFT was to be released by the end of March 2001. [Defence advised the ANAO in May 2001 that a draft SOR/RFT for the market testing of ADF health services in the ACT/Southern NSW region had been released to Defence stakeholders for review and comment in early April 2001. The SOR/RFT was being finalised for release to the short-listed tenderers when tenders for the Victorian market testing were evaluated.]

2.15 A rationalisation study, conducted by a consultant, for this region had been substantially completed at the time of the follow-up audit. The draft report<sup>18</sup> notes that *'many of the findings are consistent with the ANAO audit report on the ADF health Services.'* The draft report estimates that savings of between \$3.8 million and \$4.3 million (26 to 30 per cent) were achievable. Defence advised the ANAO that the savings estimates in this report were likely to have been overestimated due to problems with the reliability of the data and that better cost and usage data would be included in the RFT provided to tenderers for this region.

2.16 The study report noted that inefficiencies often stemmed from the onerous administrative/clinical requirements brought about by a lack of appropriate, uniform technologies; incompletely integrated Service health services and policies; and seemingly excessive policies relating to health assessment. It saw rationalisation opportunities falling into three broad categories: application of external health benchmarks; consolidation of services; and/or fundamental changes in the delivery of health care. It concluded that:

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<sup>17</sup> The main Defence establishments in the region are HMAS *Harman*, Canberra Area Medical Unit/ Canberra Area Dental Unit, RAAF Wagga Wagga and Kapooka.

<sup>18</sup> *Rationalisation and Market Testing of Health Services in the ACT and Southern NSW—Rationalisation Report*, Department of Defence (October 2000).

- the volume and acuity of in-patient care at all sites is quite low, support provided was not commensurate with the volumes and care required, there was considerable excess capacity and ward sizes were too small to be managed cost-effectively;
- the operating theatre at Duntroon should be closed and negotiations held with one or more public/private health facilities in Canberra;
- there were opportunities to consolidate health centres/regional aid posts;
- greater use be made of dental hygienists for routine cleaning and checking so that relatively more expensive dentists can be utilised more cost-effectively;
- the potential for dental laboratory services to be sourced from the private sector be examined; and
- medical administration could be consolidated to overcome inefficiencies resulting from the lack of standardisation between Services and the decentralised nature of the health service.

2.17 Recommendations in the study report had not been agreed by Defence at the time of the follow-up audit.

### *Sydney and Surrounding Areas Project*

2.18 In July 2000 Defence invited firms to register interest for provision of consultancy services to assist with the project to rationalise and market test ADF health services in Sydney and surrounding areas (15 Defence establishments). From the 30 expressions of interest received, eight were short-listed, with a view to selecting one who would start on the consultancy in April or May 2001. Defence no longer intends to market test this region but will proceed with the rationalisation study.<sup>19</sup> [Defence advised the ANAO in May 2001 that an evaluation of tenders received from consultants to assist with the review and rationalisation of ADF health services in the Sydney region had been completed and that a consultant would be appointed before the end of May 2001.]

### *Queensland Project*

2.19 The only action taken in relation to the Queensland project has been to appoint a Reserve Naval Officer as the local project director. The ANAO understands that Defence intends to start the rationalisation review in this region in June 2001.

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<sup>19</sup> At a Senate Foreign Affairs, Defence and Trade Legislation Committee ('Senate estimates') hearing on 21 February 2001, Defence advised that the Defence Health Service would not be market testing the Sydney and surrounding region, primarily because of the complexities involved in getting a contractor to 'mesh in' with the three hospitals, which are operational facilities.

## ***Issues identified by the follow-up audit***

### ***Slippage in the market testing schedule***

**2.20** The market testing and rationalisation process has progressed slowly. In Victoria, evidence indicated that market testing was at least a year behind its original schedule and that, at the current rate, the market testing process would take a number of years to complete. Several factors were said to have contributed to the delay. These were that market testing of health services on such a large scale has not previously been attempted in Australia;<sup>20</sup> there were staffing shortages in the JHSA's Commercial Support Program (CSP) Directorate; and the development of key documents associated with the market testing process took longer than expected. The market testing process has also been costly; RFT documentation for Victoria cost in the order of \$1 million. However, as other regions are progressively market tested, this documentation should provide a template for RFT documents in those regions.

### ***Rationalisation/market testing methodology***

**2.21** The ANAO queries the methodology adopted by Defence to achieve economies in delivery of health care in the Victoria region. Market testing began late in 1998, with expressions of interest invited in May 1999, but the decision to review health service delivery arrangements in Victoria with a view to rationalising service delivery was not made until September 1999. The ANAO considers that, given the long lead times involved with market testing and the risk that a preferred tenderer delivering all services to all sites may not be found, Defence should have undertaken the Victorian region rationalisation study earlier and implemented its agreed recommendations as soon as possible. In this way, Defence would have achieved efficiencies and gained savings earlier than will now be the case. The ANAO found evidence that pressure to achieve savings from the Defence Reform Program (DRP), which began in July 1997, resulted in the decision to undertake a rationalisation study being made after the market testing process had commenced.

**2.22** The ANAO understands that Defence now regards the conduct of a rationalisation study as an essential step before market testing. The ANAO supports this approach, as it can yield savings earlier and provide valuable information for market testing through identification of actual services required and the current cost of providing them. The ANAO considers that agreed recommendations from rationalisation studies

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<sup>20</sup> The ANAO understands that some State prison services have outsourced the provision of health services.



should be implemented as soon as practicable. [Defence advised the ANAO in May that the rationalisation reports for Victoria and the ACT/Southern NSW are listed for consideration by the Defence Health Service Steering Group at its next meeting, scheduled for early June 2001.]

*Rationalisation/market testing could be better informed*

**2.23** Discussions with the CSP Directorate in the Joint Health Support Agency (JHSA) indicated that the Services had not provided it with information on the number and location of uniformed positions that would need to be quarantined from the market testing process. Instead, the Directorate found it necessary to seek this information from individual units.

**2.24** JP 2060 is in the early stages of development, with detailed studies still to be undertaken. In advice to the CSP Directorate in August 2000, JP 2060 staff stated that *'any rationalisation of NSA [National Support Area] health support assets which pre-date JP 2060 force structure outcomes must remain cognisant of the minimum ADF liability likely to be required to deploy and sustain a deployable capability.'* The ANAO understands that, although they do not have a large requirement for uniformed health staff, the regions to be addressed have not been informed of the likely JP 2060 force structure outcomes. The ANAO considers that JP 2060 needs to better inform the rationalisation/market testing process of the likely numbers of uniformed members required to support the defined deployable health capability.

**2.25** The CSP Directorate advised that it was now working closely with the JP 2060 team and Senior Health Officers in the environmental commands in reviewing rationalisation opportunities in the Sydney region, where a large number of deployable health personnel are currently posted. This approach will also be followed in later regional studies, particularly for Queensland and the Northern Territory.

**2.26** Improved communication is also required between the JHSA and workforce planners so that uniformed health personnel are not posted out of areas ahead of market testing outcomes. The ANAO found that, without JHSA consultation, some personnel had been posted out of Victoria and had not been replaced, even though the market testing process had not been concluded. The ANAO was advised that this was causing major difficulties for the JHSA and Base/Unit Commanders who rely on these personnel for the delivery of health support and that it was placing considerable strain on the DHS budget. The CSP Directorate noted that these postings would result in a marked reduction in the savings to be achieved under CSP and that these issues had been raised with the Services.

### *Data limitations*

**2.27** Although considerable work had been undertaken in obtaining activity and costing data, findings of the rationalisation reports need to be interpreted carefully because of gaps in the data and data reliability problems. For example, the final report of the Rationalisation Study for the Victoria region stated that

*Significant difficulties have been encountered in obtaining comprehensive, clear and precise information on health services activity, current costs, and specific military requirements for the purposes of the review and the market testing tender documentation.*

Defence advised the ANAO that there continues to be a paucity of good clinical data at the unit level, primarily due to the absence of health information systems. Defence expects this to improve with the introduction of an ADF-wide health information system called HealthKEYS (see paragraph 6.4).

### *Staffing of the CSP cell within the JHSA*

**2.28** At the time of the follow-up audit the CSP Directorate in the JHSA had only two staff. The ANAO considered that, given the potential for obtaining major efficiencies from the market testing process and the amount of work required to manage the rationalisation/market testing process, the Defence Health Service needed to give the staffing of this Directorate higher priority. Defence has advised that action has been taken to fill a vacancy in the CSP Directorate and to provide additional staff support. Consideration is also being given by Defence to increasing the resources available to the DHS CSP Directorate.

**2.29** A number of consultants have been employed in the rationalisation/market testing processes. DHS personnel raised concerns with the ANAO about the consistency of methodologies used by the consultants, their experience in relation to health services and their understanding of the operational health requirement. Defence acknowledged to the ANAO that external consultants without a DHS background do require time to obtain an understanding of the Defence environment but that they bring more broadly-based expertise than is available in-house. This expertise was considered vital in developing options for greater reliance by Defence on the public and private health sector.

**2.30** Overall, the ANAO found that Defence was progressively assessing the scope for achieving efficiencies in non-operational health services through a regionally-based program of rationalisation and market testing, but progress in implementing the program had been slow. A

significant amount of work has been undertaken in developing rationalisation studies and market testing documentation but rationalisation recommendations have not been implemented and a preferred tenderer has not been selected. The ANAO supports the continuation of the rationalisation and market testing process throughout the National Support Area and notes Defence's intention to incorporate identified lessons to be learned from the Victoria and Southern NSW/ACT projects in forthcoming projects.

### *Defence response*

2.31 Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.1.

## **Provision of health care to ADF personnel**

### **Findings of the original audit—Recommendation No.2**

2.32 A literal reading of the Defence instruction on health care for the ADF<sup>21</sup> indicated that Defence would provide ADF members with almost unlimited health care at the highest level, free of charge.<sup>22</sup> Given that ADF members are exempt from the Medicare levy and the ADF requires complete personnel medical records, the ADF discouraged its members from using the Medicare system. This implied that the ADF accepted responsibility for providing the same range of medical and hospital services covered by Medicare. The ANAO considered, however, that there was scope for members to contribute to the cost of expensive elective treatments that were unrelated to health and fitness for military service.

#### 1997 Recommendation No.2

The ANAO recommends that Defence assess the merits and possible implications of a member contribution for any health services additional to those required for the maintenance of individual readiness or that are outside the ADF's duty of care to its employees.

Defence response: This is a substantial departmental policy issue which will require a comprehensive study by the Department before a response can be given.

<sup>21</sup> Defence Instruction (General) Personnel 16-1—*Health care of Australian Defence Force personnel* (27 September 1991).

<sup>22</sup> ADF members are provided with medical and hospital services comparable to those available under Medicare, and dental, optical, physiotherapy and physical training, pharmaceutical and medical supplies and ambulance services.

## Joint Committee of Public Accounts and Audit

2.33 In its 1998 review of the ANAO's audit report, the Joint Committee of Public Accounts and Audit recommended that

*In line with the Auditor-General's recommendation No.2, Defence undertake an immediate assessment of the merits and possible implications of a member contribution for any health services additional to those required for the maintenance of individual readiness or that are outside the ADF's duty of care to its employees.<sup>23</sup>*

## Findings of the follow-up audit

2.34 Subsequent to the original audit, a Defence study of ADF standards of health care<sup>24</sup> recommended that the Defence instruction on health care be reviewed 'taking due cognisance of Australian community standards and the requirements of operational readiness.' This has now been done and a draft instruction has been prepared. Its key provisions are as follows.

1. Provision of medical and dental services by the Defence Health Service to ADF members is a requirement of service to ensure that members are fit to undertake their operational roles (as distinct from the widely held view that free health care is a condition of service).
2. Equity with Medicare underpins the entitlement to medical care for permanent members, but the ADF usually provides a higher standard of care due to the requirement to meet and maintain operational readiness.
3. DGDHS may issue policy which may exclude or limit the provision of certain medical and dental treatment on the grounds that such treatment is contra-indicated<sup>25</sup> or unnecessary for operational readiness.<sup>26</sup>
4. Specific health interventions may be provided to Reserve personnel at the request of the Service Chiefs for individual or unit readiness, or for pre-deployment reasons.

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<sup>23</sup> Joint Committee of Public Accounts and Audit, *Review of Auditor-General's Reports 1996-97, Fourth Quarter, Report 359*, March 1998 (p. 116, para 2.61).

<sup>24</sup> *Health Care for the Fighting Force—attainment, maintenance and restoration of health for the preservation of ADF manpower*, 26 November 1997.

<sup>25</sup> 'Contra-indicated' refers to a clinical symptom or circumstance indicating that the use of an otherwise advisable intervention would be inappropriate.

<sup>26</sup> Treatments which may be considered unnecessary for operational readiness include cosmetic surgery, assisted reproductive services and sterilisation services.

**2.35** If approved, the new instruction would establish Medicare as the minimum level of entitlement to medical care for permanent members. It indicates that, because of the need to meet and maintain operational readiness, members will usually have access to a greater range of, and more timely, health care services than those available through the public health care system (for example, regular medical examinations, precautionary inoculations and the absence of waiting lists at its hospitals).

**2.36** The ANAO understands that members excluded from receiving certain treatment under the third key provision listed above may seek treatment from outside the ADF at their own expense or from ADF sources on a cost recovery basis. Should the treatment be covered by the Medicare Benefits Schedule, Defence would, on approval, reimburse the member up to the Medicare benefit limit. In this way members would pay fully or partly for the cost associated with any health services that were unnecessary for operational readiness.

**2.37** Defence's work in preparing the draft instruction addresses the concerns that originally prompted Recommendation No.2. If approved, the instruction would, for the first time, define the standard and range of services to be provided to ADF members. It would also clearly state that the provision of health care is a requirement of service, not a condition of service. By establishing Medicare as the minimum level of care to be provided to ADF members, the instruction would establish equity with the rest of the Australian community. At the time of audit, the draft instruction had been endorsed by the DHS Steering Committee but was still awaiting formal approval.

### *Defence response*

**2.38** Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.2 and considered that this issue would be concluded with the publication of the revised Defence Instruction.

## **Development of common standards and processes**

### **Findings of the original audit—Recommendation No.3\***

**2.39** The OSGADF [now the Defence Health Service Branch (DHSB)] corporate plan 1994–1998 had, as a goal, the rationalisation of single-Service health policies into common ADF health policy but there had been little progress made in achieving it. The audit also found that each of the Services continued to maintain a comprehensive range of single-Service health instructions and that there were indications that the quality of health care varied between the Services.

### 1997 Recommendation No.3\*

The ANAO recommends that Defence give a higher priority to the development and implementation of common standards and processes associated with ADF health care as a means of delivering a more uniform quality of care to all ADF members.

Defence response: Agree. There are significant costs associated with implementing a quality of care monitoring program and /or gaining accreditation. ANAO has given no guidance as to what it considers as an appropriate quality of care. Should Defence adopt civilian accreditation standards or seek civilian accreditation where possible? These are issues which this Office can undertake in consultation with other elements of the Defence Organisation, but there are, as always, costs in accreditation and quality of care standards and these will need to be addressed in terms of the future direction of the ADF and the focus on the way we will operate in war. It is disappointing that the ANAO Report has not indicated the extent to which common standards and processes already exist in the ADF health services compared to the rest of Defence. A significant number of important ADFPs<sup>27</sup> have been issued reflecting the work in developing common policy.

ANAO comment: In the report the ANAO recognises the progress that has been made towards the setting of common ADF health standards but suggests that there is a range of outstanding issues that should be addressed.

## Findings of the follow-up audit

### *Development of common ADF health policy*

**2.40** Rationalisation of policy on delivery of health care in the ADF remains an objective in the DHSB Business Plan.<sup>28</sup> A DHSB audit of ADF health policies in 2000 identified 700 policies that it had responsibility for. It found that about 100 of them were no longer relevant to ADF requirements and these were deleted. Responsibility for the remaining policies was assigned to relevant Directorates in the DHSB for regular review and update.

**2.41** Staffing shortages and the requirement to develop policy responses to issues that arise at short notice continue to affect the Branch's ability to review, update and rationalise existing health policies. Nevertheless, the ANAO was provided with a number of examples where the Branch had or was in the process of rationalising health policy. They included

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<sup>27</sup> Australian Defence Force Publication

<sup>28</sup> Objective 5.1.1, Defence Health Service Branch Business Plan, February 2000.

development of a policy on infection control in the ADF<sup>29</sup> that replaced five policies on various aspects of infection control.

**2.42** DHSB guidance on development of new ADF health policy requires Branch members to question the need for a proposed policy and then decide whether there is any scope for rationalisation of related policy documents. The ANAO was advised that, since the formation of the DHSB, no new policies required single-Service implementing instructions. If any single-Service amplification were needed, it would now be included in the body of the policy document or in an annex to it.

### *Health promotion*

**2.43** The original audit found that Air Force placed a greater emphasis on health promotion than the other two Services. The follow-up audit found that an ADF-wide Health Promotion Strategy developed by the Directorate of Preventative Health in DHSB had been approved by the Chiefs of Staff Committee for implementation in 2001. This strategy would standardise the frequency of medical examinations for all members to every five years, supplemented by annual health assessments.

### *Medical employment classification*

**2.44** A Defence Instruction on a common medical employment classification system has now been issued.<sup>30</sup> The classification system has been formally introduced and Review Boards are required to be conducted in accordance with the Instruction.

### *Common ADF health training*

**2.45** A common basic medical assistant curriculum has been developed and a pilot course has commenced at the Army Logistic Training Centre. The ANAO understands that there are concerns in the DHS that the pilot may fail because of continuing differences between Army and Navy on aspects of the pilot course.

### *Standards of care and accreditation*

**2.46** Minimum safe standards of care were established in 1999 and are set out in the Joint Health Support Agency Policy Manual. In addition, Defence advised that about 50 per cent of Defence Health Service units have been certified to the International Standards Organisation's quality assurance standard.<sup>31</sup>

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<sup>29</sup> Health Policy Directive 239 *Infection Control in the ADF*, endorsed at the December 2000 DHS Steering Committee meeting.

<sup>30</sup> DI(G) PERS 16-15 *Australian Defence Force Medical Employment Classification System*, 20 April 2000.

<sup>31</sup> AS/NZS ISO 9002: 1994 *Quality Systems—Model for Quality Assurance in Production, Installation and Servicing*.

### *Physical fitness policy*

2.47 A common ADF physical fitness policy<sup>32</sup> was issued in 1997 but each of the Services still maintains single-Service policies on physical fitness. The ANAO was advised that this was due to variations in physical fitness requirements in the different Service environments.

### *Health documentation*

2.48 In 1997 a Health Documentation Steering Group was established in the Directorate of Clinical Policy to standardise health documentation and ensure that all forms complied with accepted civilian standards. The Group no longer exists. A 1999 Defence Health Bulletin stated that *'significant problems have, and are, being experienced by the use of forms developed by units for specific unit needs. A large number of forms do not comply with accepted civilian standards, and are not common to all areas of the DHS.'*<sup>33</sup> Although efforts have been made to amalgamate and standardise health documentation in the ADF, each of the Services still maintains a large number of Service-specific health forms. The ANAO was also advised that some forms did not meet legal compensation requirements.

2.49 Overall, the ANAO considers that, since the original audit, Defence has given a higher priority to the development and implementation of common health standards and processes. However, scope remains for further development of common standards and processes, particularly in the areas of health policy, documentation, training and standards of care.

### *Defence response*

2.50 Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.3. It considered the development of common standards and processes to be an ongoing task.

## **Health policy development process**

### **Findings of the original audit—Recommendation No.4**

2.51 Cost and funding implications of policy advice on health services were not always fully considered. Examples concerned policy on assisted fertilisation; prescription and administration of vaccines; and dental standards for Army Reserve personnel. There was insufficient information on the cost of health services to assess the resource implications of many

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<sup>32</sup> Defence Instruction (General) PERS 16-11 *Australian Defence Force Policy on Physical Fitness*, 13 June 1997.

<sup>33</sup> Defence Health Bulletin No.2/99 *Health Documentation Steering Group*, 4 February 1999.



policy changes. Policy changes were made without full consultation with the relevant parties responsible for their implementation. It was essential to identify the full costs of changes in the provision of health services and ensure full consultation on funding the changes.

#### 1997 Recommendation No.4

The ANAO recommends that, wherever possible in the health policy development process, Defence undertake full consultation with relevant parties and consider the full costs and funding implications.

Defence response: Agree. The organisation did so with the introduction of policy relating to Hepatitis immunisation.

### Findings of the follow-up audit

**2.52** In April 2000 DGDHS issued guidance to DHS Steering Committee members on a new process for producing Defence Instructions and technical health policy in the DHSB. It stated that *'in the process of developing policy, all authors are to consider the impact to the customer, consulting with relevant agencies as necessary.'* The ANAO examined consultation and costing/funding aspects of some recent health policies developed by the Directorate of Clinical Policy (DCP). The policies examined were:

- Defence Instruction (General)<sup>34</sup> Admin 24–5—*Credentialling Process for Health Professionals Providing Services to the Australian Defence Force*;
- Australian Defence Force Publication (ADFP) 702—*Immunisation Procedures*;
- Health Policy Directive<sup>35</sup> (HPD) 822—*Maintenance of DHS Personnel Clinical Competency and Currency*;
- Defence Health Bulletin No. 3/2000—*Lymphatic Filariasis*; and
- *Vaccination of ADF personnel involved in Operation Gold* (Sydney Olympics Security)—this was an ad hoc policy.

<sup>34</sup> Health policy that has general application to the administration of the ADF, and not just to the DHS, is promulgated in the form of Defence Instructions (General), other departmental instructions or ADF Publications.

<sup>35</sup> Health policy that is generally restricted to the DHS is promulgated in Health Policy Directives or Defence Health Bulletins. The former are used to promulgate enduring health policy; the latter are used to disseminate other policy or information.

### *Policy consultation*

2.53 Development of the policies examined by the ANAO involved extensive consultation, sometimes substantially delaying issue of the policy. Areas consulted in policy development included the single Services, Area Health Services, specialist consultative groups (discussed below) and areas specific to the policy being developed. For example, in relation to policy on the credentialling process for health professionals, the ANAO found that career managers, recruiters and the single Service Chiefs were all consulted. DCP also sought input from external subject matter experts and, on at least one occasion, contracted a relevant expert to develop a policy.

2.54 The DHS Steering Committee plays a critical role in the consultation process by providing a forum in which key officers in the DHS come together to discuss the more significant aspects of health policies.<sup>36</sup> Draft policies are provided to DHS Steering Committee members approximately two weeks before it meets. A checklist, known as the Policy Document Control Sheet, is used to monitor each policy's progress through the policy development process.

2.55 To enhance consultation during the policy development process, the DHSB has established 24 specialist consultative groups. Through these groups the DHSB can access the talents, knowledge and experience of ADF health specialists in areas such as orthopaedic surgery, ophthalmology, aviation medicine, health administration and mental health. The ANAO was also advised that, given the shortage of medical officers and other policy development staff in DCP, the consultative groups allowed the initial stages of policy development process to be 'outsourced' to them. Some groups had proactively put forward issues to be considered for policy development. For example, the medical imaging group had suggested changes to policy on routine chest x-rays that could yield resource savings. The ANAO commends the DHSB's efforts in establishing the consultative groups.

### *Full costs and funding implications of health policies*

2.56 In a minute establishing the DHS Steering Committee, DGDHS stated an intention to capture cost data on new policies. The minute stated that *'All policy matters presented to the committee are to be fully costed.'*<sup>37</sup>

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<sup>36</sup> This committee meets every two months. Chaired by the DGDHS, its members include the DHSB directors and specialist advisers, the Director JHSA, a representative from Headquarters Australian Theatre, senior health officers from the environmental commands and a senior reserve member.

<sup>37</sup> DGDHS 4899/99, *Development of a Committee Structure to drive the Defence Health Service*, 21 December 1999.

Another DGDHS document stated that *'I expect the resource implications of all new DHS policy initiatives to be fully quantified. All direct and indirect savings that may be achieved through a DHS policy initiative are to be expressed in dollar terms.'*

**2.57** Nevertheless, the ANAO found that the cost and funding implications had not always been considered in developing recent policies. In relation to the development of a policy on lymphatic filariasis, the ANAO did not find any evidence indicating that the total estimated cost of providing treatment had been calculated or that the source of funding had been considered. Defence advised, however, that the policy, was adequately costed in the context of a policy generated to support ADF operations. The policy on maintenance of DHS personnel clinical competency and currency (HPD 822) acknowledged that there would be 'some financial and manpower resource implications' but DCP did not attempt to quantify the resource implications. Defence advised that the resource implications of this policy had been identified by the Services prior to the development of the policy and as a result *'consideration of costs was not germane to the policy.'* In relation to other policies the ANAO found that costings had been developed.

**2.58** Defence advised that cost implications are now routinely taken into account when developing health policy. Nevertheless, Defence agreed with an ANAO suggestion that policy development guidance be revised to note explicitly that cost and funding implications of all new policies are to be identified and documented. Overall, the ANAO found that Defence had substantially addressed ANAO's Recommendation No.4.

### *Defence response*

**2.59** Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No. 4. It advised that guidance on the development of policy had been amended in accordance with the ANAO's suggestion.

## **Corporate planning**

### **Findings of the original audit—Recommendation No.5**

**2.60** The first corporate plan for the OSGADF [now DHSB] was issued in 1994 and was to be updated annually. However, there had been no updates at the time of the 1997 audit. The plan's first goal, to facilitate ADF operational effectiveness, had been achieved but progress on other goals and the plan's objectives had been slow, primarily due to staff shortages. Strategies to achieve non-operational objectives were general in nature and did not provide clear direction. Most performance indicators in the plan did not enable a clear assessment of the extent to which strategies had been successful.

#### 1997 Recommendation No.5\*

The ANAO recommends that the Surgeon General update the OSGADF corporate plan with clear guidance for future action and develop performance indicators which provide meaningful measures of outcomes achieved in relation to the stated objectives.

Defence response: Agree. Performance measurement protocols and tools are required.

### Findings of the follow-up audit

**2.61** The corporate plan was superseded by the Defence Health Service (DHS) Strategic Plan.<sup>38</sup> Endorsed by the DHS Steering Committee, it covers a five-year period and contains the DHS mission, desired outcomes, goals, objectives and key performance indicators (see Appendix 2 to this report). It provides a framework for developing business plans for DHSB, the JHSA, Area Health Services and major health units. The DHS Annual Report for 1999–2000<sup>39</sup> stated that the strategic plan is to be reviewed annually, after endorsement of the DHS Annual Report.

**2.62** The KPIs mentioned above are listed in the DHS Annual Report for 1999–2000, which provides an overview of DHS achievements in relation to each of the strategic plan's outcomes. However, the ANAO found that KPIs were not specifically monitored or reported. Defence advised the ANAO that:

*...it was not envisaged that these [the KPIs] would be measurable in any meaningful way until HealthKEYS was fully operational and linked to PMKEYS<sup>40</sup> and DEFCARE. ...Some yearly reporting could be undertaken, but would be of limited accuracy at present. The ability to accurately measure KPI's is thus dependent on the rollout of HealthKEYS.*

**2.63** The ANAO agrees that it is difficult for the DHS, at present, to measure its performance against the KPIs and that biennial development of Health Status Reports will aid in their measurement. The ANAO notes, however, that it will be several years before HealthKEYS can be expected to be fully operational.

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<sup>38</sup> Defence Health Service Strategic Plan 2000-2001 to 2004-2005, February 2000.

<sup>39</sup> Defence Health Service Annual Report 1999-2000, DHSB, 12 December 2000.

<sup>40</sup> Personnel Management Key Solution

**2.64** The ANAO considers that some of the KPIs and goals included in the Strategic Plan need to be made clearer to aid in their measurement. For example, KPIs 4, 5, 6 and 7 require enhancement to allow the effectiveness of current strategies in achieving DHS strategic goals to be measured. The ANAO also considers that the linkage between the Strategic Plan's outcomes, goals and KPIs requires tightening (in particular, the link between the DHS strategic goals and the KPIs). Such improvements to the strategic plan could be made during its next annual review so that, as HeathKEYS is progressively introduced, the DHS can begin reporting achievement against its strategic goals. The ANAO also suggests that DHS achievement in relation to its KPIs be reviewed and reported to the DHS Advisory Board<sup>41</sup> bi-annually and that end-of-year KPI achievement is reported in the DHS annual report.

**2.65** The DHSB Business Plan<sup>42</sup> is based on the DHS Strategic Plan and linked to the Defence Personnel Executive Business Plan.<sup>43</sup> The DHSB Business Plan focuses on key issues to be addressed over a two-year period and contains nine major goals and a number of lower level objectives. For each objective there are a number of activities to assist in achieving the objective, with milestones, time-line and lead Directorate for each activity. The Business Plan contains clear strategies to support DHS goals.

**2.66** At its bi-monthly meetings, the DHS Steering Committee<sup>44</sup> reviews the DHSB Business Plan and progress in completing the specified activities. If a task has not been completed, the lead Directorate is required to explain the reasons for this. Most delays were identified as resulting from a lack of staff to progress the activity or delays in receiving feedback from relevant stakeholders. At these meetings, new tasks are inserted into the plan and priorities are changed as necessary. Given DHSB's resource limitations, the ANAO considered the work program in the business plan to be ambitious.

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<sup>41</sup> The DHS Advisory Board is chaired by the Surgeon General ADF and consists of the Director General DHS and the three Assistant Surgeons General. The main function of the Board is to oversee the long-term goals and plans of the DHS and provide an independent view by which management performance can be monitored against the DHS strategic plan.

<sup>42</sup> *Defence Health Service Branch Business Plan*, February 2000.

<sup>43</sup> *Draft 2000-2001 Business Plan* Defence Personnel Executive, July 2000.

<sup>44</sup> The Steering Committee is the major executive-level committee in the DHS. It comprises the DGDHS (Chair), the four DHSB directors, two DHSB specialist advisers, the Director of the JHSA, a representative from HQAST and senior health officers of the environmental commands. The Committee's roles include the development and monitoring of the DHSB Business Plan, the development of strategies to facilitate achievement of the DHS mission and the monitoring of the implementation of those strategies.

2.67 Defence has made progress in implementing the ANAO recommendation by developing a strategic plan and defining outcomes, goals and objectives. These could, however, be better linked and some of the KPIs and strategic goals could be made clearer to aid in their measurement.

#### *Defence response*

2.68 Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.5. It noted that the DHS Strategic Plan was an overarching five year plan, used as the basis for developing annual Business Plans by all elements of the DHS. It also noted that KPIs contained in the plan will not be fully measurable until HealthKEYS is in place and that this was known at the time the Strategic Plan was developed but was accepted as a longer term objective.

## 3. Organisation and Staffing

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*This chapter outlines Defence's implementation of Recommendation Nos 6, 7 and 8 of the original audit report. It discusses current command and control arrangements for ADF health resources, the development of a new medical officer career structure and the establishment of a mechanism within Defence to coordinate health and human performance research.*

### Integration of ADF Health Services

#### Findings of the original audit—Recommendation No.6

**3.1** The Surgeon General had technical control of ADF health resources but did not control the allocation of the resources. Direct command was spread over the three Services and six Commands. The wide distribution of command and control was cumbersome and confusing and resulted in inefficiencies and inequities in the allocation of health services. The ANAO considered that management of health services could be more effective if the Surgeon General had full control of ADF health services. This would ensure portfolio-level responsibility and accountability for all health related resources. When health assets were required (for example, for exercises and operational deployment) command and control would be assigned to operational commanders. Formal arrangements, such as a memorandum of understanding, between the Office of the Surgeon General ADF (OSGADF) and the operational commands could enunciate command and funding arrangements when health care assets were required to be transferred to operational units.

#### 1997 Recommendation No.6\*

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

Defence Response: Agree. This issue has been picked up by the Defence Reform Program which also supports such a recommendation.

## Defence Reform Program

3.2 The Defence Reform Program, announced in April 1997, was based on the report of the Defence Efficiency Review.<sup>45</sup> That Review recommended that *'medical services need to be pulled together and rationalised, taking account of community expectations and civil arrangements'*. The addendum to the report of the Review recommended that:

*A single, integrated, joint organisation should be formed to manage all health activities in Defence. Surgeon General Australian Defence Force (SGADF) should head the organisation and should have responsibility for related funds. ...*

*The Defence Health Service should be formed from the existing health and related staffs of current Service and civilian programs and become a sub-program with the new Defence Personnel Executive. ...*

*The rank of the position of the SGADF should be reviewed after the introduction of a rationalised health service. ...*

*The Defence Health Service should be outcome focused, jointly staffed and managed, and should be supported by more extensively outsourced services.*<sup>46</sup>

## Findings of the follow-up audit

### *Command and control of ADF health resources*

3.3 Although Defence agreed to the ANAO's Recommendation, the Surgeon General has not been given command and control of all ADF health resources. The ANAO was advised that this was because such an arrangement was inconsistent with the overall command and control paradigm in the ADF, that operational units be under direct command and control of operational commanders. Consequently, responsibility for operational health units remains with the environmental commands. However, in 1998 a decision was made to transfer command and control of all non-operational health units to the Joint Health Support Agency (JHSA). Head Defence Personnel Executive (HDPE) advised the Service Chiefs that *'health elements that are non-operational and not delivering health training, are under command SGADF and will be managed and resourced through JHSA.'*<sup>47</sup> As a result, Army<sup>48</sup> and Navy transferred their non-operational

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<sup>45</sup> *Future Directions for the Management of Australia's Defence, Report of the Defence Efficiency Review*, 10 March 1997 (see Annex E—8, Recommendation No.48).

<sup>46</sup> *Future Directions for the Management of Australia's Defence—Addendum to the Report of the Defence Efficiency Review—Secretariat Papers*, see pages 277–278 (March 1997).

<sup>47</sup> *Command and control arrangements for the Defence Health Service—Health units in the JHSA*, HDPE 312/98 (16 February 1998).

<sup>48</sup> The ANAO understands that of the 400 positions transferred by Army to DPE, only 200 were filled at the time of transfer.



health positions to the Defence Personnel Executive (DPE) to work for the JHSA. Air Force transferred all its uniformed health positions (operational and non-operational) to DPE.

**3.4** The ANAO found, however, that the JHSA still did not have direct command and control over non-operational uniformed personnel. Although uniformed personnel were technically responsible to the JHSA, they remained under the command and control of base commanders. The ANAO was advised that this was because the JHSA did not 'own' those members' salaries and therefore had no control over where they were posted. The ANAO also advised that the Services did not post members to positions in non-operational health units, as they were not a priority for them, and that this resulted in a requirement to employ contract health practitioners and placed pressure on the JHSA budget. The ANAO understands that there are difficulties associated with JHSA command and control of uniformed health personnel, including uncertainties over who is responsible for discipline and administrative support, particularly in joint units. However, these problems are not insurmountable, as demonstrated by the establishment of the jointly-staffed Canberra Area Medical and Dental Units.

**3.5** JHSA's lack of direct command and control over non-operational uniformed personnel has prevented it from allocating health resources to areas where they were most needed. To improve the ability of the JHSA to manage non-operational health support to the ADF, it would seem desirable that units that provide mainly non-operational health care be made subordinate to the JHSA. JHSA also saw a need for it to have a formal agreement with the single Services regarding the provision of non-operational health care. Such an agreement would allow JHSA to manage the provision of non-operational health support more cost-effectively.

**3.6** Prompted by the ANAO in recent performance audits, Defence has now decided to introduce customer/supplier agreements for its enabling groups.<sup>49</sup> Defence advised that customer/supplier agreements are being developed between the JHSA and the single Services. The agreements, to be implemented in 2001–2002, would define the level and standard of non-operational health support to be provided and the numbers of uniformed health staff to be supplied by the Services.

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<sup>49</sup> Audit Report No.26 2000-2001 *Defence Estate Facilities Operations* para 2.41. Customer/supplier agreements are also known as purchaser/provider arrangements.

3.7 The ANAO was advised of occurrences where uniformed personnel providing non-operational health care were being posted out of non-operational units without replacement. The result was that contract health practitioners were needed to fill these vacancies, placing pressure on the JHSA budget. Under a customer/supplier agreement, should a Service not provide the JHSA with the agreed number of uniformed health personnel, the standard of care would fall or the Service would need to fund the employment of civilian health care providers to replace uniformed staff. In this way, all parties are made aware of the full cost of providing non-operational health care, and cost shifting from the Services to the JHSA would not occur.

#### *Development of an Air Force Health Services Group*

3.8 The ANAO understands that, after the transfer of Air Force health personnel to DPE, resignation rates among the former had increased significantly. This was said to have resulted from uncertainties surrounding command and control arrangements and career structure/progression.

3.9 Air Force recently gained approval from the Air Force Capability Committee to establish an Air Force Health Services Group (HSG) on 1 July 2001. The role of the HSG will be to coordinate all Air Force health assets, clarify the chain of command and control for base health facilities and enhance the collective management and development of Air Force health personnel. Formation of the HSG requires transfer of all uniformed Air Force health personnel (except those employed exclusively in Defence staff positions) back from DPE to Air Force. The ANAO understands that Air Force has designated nearly all its uniformed health personnel as deployable. An Air Force Organisation Directive on the HSG set out Air Force's reasons for its establishment, as follows:

*The ANAO audit recommended the establishment of a tri-Service health administrative body that would provide tri-Service command and control. Under the umbrella of the DHSE, the Joint Health Support Agency (JHSA) was established for the delivery of peacetime health care. Despite the agreement on the part of the three single Services to embrace the DRP [Defence Reform Program] health recommendations, RAAF was the only service to transfer command of all its health units to DPE (with subsequent transfer back of 3 HOSP back to 395 ECWS). Unfortunately, JHSA was not established in such a manner as to enable it to assume command of the RAAF health units and both Base and FEG commanders were not in a position to take responsibility for DPE health members. As such,*

*RAAF health facilities are no longer directly responsible to base commanders, other than as a service provider of health services, nor are they directly responsible to DHS HQAC [DHS Headquarters Air Command].<sup>50</sup>*

**3.10** As part of the HSG, Air Force intends to establish a headquarters cell, with some 15 personnel, to manage their deployable health capability. Air Force's proposal to transfer all of its personnel back from DPE and classify them as operationally deployable would result in a disproportionately large number of deployable health personnel in relation to the population they would be required to support on deployment. Defence advised that these personnel support both RAAF and other ADF deployed elements, particularly in regard to the provision of Aeromedical Evacuation. The ANAO also notes that the proposal is not entirely consistent with JP 2060 preliminary outcomes and the original ANAO recommendation seeking greater integration of the Defence Health Service. Although it focuses structure and command and control along operational lines, correcting a longstanding deficiency in the provision of RAAF operational health support, the ANAO understands that it does not accord with the 'building block' approach to capability development adopted by JP 2060.<sup>51</sup>

#### *Transfer of financial resources to the DHSB*

**3.11** The original audit found that payments to external health providers, recorded under Account Group 39 (AG 39) of DEFMIS,<sup>52</sup> were the second largest health service expenditure category, behind military salaries. AG 39 expenditure has steadily increased since the original audit was conducted, and amounted to \$70 million in 1999–2000. Defence advised the ANAO that this reflected increases in the cost of civilian health services and was driven by the need to employ contract health practitioners to fill vacant military health positions. The follow-up audit found that control of this expenditure had been transferred to the JHSA and that it was actively managing these funds. AG 39 funding bids by the Area Health Services are scrutinised by the JHSA prior to their allocation. The ANAO considers that centralised control of AG 39 has improved their allocation.

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<sup>50</sup> *Formation of Health Services Group*, Air Force Organisation Directive, nn/2001 (Feb 2001).

<sup>51</sup> The JP 2060 Study has identified the fundamental capability elements or 'building blocks' of deployable health support required by the ADF. They provide the basis for designing the ADF deployable health forces structure.

<sup>52</sup> DEFMIS has been replaced by a new financial management information system called the Resource Output Management and Accounting Network (ROMAN).

**3.12** Action to address the ANAO recommendation has been slow. Establishment of the DHSB and JHSA partially implemented the recommendation but full command and control of all health resources has not been transferred to the DHS. Defence considered that such an arrangement was inconsistent with the overall command and control paradigm in the ADF. The ANAO notes that determined efforts need to be made to address the command and control issues associated with the JHSA's effective operation.

#### *Defence response*

**3.13** Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.6.

## **Medical Officer Career Structure**

### **Findings of the original audit report—Recommendation No.7**

**3.14** The ADF relies, almost exclusively, on Reserve members to provide specialist medical services during exercises and deployments. In view of the operational requirement for specialists, there was scope for employing specialists full-time in the ADF. This could help alleviate the ADF's difficulties in attracting and retaining medical officers. Defence would need to compare the costs and benefits of engaging specialists under such a proposal with the usual methods of engaging them. In common with most career structures in the ADF, the higher ranks in the health services largely entailed command and associated management responsibilities. As a consequence, promotion to higher ranks in the health services largely resulted in health professionals spending more time on management and less time on clinical duties. A Defence review found that 45 per cent of doctors would prefer to confine their work to clinical duties.

#### **1997 Recommendation No.7**

The ANAO recommends that, in conjunction with any recommendations flowing from the review of Attraction and Retention of Medical and Dental Officers, Defence examine the present medical officer structure with a view to providing more flexibility, including the employment of specialist medical officers, promotions for general practice clinicians and the streaming of medical officers into either clinical or administrative posts.

Defence response: Agree. The principles are also applicable to the management of most, if not all, health professionals in the ADF and, to some extent, to other officers.

## Findings of the follow-up audit

### *Employment of specialist medical officers*

**3.15** Defence has developed a draft instruction<sup>53</sup> for a proposed Medical Officer Specialist Training Scheme (MOSTS) that would sponsor a limited number of medical officers for medical training in specialisations required for operational deployments. It would also aim to assist in the retention of medical officers who would otherwise leave the ADF after completion of their Return of Service Obligation (ROSO).<sup>54</sup>

**3.16** The draft instruction sets out eligibility requirements for potential applicants and the range of specialisations required operationally. These include general surgery, orthopaedic surgery, anaesthetics, intensive care and emergency medicine. A ROSO would be incurred by an officer who receives the training. After successful completion of training, the specialist officer would be required to provide a period of time in clinical practice and deployment, according to ADF needs. Because of limited clinical opportunities in ADF health facilities and to ensure skills are maintained, specialist officers would be placed with a civilian hospital as part of a strategic alliance. The scheme would, initially, be available for clinical specialisations needed to support operational deployments, but could be expanded to those needed for the National Support Area.

**3.17** The primary objective of MOSTS is to complement the Reserve health specialist force so that sufficient numbers of medical specialists are available at short notice for deployment with surgical teams. The ANAO was advised that, as a result of ADF deployments to East Timor, Bougainville and elsewhere overseas, the ADF was heavily dependent on Reserve medical specialists. Some of the specialists were on their third or fourth rotations, and it was believed that the ADF had exhausted their goodwill and risked losing them. The ANAO was also advised that these Reserve specialist officers could not be absent from their medical practice for more than two weeks without harm to their practice.

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<sup>53</sup> Draft Defence Instruction (General) *Medical Officer Specialist Training Scheme*, DHSB 13 October 2000.

<sup>54</sup> ROSO is a mechanism that aims to ensure that Defence receives adequate work return from members who have, at ADF expense, obtained a skill or profession with marketable value.

**3.18** Defence advised that some medical officers had begun training in anticipation of acceptance into MOSTS and that a reserve medical specialist officer recently transferred to full-time service. The ANAO considers that implementation of the scheme would provide additional flexibility in the medical officer career structure. The ANAO notes, however, that the proposal had not been costed (Defence expect it to have minimal cost) and that the feasibility of extending the scheme to the National Support Area had not been assessed. The draft instruction has been sent to the Service Chiefs for final clearance.

### *Career streaming and promotions for general practice clinicians*

**3.19** To maintain operational medical capability, the ADF needs to attract and retain medical officers. Nearly 30 per cent of all ADF medical officer positions were vacant in January 2000. In April 1998 the Chiefs of Staff Committee had agreed that there should be a Specialist Officer Salary Structure (SOSS) for medical and dental officers employed for specific specialist duty. It was considered that, to be effective, the salary structure needed support from other measures, including career progression, training and professional development. Accordingly, it was decided to develop a Specialist Officer Career Structure (SOCS) for medical and dental officers. A project team in the Defence Health Service Branch (DHSB) undertook the SOCS study. Their report<sup>55</sup> was provided in January 2000 to HDPE, who endorsed it and requested that the proposal be implemented as soon as possible. However, HDPE queried aspects of the new career structure and noted that it had not been costed.

**3.20** The SOCS report details new medical and dental officer career structures. Under the medical officer career structure, medical officers, after acquitting their ROSO, may choose to join a general medicine specialist stream or a military medicine specialist stream. General clinicians can choose to be employed in two further streams: they can become a senior clinician (with limited scope for progression) or become clinician managers and commanders. Beyond this level, medical officers who wish to remain in the ADF can progress only through the medical command and management stream. Medical officers who choose to join the specialist stream may specialise in a limited number of areas. The SOCS report indicates that four medical officers would be trained in each specialisation each year. The report also contains competency standards for medical officers and draft profiles for every medical officer position in the ADF.

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<sup>55</sup> *Specialist Officer Career Structure for Australian Defence Force Medical and Dental Officers Report*, Defence Health Services Branch (December 1999).

**3.21** The SOCS report identifies the need for appropriate military training; suitable clinical training; adequate clinical employment and experience; job satisfaction; and flexible career management. It notes that *'although the report avoided discussing financial issues, it is clear that salary remains an important issue in the attraction and retention of ADF medical and dental officers.'* To improve recruitment and retention of medical and dental officers, the SOCS report recommends that competency standards, draft profiles and the proposed career structures be passed to the Director Salary and Allowances (DSA) for development of a SOSS for ADF medical and dental officers. Defence also noted that a draft policy had been developed to address the issue of ongoing currency and professional development and was soon to be forwarded to Service Chiefs for final clearance.<sup>56</sup>

**3.22** The ANAO's Recommendation No.7 was that, in conjunction with the 1997 review of attraction and retention of medical and dental officers, Defence examine the present medical officer structure. That review, known as the Rossi Report,<sup>57</sup> found four main areas of concern: inadequate remuneration; inadequate professional development opportunities; inadequate career management; and a perceived undervaluing of the contribution made by doctors and dentists. The SOCS would incorporate several areas identified by the Rossi Report, including the need for better career management, professional development opportunities and career streaming.

**3.23** The SOCS report provides theoretical underpinning for the medical officer pay case. The ANAO was advised that the salary structure cannot be developed further until revision of the proposed career structure is complete. It is expected that the salary structure will be submitted to the Defence Force Remuneration Tribunal in July 2001.<sup>58</sup> The ANAO understands that the salary structure must be achieved within the existing salary cap (that is, be cost neutral) but that Service Chiefs may be willing to contribute additional funds.

**3.24** Overall, the ANAO found that progress on Recommendation No.7 had been slow but that Defence has examined the medical officer structure. The proposed salary and career structures, once implemented, should provide greater flexibility, improve operational effectiveness and assist in retaining ADF medical officers.

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<sup>56</sup> The policy is entitled Postgraduate and Refresher Training for Health Service Officers.

<sup>57</sup> *A Study into the attraction and retention of medical and dental officers in the ADF*, Major General David G. Rossi AO, January 1997.

<sup>58</sup> The employment of full-time specialist medical officers will be covered in this pay case.

### *Defence response*

3.25 Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.7.

## **Coordination of Health and Human Performance Research**

### **Findings of the original audit—Recommendation No.8**

3.26 Human sciences research by some 150 personnel in nine or more areas in Defence was not coordinated centrally or ranked according to overall Defence priorities. Consequently, there was no assurance that available research resources were directed into projects designed to enhance ADF operational capability in the most effective manner. Defence lacked a human science research strategy, and priorities for such research were not integrated into ADF capability development. Human sciences research in Defence needed to be coordinated and advice provided on priorities for allocating resources to this research.

#### 1997 Recommendation No.8

The ANAO recommends that Defence establish a mechanism within OSGADF with the authority to coordinate human sciences research within Defence and to provide advice on priorities for the allocation of resources to this research.

Defence response: Agree. The chapter and recommendations are in accord with the department's intent, but do not give sufficient recognition to the considerable progress already made. The need for coordination of human factors research across Defence is acknowledged. This should be done through the establishment of Defence Human Factors Special Interest Group, to enhance the interchange between researchers; and a Human Science Interim Steering Group to examine the broader issues and initiate a review process.

### **Findings of the follow-up audit**

3.27 Defence Science and Technology Organisation (DSTO) has created a Defence Human Factors Special Interest Group that meets biannually and provides a forum for disseminating information between researchers and policy makers. The proposed Human Science Interim Steering Group did not proceed but a Defence Health and Human Performance Research Committee was established by the Defence Health Service Branch in 2000. The Committee is to oversee the program of health and human performance (H&HP) research in Defence. Key tasks will include development of an ADF H&HP research strategy and review of research proposals.



**3.28** An interim H&HP master plan,<sup>59</sup> developed to meet the 2001 DSTO research planning cycle,<sup>60</sup> identifies the areas of H&HP research considered important by the Committee. It contains six priority research areas. These areas, in general order of priority, are prevention of injury or disease; deployment of health capability; preparation (health issues related to force preparation); selection (health issues related to recruitment); casualty treatment; and casualty evacuation. The research priorities are to be reviewed annually.

**3.29** The Committee intends to meet at least three times a year. Its membership comprises the chair (DGDHS), Service Scientific advisers, representatives from DSTO, the environmental commands and the Defence Materiel Organisation. The Committee also intends to develop a more comprehensive master plan for 2001–2002 with an overarching plan covering H&HP research requirements for the ADF and subordinate plans addressing the H&HP research requirements for each of the individual Service Force Research Areas. The plan will also serve to inform the research community of the ADF's H&HP research requirements.

**3.30** The Committee will assess all H&HP research proposals against the master plan, primarily on whether they accord with the priorities established by it. Those that do and meet other selection criteria will be recommended to relevant areas in Defence for funding. The Committee has only an advisory capacity and cannot impose research priorities on DSTO's Force Research Areas (FRAs). The Committee is yet to receive official endorsement but proposes to report directly to HDPE (as Chief Personnel Officer) on significant issues affecting H&HP research in the ADF.

**3.31** Although progress has been slow, with the first meeting of the Committee in August 2000, the ANAO considers that action taken by Defence in relation to Recommendation No.8 addresses the concerns that prompted the original recommendation. The Committee, by bringing together relevant research areas in Defence, determining Defence priorities for H&HP research, providing strategic input into lower level research planning processes and vetting all H&HP research proposals, should assist Defence in maximising the value of its H&HP research.

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<sup>59</sup> The master plan is contained in the Defence Health and Human Performance Research Requirements Document 2001.

<sup>60</sup> The interim plan was used to provide input into the 2001 Research Requirements and Priorities process for each of the DSTO's Force Research Areas.

### *Defence response*

3.32 Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.8.

## 4. Facilities Planning and Utilisation

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*This chapter examines Defence's implementation of Recommendation Nos 9, 10 and 11 of the original audit report. It outlines Defence efforts to cost all ADF hospitals and medical centres and rationalise the provision of beds, assist relevant ADF health service personnel in gaining experience in treating acute trauma and review the provision of pathology services to the ADF.*

### Costing of ADF hospitals and medical centres

#### Findings of the original audit—Recommendation No.9

4.1 Defence's wide range of health facilities operated well below full capacity. ADF members were treated in these facilities but, if this was not possible, they were admitted to public or private hospitals as private patients, with Defence responsible for all associated costs. On the assumption that it was cheaper to accommodate members in ADF facilities than in civilian hospital beds, members were usually transferred from civilian hospitals to ADF facilities as their condition permitted. However, as Defence did not monitor the cost of maintaining its facilities, it was unclear that ADF facilities were the lower cost option. Lack of usage and costing data made it difficult to assess the cost of operating ADF health facilities but the ANAO considered that, in some cases, the civilian hospital option may be less costly.

1997 Recommendation No.9\*

The ANAO recommends that Defence:

- a) undertake a detailed costing of all ADF hospitals and medical centres; and
- b) rationalise the provision of these beds where their costs exceed the costs of beds in equivalent civilian facilities and their retention cannot be justified on preparedness and operational grounds.

Defence response: Agree. Any analysis must take into account the difference between civilian and military hospital beds, particularly the need to provide low dependency care. This applies specifically in barracks environments, where the differences between a military member and a civilian are significant. A civilian with a minor illness requiring time off work would remain at home, tended by family members, whereas a military member requires low dependency bedded accommodation in the absence of family support.

## **Joint Committee of Public Accounts and Audit**

**4.2** In its 1998 review of the audit report, the Joint Committee of Public Accounts and Audit supported the ANAO's recommendation, and recommended that:

*Defence take immediate action to give effect to the Auditor-General's Recommendation No.9, namely to undertake a detailed costing of all Australian Defence Force hospitals and medical centres and rationalise the provision of these beds where their costs exceed the costs of beds in equivalent civilian facilities and their retention cannot be justified on preparedness or operational grounds.<sup>61</sup>*

## **Findings of the follow-up audit**

### ***Costing of ADF hospitals and medical centres***

**4.3** Defence advised the ANAO that it is addressing Recommendation No.9 through its regionally-based rationalisation and market testing process. At the time of the follow-up audit, Victoria and Southern NSW/ACT regions were being rationalised and market tested. Baseline costings had been developed for both regions.<sup>62</sup> These costings include on and off-base health costs. The ANAO understands that on-base costs do not reflect the full cost of health service provision on-base because they do not include elements that would not be outsourced<sup>63</sup> and a number of other costs (such as fixed overheads related to facilities and administration services).<sup>64</sup> Although baseline costings for ADF health facilities in Victoria and Southern NSW/ACT have been developed for market testing purposes the ANAO found that the costing information developed did not allow ADF bed-day costs to be compared to civilian facilities. Neither of the rationalisation reports, completed at the time of the follow-up audit, compared bed-day costs for ADF in-patient facilities with those of civilian in-patient facilities.

**4.4** Defence advised that it had difficulty deriving ADF bed-day costs, for two main reasons. Firstly, the absence of reliable data continues to be a problem in all regions. Secondly, where data exists, difficulties were experienced attributing it to the in-patient services function. Defence

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<sup>61</sup> Joint Committee of Public Accounts and Audit, *Review of Auditor-General's Reports 1996-97, Fourth Quarter, Report 359*, March 1998, (p. 16, para 2.63).

<sup>62</sup> The ANAO notes that the costing methodology used in the Southern NSW/ACT rationalisation is different from that used in the Victorian rationalisation report and is also significantly less detailed.

<sup>63</sup> Baseline costings are used to compare the current cost of those services to be outsourced against tender bids.

<sup>64</sup> *ADF Health Services in Victoria, Rationalisation Study, Final Report, Department of Defence*, 20 November 2000, (p. 55, para 8.12).

advised that improving data quality and deriving attributions (particularly from non-health elements) has proved to be time consuming, costly, and heavily reliant on the willingness of areas to provide the required information. Defence considers that these factors limit the reliability of the subsequent assumptions that underlie analysis of activity and service costs.

**4.5** Defence intends to undertake a full accrual based costing for the Sydney region, but considers that a change in costing methodology would not lessen the difficulties associated with the derivation of reliable data on bed-day costs. It considered that it would be possible to develop indicative bed-day costs for ADF health centres in the regions already studied but that there could only be limited confidence in the costs developed; it would represent a diversion from the ongoing review program; and it would come to the same conclusions as the rationalisation studies completed to date (that is, that savings could be achieved by closing on-base operating theatres and greater reliance placed on the public and private health systems for in-patient services). Consequently, Defence questioned the value of conducting a nation-wide study of ADF bed-day costs.

**4.6** Overall, the ANAO found that Defence, despite serious data deficiencies, was progressively undertaking a relatively detailed costing of ADF hospitals and medical centres as part of the market testing and rationalisation process. However, the costing information was not in a form that allowed the cost of ADF in-patient beds to be compared with those of civilian facilities.

#### *Rationalisation of in-patient services*

**4.7** The Victoria rationalisation study report found that in-patient facilities were grossly under-utilised. Of the 38 690 bed-days available only 22 per cent or 8 367 were utilised during 1998–99. By comparison, Mayne Nickless [a private health care provider] reported for 1999–2000 an average hospital occupancy of 71 per cent for the 47 hospitals it operates. The study report indicates that all in-patient facilities in the region had bed occupancy levels less than 30 per cent and that a significant number of patients required no more than self-care or low dependency accommodation. In-patient services were estimated to cost \$5.4 million during 1998–99, or 20 per cent of the baseline cost of providing ADF health services in the Victorian region. The study found that there was considerable scope to reduce the cost of in-patient services and that its high costs were associated with low utilisation of the facilities, significant fixed operating costs and that the facilities were not of a size to be efficient.

4.8 The rationalisation study team considered that there was no apparent need for a hospital providing 24-hour, seven days a week, medical and nursing care at any military bases in Victoria. The team's preferred option was to close in-patient facilities (including operating theatres), outsource the work<sup>65</sup> but retain an in-house low dependency capability of up to nine beds at locations with relatively large live-in trainee populations. Supervision would be provided after-hours by a registered nurse, with patients restricted to those requiring low dependency care. This option, it was considered, would realise savings of at least \$1.2 million per annum.

4.9 Although still in draft form at the time of the follow-up audit, the rationalisation study report for Southern NSW/ACT<sup>66</sup> contains broadly similar findings to the Victoria rationalisation report. It found that, at all sites with in-patient facilities in this region, the volumes and acuity of in-patients were low (for example, influenza, minor orthopedic, chicken pox); personnel were admitted mainly for conditions for which civilians would not be hospitalised;<sup>67</sup> each site was smaller than those normally seen in the public/private sector (ward sizes of 28–32 beds were normal whereas the ADF operated between 2–10 beds); and each facility demonstrated considerable excess physical capacity.

4.10 It is clear from the analysis in the two rationalisation studies completed so far that, in relation to in-patient services, there is considerable scope for costs savings to be achieved through rationalisation and market testing of in-patient facilities. However, the ANAO notes that, at the time of the follow-up audit, the recommendations in the Victoria and Southern NSW/ACT regions' rationalisation studies had not been agreed or implemented.

#### *Market testing of the greater Sydney region*

4.11 At the time of audit fieldwork, the ANAO was advised by Defence that it would be market testing the Sydney region as part of its regionally based rationalisation/market testing program. Defence has since advised that it no longer intends to market test the Sydney region but will proceed with an activity review and rationalisation study of this region. In evidence to the Senate 'estimates committee' in February 2001 the Director General Defence Health Service stated:

*I have indicated to the Defence health service that the market testing*

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<sup>65</sup> The existence of local, civilian alternatives for in-patient care were noted.

<sup>66</sup> *Rationalisation and Market Testing of Health Services in the ACT and Southern NSW, Rationalisation Report*, Department of Defence (October 2000).

<sup>67</sup> The report recognises that Defence Bases have a high proportion of live-in single personnel who are distant from their families and those who might ordinarily provide low dependency care when required.

*process cease in Sydney, for a number of operational reasons rather than non-operational reasons. But the market testing process will continue in a rolling program around the rest of Australia. ...*

*There were complexities in the three hospitals—the Army, Navy and Air Force hospitals in Sydney—in that each of those hospitals is also an important operational facility. The complexities were such that we could not see how we were going to achieve a primary contractor to mesh in the operational requirements.<sup>68</sup>*

**4.12** The original audit considered that the three Service hospitals in Sydney were operating well below capacity and therefore were not cost-effective. It also found that, despite its clear benefits and Chiefs of Staff Committee's in-principle support, a proposal to develop a single ADF hospital in the Sydney region did not proceed. The ANAO questions whether all three hospitals in the Sydney region need to be retained in order to support the operational health capabilities they provide. It also considers that a detailed costing of the three hospitals in the Sydney region, and rationalisation of their beds based on this information, is critical to improve the efficiency of health care delivery in the Sydney area.

**4.13** Although slow to do so, Defence is now addressing Recommendation No.9. Despite bed-day rates not having been developed, rationalisation studies confirm that there is considerable inefficiency in delivery of in-patient services in the DHS. The ANAO considers that Defence should implement agreed recommendations from the rationalisation studies as soon as practicable and that, as its capacity to cost its services improves, it should routinely develop management information such as bed-day costs and compare them with those of civilian providers.

### *Defence response*

**4.14** Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.9. It noted that a comprehensive Data Survey Form has been developed for the purposes of collecting historical activity data for the rationalisation and market testing activity. It considered that the Survey Form, which is spreadsheet based, should assist with the collection of costing and activity data until the HealthKEYS system is implemented. Defence also advised that the rationalisation studies, referred to in paragraph 4.13, will be considered in June, at the next DHS Steering Committee meeting.

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<sup>68</sup> Senate Foreign Affairs, Defence and Trade Legislation Committee—*Consideration of additional estimates*, Hansard 21 February 2001, p. 54.

## Exposure of health personnel to acute trauma

### Findings of the original audit—Recommendation No.10

**4.15** Although the primary role of ADF health services is to support operational forces in combat situations, health staff had insufficient training and experience in treating trauma (wounds) and emergency cases, which are the kind most likely to occur in such situations. The greatest scope for obtaining this type of training and experience was in civilian hospitals and ambulance services. Lack of civilian recognition of ADF training of medical assistants posed a difficulty in arranging placements with the civilian sector.

#### 1997 Recommendation No.10\*

The ANAO recommends that Defence make determined efforts to reach agreement with the necessary civilian health authorities for ADF personnel to work in areas where they will be exposed to emergency treatment of wounds and injuries and that a uniform ADF policy be developed.

Defence Response: Agree. There is the potential for costs to Defence to increase to enable ADF personnel to be released for such training. A strategic alliance between 1 Field Hospital [now 1 HSB] and Liverpool Hospital is being progressed to this end.

### Findings of the follow-up audit

**4.16** The situation has not changed significantly since the original audit. Although a strategic alliance between 1st Health Support Battalion (1HSB) and Liverpool Hospital has been in operation since 1998, there are no alliances between other ADF health units and civilian hospitals. Defence advised that strategic alliance proposals were being discussed with a number of civilian hospitals including, a major Brisbane hospital, Royal North Shore Hospital and Westmead Hospital. The ANAO was advised that progress in making such agreements with civilian health authorities had been slow due to health personnel shortages and the high number of recent ADF operations in which the DHS has been involved.

**4.17** The Defence Health Service Branch (DHSB) was, at the time of the follow-up audit, about to review the 1HSB/Liverpool Hospital alliance with the aim of developing general guidance to assist other ADF health units establish similar arrangements in their region. DHSB guidance could also incorporate lessons to be learned from the strategic alliance between 1HSB and Liverpool Hospital. The ANAO understands that strategic alliances and other arrangements for enhancing the clinical training of



deployed force health support staff are to be reviewed as part of Phase 1 of Joint Project 2060.<sup>69</sup>

**4.18** An Army report on the strategic alliance between 1HSB and Liverpool Hospital<sup>70</sup> contains a survey of 1HSB clinical staff prior to their re-deployment to Australia from East Timor. In relation to those 1HSB staff who had been seconded to Liverpool Hospital prior to deployment, the survey found that the secondments had made them more competent to deploy. The report also contains a number of suggestions to improve the current alliance (see Appendix 3 to this audit report). The ANAO considers that the suggestions should be considered when developing general guidance on establishment of strategic alliances. The ANAO also considers that Army's efforts in establishing the alliance are commendable and that the arrangement provides a valuable model for cost-effectively obtaining the training and experience required for operational deployments.

**4.19** Progress in relation to Recommendation No.10 has been slow, given the time that has passed since the original audit and that there is general agreement on the importance of exposing health personnel exposed to emergency and acute trauma. The ANAO recognises that there have been impediments to the development of strategic alliances (such as a high number of deployments and shortages in uniformed health staff) but would have expected that other suitable alliances, similar to that established with Liverpool Hospital, would now be in operation. The ANAO considers that Defence should give a higher priority to progressing the development of strategic alliances, with the primary goal of enhancing skills and experience of ADF health personnel in management of acute trauma and a secondary goal of providing these personnel with improved professional development opportunities. The ANAO also supports DHSB's proposal to develop general guidance in relation to the establishment of strategic alliances.

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<sup>69</sup> *Joint Project 2060 ADF Deployable Health Capability* is an ADF project to identify and develop capabilities required to prevent, treat and evacuate casualties in joint operations in the defence of Australia.

<sup>70</sup> *Development and implementation of the Strategic Alliance between 1<sup>st</sup> Health Support Battalion and Liverpool Hospital*, Lt Col Leonard B. Brennan MHA (UNSW), Headquarters 3<sup>rd</sup> Brigade, Australian Defence Force.

### *Defence response*

**4.20** Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.10. In response to the proposed report Defence advised that papers associated with a strategic alliance with Royal North Shore Hospital were currently with the Australian Government Solicitor and were progressing well.

## **Pathology services**

### **Findings of the original audit—Recommendation No.11**

**4.21** ADF pathology laboratories provided a wide range of services and referred more complex pathology testing to external providers. The ANAO saw scope to achieve economies by contracting out a higher proportion of the ADF's pathology work or developing a central ADF reference laboratory for routine screening. The wide geographic coverage of private pathology providers was suited to the decentralised nature of the ADF. Contracts could be developed on a national or regional basis for routine pathology testing, time-sensitive testing and complex testing that ADF facilities were unable to do. It was recognised that Service hospitals may need to maintain an in-house capability to provide pathology services that were time critical and that the ADF needed to retain a deployable pathology capability.

#### **1997 Recommendation No.11\***

The ANAO recommends that the Surgeon General examine the costs and benefits of either contracting out pathology services or centralising the conduct of all routine pathology screening in an existing ADF laboratory.

Defence response: Agree.

### **Findings of the follow-up audit**

**4.22** Progress on Recommendation No.11 has been slow. In November 1999 Defence engaged a consultant to examine the provision of pathology services in the ADF and to report on opportunities for rationalisation and market testing. The consultant's draft final report<sup>71</sup> estimates the total cost of ADF pathology services in 1998–99 to be \$5.6 million. The report found that, of 286 500 pathology tests performed in that year, 262 000 (91 per cent) were performed in ADF laboratories and 24 500 (9 per cent) were outsourced. The consultant found that tests

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<sup>71</sup> *Draft Final Report on the Review of the Provision of Pathology Services to the Australian Defence Force*, Department of Defence, 4 August 2000.

undertaken by ADF laboratories were routine and, with the exception of the most common analyses, many tests were performed only in very small numbers. As with other areas of the ADF health services, the consultant had difficulty in obtaining throughput and cost data and has made estimates in places.

**4.23** Overall, the consultant found that present pathology service delivery arrangements are inefficient and that there is considerable scope for centralisation through a single tri-Service laboratory or by negotiating outsourcing arrangements with private service providers. It was considered that these inefficiencies resulted primarily from duplication of resources, under-utilisation of laboratories and equipment, low activity levels and high operating costs. The consultant saw a clear need to increase the efficiency of ADF pathology services. It was noted that the ADF required a better understanding of the cost of in-house pathology services. Laboratory information systems were essentially patient management systems and did not allow the ADF to cost service provision, improve service delivery or benchmark with the civilian sector.

**4.24** The consultant's draft final report examines the costs and benefits of eight pathology service delivery options ranging from the establishment of a single tri-Service laboratory to the outsourcing of all ADF pathology services. The option of outsourcing all ADF pathology services was found to offer the greatest savings (\$7.7 million over a five year period) and is the consultant's preferred model. The report recommends that the ADF's pathology service needs be met by purchasing services from the civilian sector and that ADF pathology services be market tested. Under the preferred model, uniformed laboratory staff would be trained by means of targeted placements in civilian laboratories. Such placements would expose staff to a greater volume and complexity of tests than they would receive in a tri-Service laboratory.

**4.25** The consultant's findings have been widely criticised by ADF health personnel. They consider that the report does not fully appreciate the requirement for a deployable pathology capability or adequately address the training of uniformed laboratory personnel. The Director Commercial Support Program—Defence Health Service (DCSP–DHS) acknowledges that the consultant's report does not adequately address the issues associated with maintaining a deployable pathology capability and the training of deployable personnel. Terms of reference for a further, short, study to cover these issues have been developed. It would be undertaken by a consultant with operational health experience, and senior environmental health commanders and the JP 2060 study team would be consulted. The report, when completed, would permit DCSP–DHS to make recommendations on the rationalisation and market testing of ADF pathology services.

4.26 Separately, pathology services in Victoria have been reviewed as part of a rationalisation study into ADF health services<sup>72</sup> in that region. That study recommends that all pathology services in Victoria be outsourced, on the basis of the likely discounted rates that could be negotiated with a service provider. At the time of the follow-up audit, pathology services in Victoria were being market tested.

4.27 The ANAO considers that, to complete the implementation of Recommendation No.11, a review of ADF deployable pathology capability should be undertaken and its findings and those of the earlier consultant's review of ADF pathology services used to develop an ADF-wide pathology services delivery model. The agreed model should make adequate provision for a deployable pathology capacity (including appropriate training arrangements) and be implemented as soon as possible.

#### *Defence response*

4.28 Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.11. In response to the proposed report it advised that a consultant appointed to undertake the study on the operational/deployable aspects of the ADF's pathology requirements had submitted an outline work plan in March 2001. Defence also advised that it was expected that the study would commence before the end of May 2001 (once the terms of reference for the study are agreed with the Environmental Command health personnel and the JP 2060 project team).

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<sup>72</sup> *ADF Health Services in Victoria, Rationalisation Study Final Report*, Joint Health Support Agency, 20 November 2000.

## 5. Financial Administration

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*This chapter discusses Defence's implementation of Recommendation Nos 12 and 13 of the original audit report. It focuses on Defence's efforts in developing systems to monitor and control all expenditure on ADF health services; examining the circumstances in which costs associated with the provision of ADF health services to civilians should be recovered; and developing and implementing cost recovery procedures.*

### Monitoring and control of health expenditure

#### Findings of the original audit—Recommendation No.12

**5.1** The main emphasis of health services financial management was on external health services and health materiel, with little consideration of other expenditure areas such as Defence salaries and operating and capital costs. The ANAO considered it essential that Defence develop systems to enable the OSGADF [now Defence Health Service Branch (DHSB)] to monitor and control all ADF health expenditure and to ensure that funds are allocated efficiently and effectively. Apart from the Defence ledger system (DEFMIS),<sup>73</sup> there was no source of readily accessible information on ADF health costs.<sup>74</sup> Accordingly, Defence was unable to determine whether it would be more cost-effective to source health services in-house or from external providers.

#### 1997 Recommendation No.12\*

The ANAO recommends that Defence develop systems to monitor and control all expenditure on health services and that up-to-date information on the full costs of providing health services be maintained.

Defence response: Agree. To implement this recommendation may require additional resources in the immediate future so that the costs of delivery of health care can be determined.

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<sup>73</sup> The Defence Financial Management Information System (DEFMIS) was recently replaced by the Resource and Output Management and Accounting Network (ROMAN).

<sup>74</sup> Only 20 per cent of total recurrent health expenditure could be directly attributed to the health services through DEFMIS.

## Joint Committee of Public Accounts and Audit

5.2 In its 1998 review of the ANAO's original audit report, the Joint Committee of Public Accounts and Audit (JCPAA) commented, in relation to the costing of services, that it was deeply concerned that Defence appeared complacent about its financial management at a time when every expectation would be that Defence would have moved towards a more sophisticated understanding and an accounting of its costs by means of integrated accrual financial management. The JCPAA repeated a recommendation that it had made in an earlier report that:

*Australian Defence Head Quarters, in conjunction with the Department of Defence, take prompt action to implement the accounting and financial management reforms proposed in the report of the Defence Efficiency Review.*<sup>75</sup>

5.3 In its 1998 response to this JCPAA recommendation, Defence advised that it had largely completed the implementation of the key financial reforms proposed in the Defence Efficiency Review and was moving towards an improved system of financial management.<sup>76</sup> The ANAO notes that the reforms proposed by the Defence Efficiency Review go beyond the scope of this follow-up audit and that enhancement of Defence's financial management system is still in progress.

## Findings of the follow-up audit

### *Financial management and control*

5.4 The focus of health services financial management continues to be on external health services expenditure. DHSB does not have centralised control of all ADF health expenditure. However, the Joint Health Support Agency (JHSA), which is subordinate to the DHSB, has been given responsibility for control of ADF expenditure on external health services.

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<sup>75</sup> Joint Committee of Public Accounts and Audit, *Review of Auditor-General's Reports 1996–97, Fourth Quarter, Report 359*, March 1998 (p. 15, para 2.58).

<sup>76</sup> Defence's response to the JCPAA's recommendation is in *Finance Minute: JCPAA Report 359, Review of Auditor-General's Reports 1996–97 Fourth Quarter (11 November 1998)*.

5.5 The original audit found that it would be desirable to have a facility for transferring funds from military and civilian salaries to the budget for external health services when contractors are employed in lieu of salaried personnel. The follow-up audit found that such a mechanism had not been developed but customer/supplier agreements were being developed between the DHS and the Services to enable the DHS to identify and recover the difference between the salaries of military personnel and the cost of contractors hired in lieu. The agreements are to be in place by July 2001.

#### *Full costs of providing health services*

5.6 Defence still does not maintain up-to-date information on the full costs of providing health services, and DHS management remained at a disadvantage because of that. Baseline costings have been developed for health services in the Victoria and Southern NSW/ACT regions, but their development has been difficult and time consuming. A consultant engaged to review ADF health services in the Victoria region noted that *'there was a scarcity of standard health activity and costing information, similar to that collected by private hospitals and State/Territory health authorities as an integral part of their Management Information Systems.'* This, the consultant believed, prevented a thorough and detailed analysis of ADF health services in Victoria.<sup>77</sup>

5.7 Similarly, a draft rationalisation study report for the Southern NSW/ACT region stated that

*It is a matter of concern that some three years following the ANAO audit report, there continues to be a dearth of basic health service statistics and financial information. Information availability has certainly challenged the development and analysis of rationalisation options.*<sup>78</sup>

Development of the costings required considerable work by unit personnel (for example, completion of activity surveys) and numerous follow-up meetings with consultants to verify the data. Despite these efforts, the ANAO understands that significant data gaps remain and that estimates were required in a number of areas.

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<sup>77</sup> ADF Health Services in Victoria, *Rationalisation Study—Final Report*, Department of Defence, 20 November 2000, p. 8 para. 2.7.

<sup>78</sup> *Rationalisation and Market Testing of Health Services in the ACT and Southern NSW, Draft Rationalisation Report*, Department of Defence, October 2000 p. 39.

### *Systems to monitor and control expenditure on health services*

5.8 A number of information systems are being or had been developed to improve Defence's ability to monitor, control and cost ADF health services. Primary among these is the HealthKEYS, which aims to provide comprehensive financial and resource information for the DHS. Rollout of the system to three trial sites has been delayed until May 2001. HealthKEYS will allow, through the use of standard medical and dental coding systems, costings for internal service provision to be developed. The HealthKEYS Business Case<sup>79</sup> indicates that HealthKEYS will, over time, be linked with a number of Defence corporate information systems including ROMAN, PMKEYS and DEFCARE, thereby improving its efficiency and effectiveness (see also paragraph 6.4 et seq.)

5.9 JHSA has developed an interim database to monitor expenditure by ADF units on external health service providers. Defence was also introducing a new pharmaceutical management information system to selected sites in the ADF. This system will allow Defence to monitor the cost and usage of pharmaceuticals in the ADF and in the future is to be linked to HealthKEYS.

5.10 Overall, the ANAO found that Recommendation No.12 was still awaiting implementation of an ADF-wide health information system. The lack of such a system prevented effective monitoring and control of health service expenditure and up-to-date information on the full costs of health service provision being maintained.

### *Defence response*

5.11 Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.12. It referred the ANAO to its comments in relation to Recommendation No.9 (paragraph 4.14).

## **Recovery of ADF health service costs**

### **Findings of the original audit—Recommendation No.13**

5.12 In some situations the costs of treating ADF members could be recovered from insurers and other third parties. Defence did not always do so. Sometimes scope for recovery came to light only when an insurer approached the ADF for details of costs. Full costs of hospital and other treatments were not being recovered. There was also potential to increase the extent of cost recovery for ADF health services provided to

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<sup>79</sup> *HealthKEYS, the 21<sup>st</sup> Century Health Solution—Business Case*, HealthKEYS project team, October 1999 (Executive Summary p. 7).



the civilian community. Three specific areas were identified: Navy treatment of civilian divers suffering the 'bends'; Air Force's aeromedical evacuation services; and payment to medical officers undertaking professional development clinical duties in approved civilian facilities during normal working hours.

#### 1997 Recommendation No.13

The ANAO recommends that Defence examine the health services provided to the civilian community by the ADF in order to determine those circumstances in which costs should be recovered and develop and implement effective cost recovery procedures.

Defence Response: Agree.

### Findings of the follow-up audit

#### *Recovery of health costs from third parties*

**5.13** A Defence Instruction on recovery of health costs was issued in 2000.<sup>80</sup> The Instruction, based on Defence Force Regulations,<sup>81</sup> sets out procedures for recovery of health costs associated with treatment provided to an ADF member at Commonwealth expense, where the member has an enforceable claim for damages against a third party. The Instruction brings together three single-Service instructions and centralises<sup>82</sup> the cost recovery role within the DHSB. The JHSA, through its Area Health Services, plays an important role in cost recovery by identifying potential cases, gathering requisite documentation and tracking health costs associated with individual cases.

**5.14** The ANAO was advised that in 1999–2000 some \$0.3 million was recovered from third parties and that this represented a substantial increase on previous years. However, discussions with the DHSB Directorate of Health Resources indicated that there was scope for greater recovery of costs as DHS personnel become more aware of opportunities and procedures for doing so. It was estimated that as much as \$1 million per annum may be recoverable. HealthKEYS, once implemented, should assist in estimating and tracking recoverable health costs.

<sup>80</sup> Defence Instruction (General) ADMIN 24–6 *Recovery of Health Costs*, (22 November 2000).

<sup>81</sup> Defence Force Regulations 1952—*Recovery of costs of treatment in certain circumstances*.

<sup>82</sup> The ANAO was advised that health costs were previously recovered by three or four separate agencies.

**5.15** Defence Force Regulation 58G requires that, in recovering dental and medical expenses, Defence charge in accordance with a prescribed schedule of bed-day rates. The rates are based on Department of Veterans' Affairs bed-day rates calculated in 1986 and therefore significantly understate current ADF bed-day costs. The ANAO notes that Defence uses a higher bed-day rate on those occasions where it has a defensible case against a third party and that it intends to update the schedule of rates as soon as practicable.

#### *Provision of health services to civilians*

**5.16** In May 2000 the DHSB asked DHS units for advice on the extent and circumstances under which health costs should be recovered from civilians. Specifically, comments were sought on the scope for cost recovery in relation to recompression chamber treatment of civilians, aeromedical evacuation of civilians and moneys received by medical officers undertaking professional development in civilian facilities during normal working hours. Little feedback was received, and it appeared that there was limited scope for cost recovery, primarily due to the infrequent and emergency nature of most of the health services provided to them.

**5.17** In regard to recompression chamber treatment and aeromedical evacuation services it was found that treatment was provided to civilians only in emergency situations and that it was covered by existing Defence Instructions.<sup>83</sup> Treatment is provided as Category 1<sup>84</sup> Defence Assistance to the Civil Community (DAAC); that is, without cost recovery. Defence also considered that the costs of administering any collection processes were likely to outweigh any gains, and that to attempt to recover costs would result in adverse public relations.

**5.18** In relation to payment of medical officers undertaking professional development in civilian facilities during normal working hours, Defence's general principle is that such moneys should be remitted to Defence. Recovery of such moneys depends primarily on advice from the Defence approving authority to the civilian health facility of the general principle and, more generally, on the honesty of the member undertaking the professional development. Policing of such arrangements is difficult

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<sup>83</sup> Defence Instruction (General) OPS 05-1 *Defence Assistance to the Civilian Community policy and procedures* and DI(G) PERS 16-2 *Service Medical and Dental Assistance to Civilians*.

<sup>84</sup> Under this category emergency assistance for a specific task(s) is provided by Defence in localised situations when immediate action is necessary to save human life, alleviate suffering, prevent extensive loss of animal life or prevent widespread loss/damage to property. The DACC Instruction requires that Category 1 tasks be provided by Defence without recovery of costs or indemnification/insurance coverage.

and there are practical difficulties in defining what constitutes 'normal working hours'. A policy on the use of civilian facilities by ADF health personnel is being developed by the Directorate of Health Capability and Development. Defence expects the policy to address this specific issue.

**5.19** The ANAO considers that Defence has addressed Recommendation No.13.

*Defence response*

**5.20** Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.13.

## 6. Health Information Systems

*This chapter examines Defence's implementation of Recommendation No.14 of the original audit report. It outlines Defence efforts in developing an ADF-wide health information system with out-patient, in-patient, dental and financial management sub-systems.*

### Findings of the original audit—Recommendation No.14

**6.1** Defence's health care management information systems were essentially manual systems with some computerised support. They were personnel-intensive, largely unresponsive and suffered from duplication of effort. They provided inadequate financial management capability and led to inefficient patient administration and data gathering. These single-Service systems operated independently of each other and did not capture and report the required level of information, particularly at the executive management level. This inadequate information base had adverse implications for ADF health service policy development and resource planning and management. It was considered that the Health Systems Redevelopment Project (HSRP), a health management information system being developed at the time, could overcome many of these difficulties.

#### 1997 Recommendation No.14\*

The ANAO recommends that Defence accord a high priority to the development of effective ADF-wide health information systems, and examine options for accelerating the implementation of an electronic patient record with out-patient, in-patient, dental and financial management sub-systems (see also Recommendation No.12).

Defence response: Agree. This is a flow-on recommendation of Recommendation No.12. Recommendation No.12 cannot be implemented without this.

### Findings of the follow-up audit

**6.2** ADF health information systems still experience difficulties of the kind identified by the original audit. The systems do not meet the information needs of the Defence Health Service, which still runs a number of stand-alone systems primarily for practice management purposes.<sup>85</sup> Most of the systems are not networked or centrally supported

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<sup>85</sup> Practice management relates to activities conducted at the front desk of a hospital or medical centre such as arranging appointments and developing schedules.

and consequently the transfer of health information between them requires substantial duplication of effort. Data on the systems relating to injury and illness types and causes are insufficient to develop and monitor preventative strategies. However, progress has been made towards development and implementation of an ADF-wide health information system with out-patient, dental and financial management sub-systems.

**6.3** The HSRP, which was to address ADF health management information needs, was cancelled in 1997 when it became too expensive (its estimated cost increased to \$25 million). An updated version of the original HSRP software, a commercial off-the-shelf package known as MAXCARE, was assessed by Defence in 1999. It was found to incorporate many of the improvements identified during a 1996 Defence trial of HSRP. Defence considered that a system based on this software would now be less expensive than HSRP, due to reductions in software costs, elimination of the requirement for a Prime Systems Integrator and an ability to leverage off infrastructure and software improvements made or proposed in Defence.

### *HealthKEYS*

**6.4** A business case<sup>86</sup> for a health management information system, called HealthKEYS and based on MAXCARE software, was developed in 1999. It proposed a phased introduction of HealthKEYS over five years for a total cost of \$8.1 million. The cost included hardware, software/licences, development of system interfaces, training and implementation costs. The business case considered that the system would produce considerable savings in administration and delivery of health services to the ADF. It conservatively estimated net savings of \$7.3 million per annum once HealthKEYS had been fully implemented. The savings would result from a reduction in injuries and illness, more efficient health record management, closure of health and other related legacy information systems (and associated avoidance of duplicate data entry) and better tracking of recoverable costs.

**6.5** The broad objectives of the HealthKEYS project are to provide accurate information on ADF members' health readiness and deployability; health management information to senior health managers; a platform for developing a deployable medical capability; practice and clinical management systems; and information to develop and assess injury and illness preventative strategies. HealthKEYS will be designed to exchange information with other corporate information systems such as PMKEYS, ROMAN and DEFCARE, thereby avoiding duplicate data entry.

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<sup>86</sup> *HealthKEYS the 21<sup>st</sup> Century Health Solution—Business Case*, HealthKEYS Project Team, 1999.

**6.6** The HealthKEYS project was approved in October 1999. In October 2000 Defence signed a three-year contract with a company for \$1.9 million for the MAXCARE software and implementation and support for the project. Project staff advised the ANAO that they had received funding of \$2.7 million for 2000-2001 (\$1.9 million for contract and hardware costs and \$0.8 million for project related costs such as training and travel and subsistence) but, at the time of the follow-up audit, no additional funding for the project had been approved.

**6.7** The ANAO understands that, since the 1999 business case, the estimated project costs has increased from \$8.1 million to \$15.4 million. The increase was attributed to Defence's move to accrual accounting and the associated requirement to budget for additional items such as project office salaries and accruals; replacement hardware; and costs associated with hardware and network maintenance.

#### *Project implementation timetable*

**6.8** The HealthKEYS project involves a lead-site 'roll-out' and two main phases (implementation of a practice and resource management module and a clinical management module). Initial roll-out to three lead sites representative of most user sites is expected to occur in May 2001. The aim of the initial roll-out is to assess how the system performs under real conditions and to ensure that any deficiencies are identified and addressed before wider roll-out.

**6.9** Phase 1 involves progressive roll-out of the system to approximately 175 sites. By the end of Phase 1 approximately 90 per cent of all ADF members would be covered by the system. This phase will involve installation of a practice and resource management module at medical and dental facilities. It is planned to begin in September 2001 and take approximately 12-15 months to complete. Features of Phase 1 of the HealthKEYS project include financial management; operational readiness indicators for deployment; management of health resources (for example, staff rostering); registration and appointmenting; unit medical and dental record tracking; and epidemiological information gathering. Business and technical risks associated with this Phase are assessed by the Project Office as low.

**6.10** Phase 2, planned for 2003, will involve the installation of additional software and hardware in the clinical areas of medical and dental facilities. Over time, this will allow development of an electronic health record for the ADF. Medical and dental clinical systems will also be developed. Business and technical risks associated with this phase are assessed as medium to high. The current scope of the project does not include an in-patient module, but that this functionality may be included in a later, but as yet, unplanned Phase 3 of the project.

### *Defence Information Systems Group concerns*

**6.11** Defence Information Systems Group (DISG) has indicated some concerns about the project, particularly that its operating/support costs had been understated and that the system architecture proposed by the project office (a decentralised architecture) was at odds with that increasingly being adopted across Defence (that is, a centralised architecture). The HealthKEYS project office considered that the latter architecture would result in unacceptable down-load times for patient records and adversely affect user acceptance of the system. The ANAO understands that DISG and the project office have now agreed to undertake the system trial using a centralised architecture and assess its performance.

### *Project risks*

**6.12** HealthKEYS is a major ADF-wide information system project involving significant cost and technical risks. The project will require careful monitoring and oversight by Defence. A risk management plan<sup>87</sup> has been developed by the project office and a HealthKEYS Project Board will oversight the project. At the time of the audit the Project Board had met twice. The ANAO considers that the project board should meet frequently, especially in the early stages of the project, and update the risk management plan regularly.

**6.13** It has taken over a decade to develop an ADF health information management system, primarily due to the failure of the HSRP project. The full benefits of HealthKEYS are unlikely to be fully realised for another four to five years. If successfully implemented, HealthKEYS should address many of the health management information deficiencies identified by the original audit and provide a platform on which additional functionality can be built. As many of the recommendations made in the original audit report rely on information to be provided by the system, the ANAO supports its development. However, Defence needs to proceed carefully in view of the project risks and increasing costs.

### *Defence response*

**6.14** Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.14.

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<sup>87</sup> HealthKEYS Risk Management Plan, Department of Defence, 25 September 2000.

## 7. Occupational Health and Safety

*This chapter discusses Defence's implementation of Recommendation No.15 of the original audit report. It examines Defence efforts to reduce injuries and illnesses in the ADF through epidemiological research, short and long-term strategies and the identification of all costs associated with compensable injuries and illness in the ADF (so that budget responsibility for these costs may be devolved to relevant sub-program managers).*

### Findings of the original report—Recommendation No.15

**7.1** The original audit commended Defence's initiatives to reduce recruits' injuries and wastage but found little evidence of research on the incidence and cause of injuries more generally, especially in Army where the major problems occurred. Full direct and indirect costs associated with injuries in the ADF were not recorded or known, apart from identified post-discharge costs (for example, lump sum compensation payments). Individual ADF programs did not have to fund the premiums paid by Defence to cover compensation costs, and therefore there was no incentive for program managers to reduce injuries leading to compensation claims.

#### 1997 Recommendation No.15\*

The ANAO recommends that Defence:

- a) give greater attention to epidemiological research into injuries and illnesses in the ADF;
- b) develop both short and long-term strategies aimed at reducing the level of injuries and illnesses in the ADF; and
- c) identify all costs associated with compensable injuries and illnesses in the ADF, and put in place arrangements for these to be the budget responsibility of the relevant sub-program managers.

Defence response: Agree. In respect of each of the sections of the recommendation the following comments are offered:

- a) a number of studies are currently under way or planned to achieve this part of the recommendation;
- b) strategies are being developed through the analysis of available data from both the accident and incident databases, and from workers' compensation data. In addition, with implementation of the OH&S [Occupational Health and Safety] component of the DEFCARE system and the introduction of common notification and reporting systems,



both due mid 1997, a more comprehensive database of information will become available from which to base the development of short and long-term strategies. As the link between the OH&S and Compensation components of DEFCARE is developed, the available data for analysis will increase accordingly; and

- c) the identification of all costs associated with workplace illness and injury is a long-term goal of both DEFCARE and HSRP Projects. The eventual linking of these systems will achieve this aim.

## Findings of the follow-up audit

### ***a) give greater attention to epidemiological research into injuries and illnesses***

7.2 Epidemiological research into injury and illness in the ADF has not been given the attention envisaged by the original audit, but measures were now being introduced to improve the amount, quality and focus of such research. These include production of an ADF Health Status Report, development of a health management information system and creation of a joint surveillance unit.

#### *ADF Health Status Report*

7.3 The ADF Health Status Report,<sup>88</sup> developed by the Defence Health Service Branch (DHSB) in 2000, provides an overview of the health of the ADF population and identifies the ADF's health priorities. The ANAO commends the development of the Report and considers that it should assist epidemiological research in Defence by identifying priority areas, highlighting deficiencies in data requirements and allowing the effectiveness of preventative interventions to be assessed.

#### *HealthKEYS*

7.4 The ADF Health Status Report notes problems in obtaining and analysing health data during the report's development. Consequently, the report identifies, as one of its main priorities, the development of an efficient and effective information system for capturing data on health indicators. HealthKEYS, a health management information system under development, should provide more standardised health data and therefore enhance the ADF's ability to conduct epidemiological research.

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<sup>88</sup> ADF Health Status Report, Department of Defence, 15 December 2000.

### *Joint surveillance unit*

7.5 The ADF Health Status Report comments on action taken in response to ANAO's Recommendation No.15(a) as follows:

*... a framework for epidemiological research into injuries and illness has not been adequately developed. Indeed the ADF does not currently have an epidemiological research capability at the present time.*<sup>89</sup>

7.6 DHSB and the Defence Injury Prevention and Management Group have held preliminary discussions regarding the possible formation of a joint surveillance unit. The unit would comprise three positions: an occupational physician; a bio-statistician; and possibly a part-time epidemiologist or toxicologist. The unit would be responsible for analysing the information generated by HealthKEYS. The ANAO considers that unit would significantly improve the Defence's ability to conduct epidemiological research.

### ***b) develop both short and long-term strategies aimed at reducing the level of injuries and illnesses in the ADF***

7.7 In support of the ANAO recommendation, the Joint Committee of Public Accounts and Audit, in its 1998 review of the ANAO report, recommended that '*Defence develop and implement as a matter of urgency, short-term strategies aimed at reducing the current level of injuries based on the findings arising from existing studies.*'<sup>90</sup>

7.8 The ADF Health Status Report comments as follows:

*... the purpose of epidemiological research into injuries and illness is to prevent them or minimise their impact. For the most part it does not appear that the ADF is using data on injuries and illness to develop short and long-term strategies for injury prevention.*<sup>91</sup>

7.9 Short-term strategies aimed at reducing injuries in the ADF since the original audit had been limited to reducing injuries amongst recruits. The ANAO commends the work carried out in relation to injuries among ADF recruits and notes that savings in both personnel and costs that have been achieved. Nevertheless the ANAO considers that there is scope for short-term strategies to be developed and implemented with application to the wider ADF population, based on the findings of studies completed at the time of the original audit. For example, it has been

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<sup>89</sup> *ibid.*, para 1.109.

<sup>90</sup> Joint Committee of Public Accounts and Audit, *Review of Auditor-General's Reports 1996–97, Fourth Quarter, Report 359*, March 1998 (p. 18, para 2.73).

<sup>91</sup> *ADF Health Status Report*, Department of Defence, 15 December 2000, para 1.110.

known, from as early as 1991, that sport and physical training are the two main causes of injuries in the ADF. Implementation of short-term strategies in these areas would have led to earlier personnel and monetary savings.

**7.10** A priority identified by the ADF Health Status Report was to develop an ADF Health Promotion Program. The program, which has been endorsed by the Chiefs of Staff Committee (COSC), has two components: the development of an individual health promotion program (designed to identify risk factors in a person's lifestyle) and the development of population health programs (designed to improve the health of the ADF community at large). As part of the population health component, three priority areas have been chosen for the development of long-term strategies: injury prevention; mental health; and cardiovascular health. At the time of the follow-up audit the injury prevention strategy had been developed and endorsed by COSC;<sup>92</sup> work on the cardiovascular health strategy was nearing completion; and the mental health strategy was in the early stages of development. The ANAO supports the development of these strategies and considers that they should enhance the general health of the ADF population and result in cost savings for Defence through reduced injury and illness.

**c) *identify all costs associated with compensable injuries and illnesses and put into place arrangements for these to be the budget responsibility of the relevant sub-program managers***

**7.11** Defence is still unable to identify all costs associated with compensable injuries and illness but is making progress towards this goal. Defence has been working on the links between occupational health and safety, compensation and those costs relating to compensable injury and illness expended in the Defence Health Service budget. Achievement of this part of Recommendation No.15 depends on successful implementation of HealthKEYS and its linkage with DEFCARE. HealthKEYS should allow the full cost of treating individuals with compensable injuries and illnesses to be calculated.

**7.12** Budget responsibility for all costs associated with compensable injuries and illnesses has not been devolved to relevant sub-program managers as recommended by the original audit and agreed by Defence. A 1999 review of the Military Compensation Scheme (Tanzer Review),<sup>93</sup>

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<sup>92</sup> *Injury prevention strategy for ADF sport and physical training.*

<sup>93</sup> *Review of the Military Compensation Scheme (Tanzer Review)*, Department of Defence, March 1999 (paras 341 and 342).

recognised, as did the ANAO's original report, that there would be benefits from devolving budget responsibility for the full cost of compensation (including health costs) to an appropriate level in Defence so that commanders would have an incentive to reduce injury costs. However, this issue has not yet been considered by the Defence Executive.

#### *Defence response*

**7.13** Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.15.

## 8. Dental Services

*This chapter addresses Defence's implementation of Recommendation No.16 of the original audit report. It examines Defence efforts in reviewing ADF dental services, specifically work practices, the number of dental personnel and the standard of treatment provided to members.*

### Findings of the original audit—Recommendation No.16

8.1 The audit found that:

- most ADF dental services were provided by permanent clinics and most dental personnel generally did not deploy;
- a 1996 review of Naval health services found scope for replacing some dental personnel with contract health staff under certain circumstances;
- the ADF was not meeting its performance requirements for dental fitness, primarily because dental personnel, especially in Army, were being misemployed on military duties; and
- the ADF had a significantly higher ratio of dental staff to dependent populations than the Australian community.

8.2 The audit estimated the average cost of dental treatment in the ADF to be \$987 per member.<sup>94</sup> This was over eight times the Australian average of \$113 per person. The audit report noted that civilian dental services were largely reactive and that ADF dental services were largely preventative, but it considered the cost differential to be significant and warranted further attention, particularly the possibility that ADF standards of treatment may be higher than necessary.

#### 1997 Recommendation No.16\*

The ANAO recommends that Defence review ADF dental services, particularly in regard to work practices, the number of dental personnel and the standard of treatment given, with a view to increasing the cost-effectiveness of dental services.

Defence response: Agree. Defence agrees in general terms with the thrust of the recommendation, except for the implication that the standard treatment provided could be reduced. Treatment provided is focused on prevention, function and minimising the potential for dental casualties

*continued next page*

<sup>94</sup> Excludes costs associated with training of dental personnel.

in the deployed situation. Such a focus relies on minimal intervention. ADF dental services do not restore teeth unless restoration is essential. Any treatment provided is necessary for that patient's dentition to function adequately for the greatest possible duration. Failure to provide needed treatment in a timely manner would result in greater clinical problems and greater attendant costs. Treatment of a purely cosmetic nature is generally not in the best interests of the longevity of the dentition and thus rarely, if ever, provided.

### Findings of the follow-up audit

8.3 There have been two reviews of ADF dental services since the original audit, one in 1997<sup>95</sup> and the other in 2000.<sup>96</sup> The report of the latter review was endorsed by the DHS Steering Committee and provided in June 2000 to the Deputy Service Chiefs. Its recommendations can be found at Appendix 4 to this report. At the time of the follow-up audit, only the Deputy Chief Air Force had formally responded to the report. The ANAO was advised that, despite the lack of feedback, relevant manning areas in each Service were undertaking workforce planning on the basis of the personnel numbers contained in the report.

#### *Work practices*

8.4 Neither of the two reviews undertook a detailed review of work practices. The 1997 review attempted to benchmark work practices but found this difficult because *'there are few, if any, directly analogous organisations in Australia with which direct comparisons can be made.'* It considered the most valid comparison in Australia would be with health insurance dental clinics. Data obtained from a private health insurance fund indicated that, once adjusted for dental officers' military duties, the manpower planning ratio used by the ADF for dental officers was valid.<sup>97</sup>

8.5 The 1997 review also noted a trend in dentistry, particularly in private practice, to increase the dental support to dentist ratio to obtain greater efficiencies and perform the sterilization function. The review stated that *'The ADF has not embraced this change and, in the main, retains the work practice of one dental assistant per dentist with an additional assistant to work as a receptionist in the multi-surgery clinics'*.<sup>98</sup> The ANAO understands

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<sup>95</sup> *Review of ADF Dental Services*, Dental Review Team, 19 December 1997.

<sup>96</sup> *The Optimisation of Dental Service Provision to the Australian Defence Force*, DHSB, 16 May 2000.

<sup>97</sup> This ratio—one dental officer to a population of 800 members—was sourced from Health Policy Directive No.407 *A guide to dental patient to staff ratios*. The Dental Review Team did not review the ratios in regard to other dental personnel.

<sup>98</sup> *Review of ADF Dental Services*, Dental Review Team, 19 December 1997, p. 15 para 110.

that, since the 1997 review, Defence has made changes to support ratios except in areas where facility constraints preclude them. The review also saw scope for excess staff capacity in one unit to be used by a nearby unit with insufficient staffing. The ANAO was advised that this now occurs in many areas but that there have been difficulties in formalising the arrangement, owing to '*administrative and cultural barriers*'.

**8.6** The 2000 report on the ADF dental service contained little analysis of ADF dental work practices. It noted the reduced efficiency of dentists, due to increased infection control procedures, and that large practices often find it more cost-effective to employ additional ancillary staff for this purpose. The ANAO noted the difficulties involved in benchmarking ADF dental work practices against other public and private organisations and that the ADF dental service cannot always achieve economies of scale<sup>99</sup> but considered that ongoing review of work practices is important. The ANAO found that there was still an imbalance between Army dentists' clinical and military duties, with adverse implications for dental standards.<sup>100</sup>

**8.7** ANAO discussions with dental staff from the DHSB indicated that work practices are to be reviewed as part of the development of a quality assurance program for ADF dental services.<sup>101</sup> The program would include benchmarking of ADF dental work practices against those of State dental services and private health insurance dental clinics. Although these dental services are expected to be more efficient than the ADF's, benchmarking would give an indication of the number of members a dental officer, on average, should be treating. The ANAO supports the benchmarking proposal, which could lead to adoption of more efficient ADF work practices.

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<sup>99</sup> For example, the dispersed nature of Defence bases means that the ADF dental service is unable to achieve the economies of scale that can be achieved by private health insurance dental clinics (which may employ up to 10 dentists in a clinic).

<sup>100</sup> A September Minute from Specialist Adviser–Dental to Col Health indicated that 20–40 per cent of Army members had not had an annual dental examination in the last 12 months.

<sup>101</sup> The quality assurance program was only in the early stages of development at the time of the follow-up audit fieldwork but is due to be completed in the second half of 2001.

### *Number of uniformed dental personnel*

8.8 As part of the 2000 review of ADF dental services, Defence reviewed the number of dental personnel and has proposed a workforce structure involving a mixture of civilian and uniformed dental staff. The review methodology was to establish the minimum sustainable number of uniformed dental personnel required for operational purposes and how, beyond that requirement, peacetime support could be provided most cost-effectively. As part of the review, costs associated with uniformed and civilian providers in metropolitan areas were compared.<sup>102</sup> In comparison with civilian dental personnel, it was found that uniformed:

- dentists were comparable in cost with civilian dentists;
- dental specialists were found to be significantly less costly as long, as they were employed in their speciality on either a full or part-time leave without pay basis;
- dental hygienists were significantly less costly;<sup>103</sup>
- dental technicians were slightly more costly; and
- dental assistants were significantly more costly.

8.9 The dental workforce structure recommended by the review is shown in Table 1. It proposes a structure of 79 dental officers and 166 ‘other ranks’ personnel. This represents a reduction of 40 dental officers, 52 dental technicians, 21 dental hygienists and 74 dental assistants from the current dental workforce structure. The proposed structure also recommends an increase of 17 full-time equivalent (FTE) civilian dentists and 45 civilian FTE dental assistants. A more detailed breakdown of the proposed dental workforce structure by trade can be found at Appendix 5 of this report.

**Table 1**  
**Proposed ADF dental workforce structure**

	<i>Dental Officers</i>	<i>Other Ranks</i>	<i>Civilian (FTE)</i>	
			<i>Dentists</i>	<i>Assistant</i>
Current establishment	119	311		
Proposed establishment	79	166	17	45
Reduction	40	145		

Source: *Report on the Optimisation of Dental Service Provision to the ADF*, 16 May 2000 (para 41).

<sup>102</sup> The comparison was based on variable recovery costs from Edition 5 of the *Commercial Support Program Ready Reckoner* for uniformed staff.

<sup>103</sup> The ADF trains its dental hygienists to a lower standard than civilian hygienists and uses them in a more restricted role. The dental hygienist trade also provides a career path for dental assistants in the ADF.



**8.10** The review considered that, given Air Force's small operational requirement for dental technicians and that Navy no longer has an operational requirement for this trade,<sup>104</sup> operational dental technician support for the ADF should be provided by Army. It was considered that this could be achieved without the requirement for additional Army dental technicians.<sup>105</sup>

**8.11** It was stressed to the ANAO that achievement of the proposed reductions in uniformed dental positions was contingent on successful market testing of the ADF's health services in the Victoria region. The ANAO was advised that, if that market testing activity was successful, Defence would need to outsource only one other region to achieve the proposed reductions in uniformed dental personnel.

**8.12** It is estimated that the reductions in uniform dental personnel would save approximately \$13 million annually. The estimated annual cost of civilian support under the proposed workforce structure is \$3.8 million and external dental laboratory support \$1.5 million. The review considered that the proposed dental workforce structure would provide a sustainable operational dental capability and an efficient service to ADF personnel when uniform dental personnel are not deployed. The ANAO supports the implementation of the proposed workforce structure but notes that the Services had agreed to it only in principle.

**8.13** Given the smaller operational requirements of Navy and Air Force, the review also considered whether Army should provide all operational dental services for the ADF. It was found, however, that this would be impracticable, mainly because of Army's current inability to provide its own core requirement of uniformed dental personnel, with little or no spare capacity for the other Services.<sup>106</sup>

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<sup>104</sup> Navy ceased providing dental laboratory services at sea in 1991 and ceased training dental technicians in 1996.

<sup>105</sup> The Army operational requirement for dental technical skills is considered important but small.

<sup>106</sup> At the time of the review, Army was 50 per cent below its requirement for junior dental officers. The ANAO understands that this has been the case for a number of years due to Army's inability to attract and retain such personnel.

### *Joint Committee of Public Accounts and Audit*

**8.14** In its 1998 review of the ANAO's original audit report, the Joint Committee of Public Accounts and Audit (JCPAA) recommended that *'Defence take steps towards sourcing its requirement for dentists from outside the full-time Australian Defence Force.'*<sup>107</sup> The follow-up audit found that, under the proposed workforce structure, Defence would reduce the number of dental officer positions to the minimum required for operational dental support. This would involve reducing the number of uniformed dentists by 40 and increasing the number of civilian dentists by 17. The proposed dental workforce structure is yet to be approved but, should it be implemented, it would largely address the JCPAA's concerns.

### *Standard of treatment provided*

**8.15** Defence has not reviewed in detail the standard of treatment provided to ADF members and does not have information systems in place to do so. For example, Defence is unable to identify, on an ADF-wide basis, the amount, type or cost of complex dental treatments being provided to members. This situation is expected to improve with the implementation of HealthKEYS.

**8.16** The 2000 review found it difficult to benchmark ADF dental services because 80 per cent of dental services in Australia are provided by private practitioners (who treat patients largely on a reactive rather than preventative basis). In addition, unlike medical services, dental services in Australia do not have a Medicare-style funding arrangement with which to benchmark community standards of treatment. The 2000 review considered that the minimum standard of treatment should be the same as that provided to civilians who can access free public dental care but without waiting time requirements. It also considered that a full range of services should be provided but with restrictions on complex treatments. It noted ADF policies restricting complex dentistry (such as implants and orthodontics) and conceded that *'greater adherence to these policies would reduce the number of complex treatment not related to a functional requirement.'*

**8.17** The original audit report suggested that the high per capita cost of dental support relative to the Australian community indicated that the standard of treatment provided to ADF members may be higher than necessary. The 2000 review considered that general Australian dental

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<sup>107</sup> Joint Committee of Public Accounts and Audit, *Review of Auditor-General's Reports 1996–97, Fourth Quarter, Report 359*, March 1998 (p. 16, para 2.66).

statistics reflected a very large unmet need and that the most suitable Australian comparators were the private health funds' dental clinics. Defence advised that costing information obtained informally from a health fund clinic indicated that the average cost of treating civilian patients in that clinic compared favourably with an average cost per member developed by Defence. Defence therefore considers that the standard of treatment provided to ADF members is comparable to that provided by private health insurance dental clinics to its members.

**8.18** The ANAO was advised that, as with work practices, the standard of dental treatment provided to ADF members would be more fully examined by DHSB dental staff as part of a planned quality assurance program. As part of this program ADF standards of treatment would be benchmarked against public dental services and private health insurance clinics. The ANAO supports such an initiative and considers that any review of ADF dental treatment standards should be supported by cost and activity data.

#### *Defence response*

**8.19** Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.16.

## 9. Health Materiel

*This chapter reviews Defence's implementation of Recommendation Nos 17, 18 and 19 of the original audit report. It examines Defence efforts in reviewing availability and usage of therapeutic substances, arrangements for dispensing and issuing of pharmaceuticals (including the number of uniform and civilian pharmacists), and the prime vendor arrangement to supply pharmaceuticals directly to some ADF units.*

### Review of therapeutic substances

#### Findings of the original audit—Recommendation No.17

**9.1** The Surgeon General created a Therapeutic Advisory Working Party (TAWP) in 1991 to advise him on the availability and use of therapeutic substances in the ADF. The TAWP had not met for a number of years. In 1996 the Surgeon General decided to re-activate the TAWP with the aim of rationalising the range of therapeutic substances in use in the ADF. He identified an urgent need to review the whole range of over-the-counter therapeutic products to ensure only appropriate items were supplied. Efficiencies were expected from reducing the range of alternative products in the inventory and purchasing less expensive generic brands. The ANAO supported the direction taken by the Surgeon General.

#### 1997 Recommendation No.17\*

The ANAO recommends that the Surgeon General conduct a comprehensive review of the availability and usage of therapeutic substances in the ADF.

Defence response: Agree. The ANAO Report acknowledges the activities commenced in respect of therapeutics in the ADF. The increased emphasis for a comprehensive review is agreed. Equally important is the ability to be able to track the utilisation of medication for patient care purposes.

#### Findings of the follow-up audit

##### *Availability of therapeutic substances*

**9.2** The TAWP has not been reactivated and there has been no comprehensive review of the availability and usage of therapeutic substances. A preliminary review of the availability and usage of therapeutic products, however, was undertaken in November 1996. It found that, although there was scope for rationalising pharmaceuticals,

fundamental issues needed to be addressed before reactivating the TAWP. Primary among these issues was the need to define members' health care entitlements in a clear and practical way. The review noted that defining this entitlement would have important implications for the availability and usage of therapeutic substances in the ADF.

**9.3** The preliminary review also noted that any restrictions on the range of therapeutic substances provided to ADF members would raise significant issues such as restrictions on the professional prescribing rights of medical practitioners and pharmacists, diminution of a perceived condition of Service by members and standard of care issues. Therapeutic substances are currently reviewed as required by the Directorates of Clinical Policy and Health Resources in the Defence Health Service Branch.

**9.4** Over-the-counter (OTC) therapeutic products can be issued without prescription. In 1997 HDPE advised the Chief of the Defence Force that:

*... the cost of all over-the-counter items is estimated to be in the order of \$1.5 million. Prima facie, the cost of implementing an administrative system to recover such costs would not be effective and any small gain would probably not compensate for the likely perceptions regarding erosion of conditions of service.*<sup>108</sup>

**9.5** The ANAO was advised that, if members were required to pay for OTC items, member productivity may decline (as members with colds may simply stay at home rather than 'soldier' on) and ADF medical officers and pharmacists would lose visibility of members' medication histories.

### *Usage of therapeutic substances*

**9.6** Defence still cannot centrally monitor the prescribing and dispensing patterns of its medical practitioners and pharmacists. Use of pharmaceutical products in the ADF is monitored by logistics and health staff through vetting of monthly print-outs from the prime vendor contract (see paragraph 9.18). The information is examined for trends and problems but, as it is assumed that the purchasing patterns of units reflect their issuing/prescribing patterns, it is only an indicator of the latter. Two health management information systems, HealthKEYS and Pharmaceutical Integrated Logistic System (PILS – see paragraph 9.10), are to be implemented this year and should, in time, enable Defence to centrally monitor the prescribing patterns of its medical practitioners and the dispensing/issuing patterns of its pharmacists (that is, the usage of therapeutic substances in the ADF).

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<sup>108</sup> HPDE 1570/97 *Standards of health care and funding mechanisms for serving members of the ADF*, July 1997.

### *Defence response*

9.7 Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.17.

## **Pharmaceutical dispensing and issuing**

### **Findings of the original audit—Recommendation No.18**

9.8 Of the 500 ADF units supplied by the pharmaceutical distribution system, less than 10 per cent had trained pharmacists (although dispensing in excess of 50 per cent of the ADF's pharmaceuticals). Problems arose when untrained junior staff misinterpreted or misidentified essential urgent requirements with pharmaceuticals or failed to observe basic legal requirements. There was a need to monitor the usage of pharmaceuticals by those units that did not have a pharmacist dispensing them. Where possible, distribution and control over pharmaceutical supply by Defence should replicate the stricter civilian requirements. Pharmacists in the Central Dispensing Points (CDPs)<sup>109</sup> and the pharmaceutical distribution system needed to use Defence Pharmacy Dispensing and Stock Management System (DEPHADS) for routine monitoring. The number of pharmacists required in uniform should be decided from an ADF perspective, rather than on the basis of maintaining separate career structures for both Army and Air Force.

#### **1997 Recommendation No.18**

The ANAO recommends that Defence review the present arrangements for the dispensing and issuing of pharmaceuticals, including the number of uniform and civilian pharmacists, with a view to ensuring that safety and legal requirements are being met in a cost-effective manner.

Defence response: Agree.

### **Findings of the follow-up audit**

9.9 As recommended, arrangements for dispensing and issuing pharmaceuticals have been reviewed and Health Policy Directives issued on control of therapeutic substances<sup>110</sup> and provision of pharmaceutical services.<sup>111</sup> The policies seek to conform with State and Territory legislation and encourage uniformity throughout Defence. They cover the role of pharmaceutical officers; dispensing and issuing of therapeutic substances; the role of drug advisory committees; and methods for supply of pharmaceuticals at ADF health facilities not supported by a pharmacist.

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<sup>109</sup> Central Dispensing Points refer to facilities at the ADF's larger bases that have trained pharmacists.

<sup>110</sup> Health Policy Directive No. 140—*The control of therapeutic substances*, 12 March 1999.

<sup>111</sup> Health Policy Directive No. 229—*Provision of pharmaceutical services*, 24 August 1999.

### *Pharmaceutical Integrated Logistic System*

**9.10** The original audit found that problems arose with the DEPHADS drug management system because pharmacists were not using all its modules and it was not networked. At the time of the follow-up audit, Defence was introducing a new computerised drug management system, the Pharmaceutical Integrated Logistic System (PILS). It is to be rolled out to the 35 CDPs and will allow dispensing/issuing figures and stock levels to be monitored centrally. The ANAO understands that CDPs will be required to use all of its functionalities and that pharmacists will be more likely to do so because of the incentives the system offers (for example, bar code scanning). PILS may be expanded beyond CDP sites to sites without a pharmacist. PILS is expected to improve Defence's ability to monitor the issuing and dispensing of pharmaceuticals.

**9.11** The ANAO was advised that units were being encouraged to have prescriptions dispensed and stores ordered through CDPs or, if unable to access a CDP, through Medical and Dental Company DNSDC,<sup>112</sup> where orders are vetted by trained pharmacists. Such arrangements should enable closer monitoring of pharmaceuticals usage.

### *Number of uniformed and civilian pharmacists*

**9.12** Defence considers that the current number of pharmacists in the ADF (both civilian and uniformed) is the minimum needed to support the ADF population safely and that there is no scope to reduce the number. However, the ANAO was advised that some scope exists to civilianise a limited number of uniformed positions, but that minimal savings would result. There are indications that the requirement for uniformed pharmacists may be better met on a single-Service basis, given the high turnover of uniformed pharmacists, the low number of uniformed pharmacists in Air Force and the needs of structural overlay.<sup>113</sup>

**9.13** Notwithstanding Defence's views, it appears that there would be merit in reviewing the relative costs of uniformed and civilian pharmacists and the scope to civilianise those positions not required to be in uniform. Additionally, Defence could consider in the longer term the provision of uniformed pharmacy services on a single-Service basis.

### *Defence response*

**9.14** Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.18.

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<sup>112</sup> The Defence National Storage and Distribution Centre.

<sup>113</sup> Structural overlay refers to the requirement to provide positions for respite postings and for inexperienced personnel to be posted to larger units where they are able to access professional mentoring.

## Prime vendor arrangement

### Findings of the original audit—Recommendation No.19

**9.15** In 1995 Headquarters Logistic Command (HQLC) [now part of Defence Materiel Organisation] entered into a prime vendor arrangement with a company to supply pharmaceuticals direct to the ADF's CDPs. In return for a distribution fee, the prime vendor took over a significant proportion of the ADF's storage and distribution of pharmaceutical supplies. HQLC also negotiated standing offers with suppliers for all commonly required pharmaceutical items. CDPs could place orders direct with the prime vendor, who was responsible for obtaining the items through the standing offers and delivering them to the requesting facility. The prime vendor provided good service, and its same-day service had allowed stock levels to be reduced. But performance measures in the prime vendor contract were not sufficiently precise and the prime vendor could substitute more expensive brands for generic brands when standing offer suppliers could not supply the latter.

#### 1997 Recommendation No.19

The ANAO recommends that HQ Logistics Command, in consultation with the Surgeon General, enter into negotiations with the prime vendor to amend the standing offer contract to:

- a) ensure that sufficient stocks are held to cover historical monthly usage;
- b) minimise the risk of more expensive items being supplied as alternatives to generic brand items; and
- c) develop more demanding performance measures with the aim of minimising costs to Defence.

Defence response: Agree.

### Findings of the follow-up audit

**9.16** Approximately two-thirds of the ADF's expenditure on pharmaceuticals (excluding the cost of vaccines) is incurred under the prime vendor contract (\$4.9 million in 1999-2000).<sup>114</sup> The remainder is supplied through Randwick Logistic Company,<sup>115</sup> whose logistics services have been contracted out since the original audit was conducted. At the time of the follow-up audit, the ANAO was advised that the prime vendor

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<sup>114</sup> The ADF is not considered a major customer in the Australian pharmaceuticals market; its demand is considered equivalent to that of a large metropolitan hospital.

<sup>115</sup> Randwick Logistic Company is now known as Medical and Dental Company DNSDC.



contract would be re-tendered soon and that all standing offer contracts (approximately 400) had recently been re-let.

**a) *ensure that sufficient stocks are held to cover historical monthly usage***

9.17 The ANAO was advised that the prime vendor had developed a good understanding of the ADF's pharmaceutical usage pattern and kept appropriate quantities of ADF preferred brands in stock. The ANAO understands, however, that the prime vendor is constrained by the need to use price-favourable standing offers the ADF has negotiated with other suppliers and their general practice of retaining only stock likely to be sold within its limited shelf life.

**b) *minimise the risk of more expensive items being supplied as alternatives to generic brand items***

9.18 Logistics and health service staff are minimising the risk of more expensive items being supplied as alternatives to generic brand items by providing monthly updates of the pharmaceutical Standing Offer list to CDPs and reviewing monthly reports from the prime vendor to see whether any units are ordering pharmaceuticals not on that list. The ANAO was advised that inadvertent ordering of non-standing offer items was infrequent and, if the resulting cost was significant, the unit would be contacted and reminded of the requirement to purchase items only on the standing offer list. The introduction of PILS (see paragraph 9.10) will allow CDPs' purchasing and dispensing patterns to be monitored and should help to minimise the risk of more expensive items being purchased as alternatives to generic brand items.

**c) *develop more demanding performance measures with the aim of minimising costs to Defence.***

9.19 The original audit found that performance measures in the prime vendor contract were not sufficiently precise. For example, the contract contained a customer satisfaction level of 95 per cent but this did not take into account the criticality or relative demand of the other 5 per cent of items not able to be supplied as required. During the follow-up audit the ANAO was advised that there were no performance problems with the supply of critical or high demand items and that, in the few cases where they could not be supplied, units had contingency plans in place. The ANAO also found that the prime vendor contract had been amended in a number of areas to improve performance and minimise costs. The amendments relate to improved recall facilities, expanded monthly performance reporting, better specification of expiry dates and expanded warranty provisions.

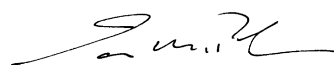
9.20 The follow-up audit found that Defence had addressed this recommendation.

*Defence response*

9.21 Defence agreed with the ANAO's findings in relation to the implementation of Recommendation No.19.

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Canberra ACT  
15 June 2001



Ian McPhee  
Acting Auditor-General

# **Appendices**



## Appendix 1

### Responsibilities of the Surgeon General and Staff

#### Surgeon General Australian Defence Force and Assistant Surgeon Generals

The Surgeon General Australian Defence Force (SGADF) and Assistant Surgeon Generals act in an outreach capacity. They aim to build and maintain linkages with the civilian health community. They also function in an advisory capacity for the Defence Health Service. SGADF is the chair of the Defence Health Consultative Group and the Australian Defence Medical Ethics Committee (ADMEC).

#### Director General Defence Health Service

Director General Defence Health Service (DGDHS) is responsible for the provision of health care and, from the health perspective, the preparedness of ADF members for operations, as well as preparing the Defence Health Service for deployment in support of operations. DGDHS is also responsible for the technical control, specified program management requirements and certain administrative support functions of the Defence Health Service.

#### Directorate of Health Capability and Development

The Directorate of Health Capability and Development (DHCD) is responsible for:

- the direction of ADF technical and operational health doctrine including operational preventative medicine, the coordination of health capability planning and programming, the direction of ADF health involvement in international interoperability programs and the coordination of the ADF's nuclear, biological and chemical health preparedness;
- coordination of strategic level health planning and health input for ADF operations; provision of advice and development of policy on collective education and training and determining requirements for individual education, training and continuing professional development of DHS personnel; and
- management of the Reserve component of the DHS including maintaining a list of Reserve members suitably trained and available for operational deployment and selecting and appointing DHS specialist consultants.

## **Directorate of Clinical Policy**

The Directorate of Clinical Policy (DCP) is responsible for advice on clinical health and determining common clinical health policy. DCP exercises technical control of clinical medical services and provision of clinical medical input into ADF policy formulation. DCP also provides advice on the professional training and development of ADF medical officers.

## **Directorate of Preventative Health**

Directorate of Preventative Health (DPH) is responsible for:

- occupational medicine and the development of health promotion and prevention policies in the ADF;
- identifying and targeting high risk categories and activities and providing strategic direction within Defence to promote a culture which facilitates the prevention of illness and injury in Defence;
- analysing epidemiological data available within Defence to assess occupational medicine problems and developing health promotion strategies;
- liaising with professional colleagues and State and Commonwealth Health Departments on clinical issues involving health prevention and promotion; and
- directing the strategic level health intelligence and surveillance function and formulating policy and providing technical guidance to providers of operational health intelligence.

## **Directorate of Health Resources**

The Directorate of Health Resources (DHR) is responsible for:

- developing ADF policy and advising on ADF health resources, clinical pharmacy policy, and logistics, including health care entitlements and cost implications;
- providing health advice for the priority, development and design of ADF health facilities;
- developing and coordinating DHSB input to portfolio financial and planning documents;
- developing ADF corporate health policy, including that related to the use of the civilian health infrastructure; and
- developing and coordinating health input on day-to-day structural and workforce planning matters affecting the Defence Health Service.

**Specialist Adviser—Dental**

Specialist Adviser—Dental (SA DENT) exercises technical control over ADF dental services; provides dental advice and input on policy formulation in the areas of health capability, health standards and treatment programs, preventative health, and health resource policy and programs; provides advice on the professional training and development of ADF dental officers; and undertakes specific project responsibilities as directed.

**Specialist Adviser—Nursing**

Specialist Adviser—Nursing (SA NURS) exercises technical control over ADF nursing services; provides nursing advice and input on policy formulation in the areas of health capability, health standards and treatment programs, preventative health, and health resource policy and programs; provides advice on the professional training and development of ADF nursing officers; and undertakes specific project responsibilities as directed.

## Appendix 2

### DHS Strategic Planning Framework

The Defence Health Service Annual Report 1999–2000<sup>116</sup> includes the following strategic planning framework for the DHS.

**DHS vision:** To achieve a world class military health service for the ADF.

**DHS mission:** To optimise the health of ADF personnel.

**DHS planned outcomes:**

1. provide a fit and healthy force;
2. prevent casualties;
3. treat casualties;
4. develop health capabilities; and
5. manage and sustain the health system.

**DHS goals:**

1. to provide strong and positive health leadership;
2. to reduce preventable injury and illness in the ADF;
3. to enhance the wellbeing in ADF members;
4. to improve ADF individual health readiness;
5. to improve the quality of ADF health care;
6. to optimise ADF operational health support;
7. to improve health skills and knowledge;
8. to provide quality health management; and
9. to provide the ADF with a comprehensive health information management system.

**DHS key performance indicators**

1. percentage of ADF personnel fully fit for operational duties;
2. incidence and cost of preventable injury, illness and wounding in ADF personnel;
3. patient morbidity and mortality rates in DHS treatment services;
4. fitness for purpose of ADF operational health capabilities;
5. effectiveness of DHS management and sustainment systems;
6. satisfaction of customers with the services the DHS provides; and
7. costs of DHS services.

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<sup>116</sup> *Defence Health Service Annual Report 1999–2000*, DHSB, 12 December 2000.



## Appendix 3

### The Strategic Alliance between 1HSB and Liverpool Hospital

1. The ADF seeks to maintain well trained health staff for possible deployment at short notice. During past deployments ADF health personnel have lacked currency in the knowledge and skills required for treating acute trauma. The strategic alliance between 1<sup>st</sup> Health Support Battalion (1HSB) and Liverpool Hospital aims to remedy this. Phase 1 of the alliance, a trial phase, began in December 1998. This was to validate the concept and confirm qualitative aspects of the agreement.
2. The agreement involves 1HSB providing limited numbers of staff to Liverpool Hospital to work in selected areas (for example, the Intensive Care Unit) of the Hospital and providing the Hospital with access to 1HSB's hydrotherapy pool. In return, Liverpool Hospital agreed to provide emergency care to Service personnel free of any charges controlled by the hospital. The agreement aims to be cost neutral. A discount factor is applied to ADF staff to reflect the time required for orientation and the assessed value of the staff to the Hospital. The Commonwealth provides Public Liability Indemnity to the Hospital for all Army personnel employed at the hospital.
3. A principal objective of the alliance, from Army's perspective, is to provide an opportunity for Army health service personnel to acquire experience and skills in management of acutely sick and injured patients, thereby enhancing their operational readiness. Army's commitment to the alliance is one Full Time Equivalent (FTE) Medical Officer, two FTE Registered Nurses and 4 FTE Army Medical Assistants. Staff from 1HSB are seconded for varying periods. For example, nurses are seconded for two periods of eight weeks; medical assistants are seconded for two periods of four weeks. The agreement provides for immediate withdrawal of Army personnel needed for operational deployments. This was tested in 1999, when 1HSB was required to deploy to East Timor and the alliance was suspended for the period of the deployment. An interim report on progress of the alliance to 15 April 1999 found that it was progressing well, attaining most of the outcomes specified in the agreement.

4. An Army report on the strategic alliance with Liverpool Hospital<sup>117</sup> contains a survey of 1HSB clinical staff prior to their re-deployment to Australia from East Timor. In relation to those 1HSB staff who had been seconded to Liverpool Hospital, prior to deployment, the survey found that:

*... respondents felt that the secondments improved their clinical skills, were clinically more relevant than work in the barracks hospital, were not a waste of time and that all clinical personnel should complete at least one attachment per year. Respondents also felt strongly that they did not suffer stress during the deployment from any perceived lack of skills.*

5. All groups agreed that the secondments made them more competent to deploy and provided them with exposure to sick children and older adults that they would not normally get.

6. The report identified a number of strengths and weaknesses with the alliance and suggested that it could be improved by:

- raising its profile as a training activity and minimising conflicts with other duties;
- recognising the importance of secondments in maintaining skills by making annual completions of attachments necessary for the achievement of employment proficiency;
- formalising the structure, with set objectives, improved access to training activities and feed-back on performance;
- appointing a coordinator to provide more hands-on involvement in organising secondments;
- developing team based concepts;
- considering secondments involving paediatrics, obstetrics and gynaecology; and
- more hands-on experience in trauma responses during secondments to the Emergency Department.

7. The report also indicated that:

- radiology and pathology staff also may benefit from exposure to secondments, particularly to acute trauma patients for radiology staff and cross matching of blood for pathology staff;

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<sup>117</sup> *Development and implementation of the Strategic Alliance between 1<sup>st</sup> Health Support Battalion and Liverpool Hospital*, Lt Col Leonard B. Brennan MHA (UNSW), Headquarters 3<sup>rd</sup> Brigade, Australian Defence Force.

- there may be value in secondments for other staff such as physiotherapists, pharmacists and psychologists;
- specialist clinical training of medical and nursing officers at Liverpool Hospital is an area of possible future development; and
- an alliance with the NSW Ambulance Service providing for secondments of medical assistants may be worth investigation. Secondments to the various State rescue services, Careflight and the NSW Air ambulance should also be considered as future options.

8. The alliance resumed with the return of 1HSB staff from East Timor. The ANAO understands that the agreement is yet to proceed to a planned Phase 2. This Phase would involve a greater number of service personnel committed by Army to the Hospital, increased use of 1HSB facilities by the Hospital and more comprehensive services provided to Army personnel. The ANAO was advised that both parties have agreed that it would be preferable not to treat Liverpool Hospital patients at 1HSB, because of the risk that 1HSB staff may be required to deploy at short notice.

## Appendix 4

### Recommendations of May 2000 Review of the ADF Dental Service

The May 2000 review<sup>118</sup> on optimisation of dental service provision to the ADF recommended that:

- (a) the proposed uniformed dental workforce structures be accepted in principle and Air Force review its proposed dental workforce numbers;
- (b) a mix of uniform and civilian personnel to provide dental services in the ADF. (Funding for the civilian personnel to be recognised, to avoid a steady decline in operational readiness of ADF personnel);
- (c) reserve dental treatment be focussed on operational need based on readiness to move, and occupational requirements such as divers and aircrew;
- (d) the number of ADF dental laboratories be reduced from 35 to six (to be achieved progressively by closing smaller dental laboratories and centralising the staff at larger dental facilities);
- (e) dental facilities at Harman; Fairbairn and Larrakeyah Barracks should close at the end of December 2000;
- (f) the ADF provide emergency, routine and specialist dental care with restrictions placed on complex dental procedures, with a greater emphasis of care needs on personnel and ADF requirements;
- (g) benchmarking of ADF dental services against state government dental services and health fund clinics to determine the criteria for the restriction of complex dental services and the cost of the service; and
- (h) a comprehensive quality strategy be developed to enable the effectiveness and efficiency of ADF dental services to be monitored.

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<sup>118</sup> *Optimisation of Dental Service Provision to the ADF*, DHSB, 16 May 2000.

## Appendix 5

### Proposed Personnel Structure of ADF Dental Services

	<i>Dental Officers</i>	<i>Dental Technicians</i>	<i>Dental Hygienists (4)</i>	<i>Dental Assistants</i>	<i>Total</i>
<b>Navy</b>					
Current liability (1) (2)	31	10	6	45	92
Proposed liability	21	0	5	22	48
Current Asset (3)	24	4	5	25	34
<b>Army</b>					
Current liability	49	39	27	95	210
Proposed liability	37	17	18	66	138
Current Asset	36	39	20	90	185
<b>Air Force</b>					
Current liability	39	20	15	54	128
Proposed liability	21	0	6	32	59
Current asset	40	16	8	38	102
<b>Total ADF</b>					
Current liability	119	69	48	194	430
Proposed liability	79	17	29	120	245
Current Asset	100	59	33	153	321

Source: Report on the Optimisation of Dental Service Provision to the ADF, Annex C, May 2000.

Notes:

- (1) 'Liability' refers to the approved personnel establishment and 'asset' to the posted personnel strength.
- (2) Liability and asset data is based on information dated May 2000 (Army and Air Force) and January 2000 (for Navy).
- (3) The breakdown of the current asset for other ranks personnel is approximate.
- (4) Air Force does not intend to manage hygienists separately from dental assistants.

## Appendix 6

### Performance Audits in Defence

*Set out below are the titles of the ANAO's previous performance audit reports on Defence operations tabled in the Parliament in the last five years.*

Audit Report No.26 1995-96  
*Defence Export Facilitation and Control*

Audit Report No.28 1995-96  
*Jindalee Operational Radar Network Project (JORN Project)*

Audit Report No.31 1995-96  
*Environmental Management of Commonwealth Land*

Audit Report No.15 1996-97  
*Food Provisioning in the ADF*

Audit Report No.17 1996-97  
*Workforce Planning in the ADF*

Audit Report No.27 1996-97  
*Army Presence in the North*

Audit Report No.34 1996-97  
*ADF Health Services*

Audit Report No.5 1997-98  
*Performance Management of Defence Inventory*

Audit Report No.34 1997-98  
*New Submarine Project*

Audit Report No.43 1997-98  
*Life-cycle Costing in Defence*

Audit Report No.2 1998-99  
*Commercial Support Program*

Audit Report No.17 1998-99  
*Acquisition of Aerospace Simulators*

Audit Report No.41 1998-99  
*General Service Vehicle Fleet*

Audit Report No.44 1998-99  
*Naval Aviation Force*

Audit Report No.46 1998-99  
*Redress of Grievances in the ADF*

Audit Report No.13 1999-2000  
*Management of Major Equipment Acquisition Projects*

Audit Report No.26 1999-2000  
*Army Individual Readiness Notice*

Audit Report No.35 1999-2000  
*Retention of Military Personnel*

Audit Report No.37 1999-2000  
*Defence Estate Project Delivery*

Audit Report No.40 1999-2000  
*Tactical Fighter Operations*

Audit Report No.41 1999-2000  
*Commonwealth Emergency Management Arrangements*

Audit Report No.50 1999-2000  
*Management Audit Branch – follow-up*

Audit Report No.3 2000-2001  
*Environmental Management of Commonwealth Land – follow-up*

Audit Report No.8 2000-2001  
*Amphibious Transport Ship Project*

Audit Report No.11 2000-2001  
*Knowledge System Equipment Acquisition Projects in Defence*

Audit Report No.22 2000-2001  
*Fraud Control in Defence*

Audit Report No.26 2000-2001  
*Defence Estate Facilities Operations*

Audit Report No.32 2000-2001  
*Defence Cooperation Program*

Audit Report No.33 2000-2001  
*ADF Reserves*

Audit Report No.41 2000-2001  
*Causes and Consequences of Personnel  
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*Information Technology in the Health Insurance Commission*  
Health Insurance Commission

Audit Report No.48 Performance Audit  
*Air Traffic Data Collection*  
Airservices Australia

Audit Report No.47 Performance Audit  
*Managing for Quarantine Effectiveness*  
Department of Agriculture, Forestry and Fisheries—Australia

Audit Report No.46 Performance Audit  
*ATO Performance Reporting under the Outcomes and Outputs Framework*  
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*Bank Prudential Supervision*  
Australian Prudential Regulation Authority

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*Causes and Consequences of Personnel Postings in the Australian Defence Force*  
Department of Defence

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*Management of the Adult Migrant English Program Contracts*  
Department of Immigration and Multicultural Affairs

Audit Report No.39 Performance Audit  
*Information and Technology in Centrelink*  
Centrelink

Audit Report No.38 Performance Audit  
*The Use of Confidentiality Provisions in Commonwealth Contracts*

Audit Report No.37 Performance Audit  
*The Use of Audit in Compliance Management of Individual Taxpayers*  
Australian Taxation Office

Audit Report No.36 Performance Audit  
*Municipal Services for Indigenous Communities*  
The Aboriginal and Torres Strait Islander Commission

Audit Report No.35 Performance Audit  
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