The Auditor-General
Audit Report No.37 2001–02
Performance Audit

Purchase of Hospital Services from State Governments
Follow Up Audit

Department of Veterans' Affairs

Australian National Audit Office

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Australian National
Audit Office

Canberra ACT
15 March 2002

Dear Madam President
Dear Mr Speaker

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

P. J. Barrett
Auditor-General

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

AUDITING FOR AUSTRALIA

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Abbreviations/Glossary

Abbreviations

ANAO	Australian National Audit Office
AR-DRG	Australian Refined Diagnosis Related Groups
Commission	Repatriation Commission
CPI	Consumer Price Index
DMIS	Departmental Management Information System
DRG	Diagnosis Related Group
DVA	Department of Veterans' Affairs
HIC	Health Insurance Commission
HOTSPUR	Hospital Purchasing System
ICD	International Classification of Diseases
MDC	Major Diagnostic Category
NHDD	National Health Data Dictionary
NHMD	National Hospital Morbidity Database
NATMOC	National Treatment Monitoring Committee
RGH	Repatriation General Hospital
RPPPs	Repatriation Private Patient Principles
RPPS	Repatriation Private Patient Scheme
SATMOC	State and Territory Treatment Monitoring Committee
TAS	Treatment Accounts System

Glossary

Admitted patient	A patient who has undergone a hospital's formal admission process. Admitted episodes of care are provided over a period of time and can occur in hospital and/or in the person's home.
Australian Refined Diagnosis Related Groups	An Australian system of Diagnosis Related Groups (DRGs).
Arrangements	The Commonwealth (Repatriation Commission) has entered into detailed formal agreements of a contractual nature with State and Territory Governments concerning the provision of treatment, care and welfare of eligible persons.
Australian Health Care Agreements	The Australian Health Care Agreements (AHCAs) are joint Commonwealth and State/Territory agreements for the provision of health services. They involve five–year, bilateral funding agreements between the Commonwealth and each of the State/Territory Governments. The AHCAs commenced on 1 July 1998 and expire on 30 June 2003.
Block funding	Block funding refers to fixed amounts of funding previously given by DVA to State and Territory Governments for agreed volumes of services in a given year.
Casemix	An information tool involving the use of scientific methods to build and make use of classifications of patient care episodes. The Casemix system allows an estimation of the relative cost and hospital resources used in treating different patients by assigning cost weights to each DRG. In popular usage, the mix of types of patients treated by a hospital or other health care facility.
Cost weights	Cost weights reflect the different level of resources required to deliver different episodes of care. A separation for an episode of care assigned a cost weight of 8.0 is, on average, 10 times more costly than an episode of care assigned a cost weight of 0.8.

Deed of Variation	A formal mechanism (in writing) through which changes to Arrangements between the Commonwealth and State/Territory Governments are made. A deed of variation is used, for example, to make changes to the amounts paid by DVA under the Arrangements for hospital services provided by the States and Territories.
Diagnosis Related Groups	Under Casemix, each 'episode of care' is identified as falling within a Diagnosis Related Group (DRG). DRGs are a patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by that hospital. DRGs provide a summary of the varied reasons for hospitalisation and the complexity of cases a hospital treats.[1]
Episode of care	A phase of treatment for an admitted patient. An episode of care could represent a patient's entire hospital stay or may represent a type of treatment received, for example acute care or rehabilitative care.
Gold Card	The Repatriation Health Card—For All Conditions (Gold Card) provides eligibility for all conditions. The conditions under which the Gold Card is granted include where a person: • receives a Disability Pension at 100 per cent of the General Rate or higher; or • receives a Disability Pension at 50 per cent of the General Rate or higher and any amount of Service Pension; or • is an ex Australian Prisoner of War; or • is a First World War veteran; or • receives a War Widow/er's Pension; or • is a female Second World War veteran with qualifying service; or • is an Australian veteran on a Service Pension with income and assets which satisfy the treatment benefits limits; or

[1] Australian Institute of Health and Welfare, National Health Data Dictionary - Version 10. Canberra, 2001, p. 148.

	• is a Second World War veteran aged 70 years or more, who served in the Australian Defence Forces, and who has qualifying service from that conflict.
HOTSPUR	The public-hospital reconciliation and data system being developed by DVA.
National Hospital Morbidity Database	A compilation of electronic summary records collected by admitted patient morbidity data collection systems in Australian hospitals. This database is maintained by the Australian Institute of Health and Welfare.
Non-admitted patient	A non-admitted patient is defined as a patient who attends a functional unit of a hospital and receives care but is not admitted. Non-admitted services include Emergency Department services, outpatient services or other services provided by the hospital including community/outreach services.
Private patient	An eligible veteran who has shared-ward hospital accommodation and the choice of attending specialist.
Repatriation	Assistance given to ex-service personnel returning to civilian life, in the form of pensions, medical care, allowances for dependants, etc.
Repatriation Commission	Responsible under the *Veterans' Entitlements Act 1986* for granting pensions, allowances and other benefits, providing treatment and other services through hospital and community facilities; providing advice to the Minister on matters relating to the Act's operation; and, subject to the Minister's control, generally administering the Act.
Repatriation General Hospitals	Major tertiary teaching hospitals providing a full range of acute surgical and medical care to veterans, their dependants; and, in latter years, community patients. Formerly owned and operated by the Repatriation Commission.
Repatriation Private Patient Scheme	Scheme through which DVA provides free hospital treatment to eligible veterans and dependants.

Separation	As defined in the Arrangements, a separation is a complete episode of care and may involve stays in more than one hospital. Generally, readmission to hospital within 24 hours of discharge, in respect of the same condition, counts as part of the same separation.
White Card	The Repatriation Health Card—For Specific Conditions. Provided to Australian and other veterans who are ineligible to receive treatment for all conditions. It is issued where particular disabilities have been accepted as war-caused or service-related.

Summary and Recommendations

Summary

Background

1. The Commonwealth provides eligible veterans with medical treatment as part of the package of repatriation benefits provided under the *Veterans' Entitlement Act 1986*. Originally, medical treatment (including hospital care) was provided directly by the Commonwealth through a network of Repatriation General Hospitals (RGHs). In 1989 the Commonwealth decided to divest itself of the remaining RGHs and integrate them with the State health systems. To facilitate this integration, the Commonwealth entered 10–year Arrangements with four States to incorporate the RGHs into their State health systems. Audit Report No. 40 of 1997–98, *Purchase of Hospital Services from State Governments*, reported to Parliament on DVA's administration of the purchase of hospital services from State Governments. The report made nine recommendations, all of which were agreed to by DVA.

2. DVA has entered into Arrangements now with all States and Territories to buy hospital services delivered by their public hospitals. In 2001–02, $2.2 billion was budgeted for veterans' hospital and health services with $1.2 billion of that amount for treatment in public and private hospitals.

Audit objective and methodology

3. The objective of the follow-up audit was to:

- assess the extent to which the Department of Veterans' Affairs had implemented the nine recommendations of Report No. 40, taking account of any changed circumstances or new administrative issues that the Department identified as affecting their implementation; and
- offer continued assurance to the Parliament on the management of the purchase of hospital care services.

4. The ANAO examined also whether DVA had made arrangements to rank, resource and identify appropriate actions to implement the recommendations, and to monitor and assess their effectiveness.

5. The ANAO wrote to DVA asking for information about its implementation of the recommendations of Report No. 40. After receiving DVA's response, the ANAO interviewed key personnel and reviewed DVA documents.

Overall audit conclusion

6. The ANAO concluded that, overall, DVA had either implemented or made satisfactory progress in implementing all but one of the recommendations of the earlier audit. The ANAO has made one recommendation from this audit to improve the utility of Arrangements with States and Territories after a deed of variation has been concluded.

Key Findings

7. The table below summarises DVA's progress in implementing the recommendations of the earlier audit. More detail is in Appendix B.

Recommendation	*Summary*	*Findings*
No. 1	DVA should introduce a comprehensive penalty and incentive regime in future Arrangements	Implemented
No. 2	DVA should attach conditions to future grants of money where these grants are for specific purposes, in order to facilitate the fulfilment of DVA objectives	Implemented
No. 3	DVA should complete reconciliations of data within the timeframes specified by the Arrangements	Implemented in some States but not in others
No. 4	In order to facilitate reconciliation, DVA should ensure that appropriate IT systems are in place	Not fully implemented – implementation is in progress, with a new IT system scheduled to be introduced from October 2002
No. 5	DVA should review its current allocation of responsibilities for the reconciliation of Commonwealth and State data	Implemented
No. 6	DVA should ensure that its Arrangements contain provision for the supply of public-hospital data relating to all veteran treatment episodes in public hospitals to enable DVA to make informed judgements on the cost and quality of alternate suppliers of hospital services	Implemented in relation to cost, not fully implemented with respect to quality
No. 7	DVA should include in its annual report the number of complaints received by the Treatment Monitoring Committees	Implemented
No. 8	DVA should develop a performance indicator to monitor and report on its progress in performing reconciliations	Not yet implemented – DVA has advised that this will be included in the new IT system
No. 9	DVA should ensure that staff concerned have an understanding of DVA's strategy for monitoring clinical standards in public hospitals	Implemented

Recommendations

Set out below is the ANAO's recommendation with report paragraph reference and DVA's response.

Recommendation No.1 Para 2.14

The ANAO recommends that, where changes to its Arrangements with the States and Territories for the purchase of hospital services for veterans are made, DVA produce a consolidated copy of the Arrangement that incorporates these changes to facilitate ease of comprehension and understanding of the entirety of obligations under the Arrangement.

DVA response: Agreed.

Audit Findings and Conclusions

1. Introduction

This chapter describes briefly the background to the provision of hospital services to veterans and the environment in which the purchase of State hospital services operates (for more detail, see Appendix A). It sets out also the audit approach, objective and methodology.

Overview of the provision of hospital services for veterans

Repatriation General Hospitals

1.1 For more than 80 years the Commonwealth has provided eligible veterans with repatriation benefits.[2] Medical treatment was provided for veterans originally through a network of military hospitals that the Commonwealth had established across Australia. After World Wars I and II, their control was transferred to the Repatriation Commission, which thus became a direct provider of hospital care for veterans.

1.2 In 1989, after a review of the repatriation hospital system, the Commonwealth Government decided to divest itself of these hospitals.

1.3 That decision was predicated on the Commonwealth entering into Arrangements with State Governments to:

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

1.4 When divesting the RGHs, the Commonwealth's preference was that they be integrated with the States' health systems. The Commonwealth entered 10–year Arrangements with four States—New South Wales, South Australia, Tasmania and Victoria—to incorporate the RGHs into their health systems. In Queensland and Western Australia the RGHs were sold to the private sector.

[2] A fuller description can be found in Appendix A.

The eligible veteran population

1.5 The majority of veterans are eligible for treatment by virtue of Part V of the *Veterans' Entitlement Act 1986*. Sections 85–89 of the Act outline the criteria under which a veteran or dependant can become eligible for treatment.[3]

1.6 With the ageing of the veteran population, the number of people eligible for health care under the repatriation system is in long-term decline. At 30 June 2001, the total veteran treatment population was 345,131.[4] DVA estimates that that population will have declined by 17 per cent between 1997 and 2007, when an estimated 42 per cent of male and 56 per cent of female Gold Card holders will be aged 80 and over. Table 1 shows the treatment population by age group at 30 June 2001 and Diagram 1 outlines the treatment population by postcode.

Table 1

Treatment population by age group as at 30 June 2001

Age	New South Wales	Victoria	Queensland	South Australia	Western Australia	Tasmania	Unknown	Australia
<55	11 914	6 278	11 981	3 743	4 433	1 305	7	**39 661**
55-59	4 191	2 153	4 191	1 172	1 404	446	7	**13 564**
60-64	2 829	1 233	2 887	605	1 005	288	5	**8 852**
65-69	4 249	2 139	3 126	799	1 181	428	0	**11 922**
70-74	12 170	7 465	6 664	2 513	2 594	1 249	5	**32 660**
75-79	43 736	28 932	21 990	10 231	9 177	4 216	17	**118 299**
80-84	29 467	19 987	15 442	7 158	6 292	2 565	9	**80 920**
85+	13 666	10 237	7 060	3 426	3 516	1 241	3	**39 149**
Unknown	25	24	30	12	11	2	0	**104**
Total	**122 247**	**78 448**	**73 371**	**29 659**	**29 613**	**11 740**	**53**	**345 131**

Source: Department of Veterans' Affairs

1.7 Although the number of eligible veterans is declining, DVA has seen an increasing demand for hospital services because of the growth in the proportion of those aged 80 and more (see Table 2). It predicts that demand for health and aged-care services will peak in the next 10 years.

[3] The Repatriation Private Patient Principles indicate, in general terms, those persons eligible for hospital treatment. The Repatriation Private Patient Principles are reproduced in Appendix C.

[4] Department of Veterans ' Affairs, Annual Report 2000-01, AGPS, Canberra, 2001, p. 154.

Diagram 1

Treatment population by postcode as at June 2001

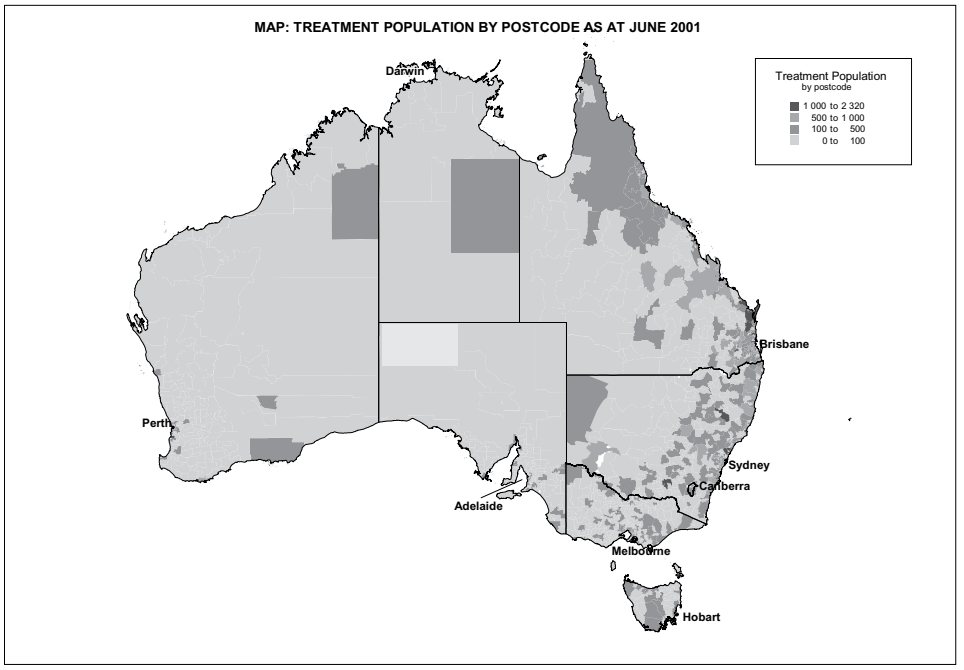

Table 2

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

Year	Public sector	Private sector	Total
1996-97	115 024	131 023	246 047
1997-98	107 984	153 306	261 290
1998-99	122 177	172 752	294 929
1999-00	129 486	204 326	333 812

Source: Department of Veterans' Affairs

1.8 Veteran separations in the public sector represented 47 per cent of total veteran separations in 1996–97 and only 39 per cent in 1999–00. Although public-hospital separations were only 39 per cent in 1999–00, public-hospital expenditure, at $496 million, represented 45 per cent of DVA's total hospital expenditure of $1 111 million.[5]

[5] See Appendix A for further discussion.

Repatriation Private Patient Scheme

1.9 The Repatriation Private Patient Scheme (RPPS) was established after the RGHs were transferred from the Commonwealth to the State Governments or private ownership. The scheme provides eligible veterans and dependants with free treatment at any public hospital or privatised Repatriation Hospital, as private patients, in shared wards, with their own choice of doctor.

1.10 The primary objective of the Repatriation Private Patient Scheme is to ensure that eligible veterans obtain access to the nearest suitable hospital to receive treatment.

Previous audit coverage

1.11 Previous audit reports containing information relevant to the purchase of hospital services include the following:

- *Use of Private Hospitals*, Department of Veterans' Affairs, Efficiency Audit Report No. 28, 1993–94.
- *Use of Private Hospitals*, Follow-up audit, Department of Veterans' Affairs, Performance Audit Report No. 28, 1996–97.
- *Purchase of Hospital Services from State Governments*, Department of Veterans' Affairs, Performance Audit Report No. 40, 1997–98.

Purchase of Hospital Services from State Governments, Audit Report No. 40, 1997–98

1.12 The primary objective of the earlier audit was to form an opinion of DVA's management of the purchase of hospital services from State and Territory Governments. The ANAO made nine recommendations for improvement, all of which were agreed to by DVA.[6] The audit dealt only with the purchase of public-hospital services for veterans from States with which DVA had Arrangements—at the time of the audit, Tasmania, New South Wales, Victoria and South Australia. DVA has long-term Arrangements now with all States and Territories.

1.13 Overall, the ANAO concluded that:[7]

> *The administrative effectiveness of DVA's management of the purchase of hospital services from State and Territory governments generally was*

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[6] Refer to Appendix B for a table of the nine recommendations from the original report and DVA's response.

[7] ANAO Report No. 40 1997–98, DVA Purchase of Hospital Services from State Governments, AGPS, Canberra, 1998, p. xv.

sound. However, the ANAO found scope for progressive improvement in the following areas:

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

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

The follow-up audit

Audit objective and focus

1.14 The follow-up audit was restricted to DVA's implementation of the recommendations of *Purchase of Hospital Services from State Governments*, Audit Report No. 40, 1997–98.

1.15 Specifically, its objective was to:

- assess the extent to which the Department of Veterans' Affairs had implemented the nine recommendations of Report No. 40, taking account of any changed circumstances or new administrative issues that the Department identifies as affecting their implementation; and
- offer continued assurance to the Parliament on the management of the purchase of hospital care services.

Audit criteria

1.16 The follow-up audit's primary criterion was to ensure that DVA had implemented all the report's recommendations. The ANAO examined also whether DVA had made arrangements to rank, resource and identify appropriate actions to implement the recommendations, and to monitor and assess their effectiveness.

Audit methodology

1.17 The ANAO wrote to DVA asking for information about its implementation of the recommendations of Report No. 40. After receiving DVA's response, the ANAO interviewed key personnel and reviewed DVA documents.

1.18 The follow-up audit was conducted in accordance with ANAO Auditing Standards at a cost of $77 000.

2. Arrangements with the States and Territories

This chapter deals with DVA's Arrangements with State and Territory health departments for providing veterans with hospital services and outlines the provisions in the Arrangements that ensure that the Commonwealth receives value for money. It examines DVA's progress in implementing recommendations 1 to 6 of the earlier audit.

Introduction

The State and Territory Arrangements

2.1 DVA has Arrangements now with each State and Territory to buy public-hospital services for veterans. Table 3 lists the duration of each of the Arrangements, including the number of changes to the original Arrangement as effected by a formal deed of variation.

Table 3

Commonwealth–State Arrangements

	NSW	VIC	QLD	SA	TAS	NT	ACT	WA
Start date	1 July 1993	1 July 1998	1 July 1998	9 Mar 1995	1 Jul 1992	1 July 1998	1 July 1998	1 July 1998
End date	30 Jun 2003	30 Jun 2004	30 Jun 2004	30 Jun 2005	30 Jun 2002	30 Jun 2004	30 Jun 2004	30 Jun 2004
Deeds of Variation	3	2	1	1	-	-	2	-

Source: Data collected from copies of the Arrangements provided by the Department of Veterans' Affairs

2.2 The Arrangements provide a mixture of fee-for-service and block-funded payments. The payment arrangements are generally based on an adaptation of the hospital Casemix funding model already used in the State or Territory concerned for funding its own public hospitals.

2.3 In all States and Territories except Queensland, Tasmania and the Northern Territory, the Arrangements specify that DVA make monthly payments in advance. Each payment amount is based on an estimate of the level and type of veterans' treatments likely in the month. In Queensland, Tasmania and the Northern Territory, the Arrangements provide for payment in arrears on receipt of an invoice detailing the number and types of treatments provided.

2.4 Under the current Arrangements, the Commonwealth has moved away from a block-funded approach towards a system of payments for actual services provided. In this respect, the relationship between DVA and the State and Territory Governments is now more akin to that between purchaser and provider.

2.5 The Arrangements, and their role in facilitating this relationship, are discussed under two major subheadings:

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

The form of the Arrangements

Legal basis for the Arrangements

2.6 Part V of the *Veterans' Entitlements Act 1986* confers power on the Repatriation Commission to enter into Arrangements under s 89 of the Act for the provision of hospital treatment for veterans and other eligible persons.

2.7 The Arrangements define the parties' responsibilities and obligations, although they do not establish a contractual relationship. If there is a dispute between the parties, the Arrangements provide a mechanism for resolving the dispute. The mechanism also allows for arbitration by an independent arbitrator, where the parties alone are unable to resolve the dispute. However, the dispute-resolution process does not envisage resort to the courts.

Structure of the Arrangements

2.8 The Arrangements take the form of written agreements between the Commonwealth Government, the Repatriation Commission and the State and Territory Governments. They include provision for parties to vary the terms by written agreement. Such changes are usually effected via a deed of variation, used for example, to implement adjustments in the schedule of prices.

2.9 Over the life of the Arrangements a number of deeds of variation may be concluded, so that a current Arrangement includes the effect of any deeds of variation.

Consolidation of Arrangements

2.10 To understand the content of an Arrangement, all the original documents and deeds of variation must be examined and cross-referenced to ascertain which provisions still operate and which have been rendered obsolete. This makes it difficult to obtain a picture of the obligations of either party.

2.11 In addition, since the deeds of variation concern mainly pricing, reference to them tends to focus unduly on aspects relating to payment and reconciliation at the expense of other provisions not varied frequently, such as those dealing with quality and partnering.

2.12 In its field work, the ANAO found that the DVA Victorian State Office had produced an 'administrative version' of its Arrangement with the State Government of Victoria—a consolidated copy of the Arrangement, revised to account for amendments effected by the deeds of variation. This enabled the whole Arrangement to be viewed in a single document, and placed all its aspects in perspective. No such consolidation had been produced in any other State or Territory.

2.13 The ANAO suggests that DVA should examine the Victorian office's initiative as a means of improving documentation of the Arrangements. The use of deeds of variation tends to emphasise those parts of the Arrangements subject to frequent variation. Administrative consolidations of the Arrangements will facilitate understanding of all aspects of the Arrangement, minimising the potential to focus on only those aspects that are frequently varied.

Recommendation No. 1

2.14 The ANAO recommends that, where changes to its Arrangements with the States and Territories for the purchase of hospital services for veterans are made, DVA produce a consolidated copy of the Arrangement that incorporates these changes to facilitate ease of comprehension and understanding of the entirety of obligations under the Arrangement.

DVA response

2.15 Agreed.

Clearly defined incentives and penalties

2.16 In the earlier audit, the ANAO noted that the Arrangements took the form of agreements requiring performance by both parties. Like any comprehensive agreement, each Arrangement requires clearly defined penalties for non-performance and incentives for superior performance. If there are no penalties, a party can ignore an onerous provision. If there are no incentives, there is no reason for a party capable of superior performance to perform above the level specified in the contract. The ANAO concluded in the earlier audit that, although there were penalties and incentives in the Arrangements, there was scope for improvement in both cases for greater effectiveness.

Recommendation No. 1 of Audit Report No. 40, 1997–98

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

Findings of the follow-up audit

Penalties

2.17 Where DVA makes payments in advance, all of the current Arrangements contain provision for the adjustment of charges for acute services according to the actual value of services provided. In general, a State or Territory will be reimbursed according to the actual number of veterans treated and the type of treatment provided. Where the value of services provided is lower than estimated, there is provision to reduce the amount paid by DVA. The Arrangements specify the method of calculating the adjustment and the types of service included in these calculations, which may vary according to the terms of the individual Arrangement. These Arrangements are appropriate for these circumstances.

2.18 Where there is provision for such adjustment, failure to provide the information on episodes of care required by DVA will result in no payments being made for those episodes.

2.19 In the States examined, the Arrangements also specified the time frames within which data was to be provided and reconciliation performed. In some cases they provided for penalties for failure to provide the data within those time frames.

2.20 Some of the Arrangements also provide penalties for failure to meet certain quality criteria, but the ANAO found that these provisions had not been formally activated in any of the States visited.

Incentives

2.21 The provision to adjust charges according to the actual levels of service also acts as an incentive to encourage the most appropriate treatment for veterans. Where the number of services provided is greater than that expected, DVA will pay the cost of the extra services.

2.22 The shift towards full-cost payment from 1998 provided an incentive for public hospitals in that it made the financial aspect of treating veterans

attractive by comparison with that of treating public patients under the Australian Health Care Agreements.[8] In the States visited for the follow-up audit, public hospitals could receive a greater level of funding for the treatment of veterans. For example, funding for the number of non-DVA patients that a Victorian hospital can treat is capped, while the number of eligible veterans able to be treated is not capped. Therefore Victorian public hospitals are able to retain the full cost of treating veterans thus passing on the additional financial incentive to individual hospitals.

2.23 Although incentive provisions act to encourage and reward superior performance, the effectiveness of payment incentives depends on the timeliness of the payment for the extra services provided. When the time gap between the provision of additional services and payment for them is significant, the incentive's value is diminished. In two of the States examined in the follow-up audit, the ANAO found that DVA was not conducting reconciliations in a timely fashion, which was delaying payment for extra services provided.[9]

2.24 The ANAO found also that DVA did not have a formal mechanism for monitoring the effectiveness of these incentives and penalties, and their contribution to eliciting superior performance. Nor did it compare the relative effectiveness of the various penalties and incentives between the States and Territories. However, DVA Central Office staff were involved during negotiation of the Arrangements with each State and Territory, providing a mechanism for examples of good practice to be incorporated into subsequent Arrangements. The ANAO considers that a periodic formal review of effectiveness would enhance the ability of DVA to include an appropriate mix of incentives and penalties in each Arrangement.

Conclusion

2.25 The ANAO considers that DVA has implemented recommendation 1 of the earlier audit, having implemented a regime of penalties and incentives in its Arrangements with the States and Territories to encourage public hospitals to provide eligible veterans with services.

2.26 However, the effectiveness of these measures would be enhanced by improving reconciliation processes to allow more timely payment for additional services.

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[8] Under the Australian Health Care Agreements (previously designated the Medicare Agreements), the Commonwealth provides funding to State and Territory Governments towards the provision of public hospital services.

[9] Refer to 'Accounting for services' para 2.37, for further discussion of the reconciliation process.

2.27 The ANAO suggests that DVA investigate whether incentives and penalties could be applied more effectively to the aspects of the Arrangements relating to quality of service. This would enable DVA to encourage and reward superior performance in this aspect of service delivery while assuring performance to a minimum standard.

Funding for specific purposes

2.28 At the time of the earlier audit, as part of the Arrangements the Commonwealth made payments to a number of States to improve facilities at the former RGHs. Two payments were made to the South Australian Government for the construction of a rehabilitation facility at Daw Park Repatriation General Hospital, Adelaide.

2.29 The ANAO noted in the earlier audit that there had been a delay between payment of the capital funds and construction of the facility. The delay had been a source of complaint by, and disappointment in, the veteran community and had been the subject of correspondence by DVA with the State Government.

2.30 The ANAO concluded that when Commonwealth money is paid to a State for a specific purpose there should be clearly defined terms and conditions and provision for remedial action if the money is not spent as intended.

Recommendation No. 2 of Audit Report No. 40, 1997–98

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

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

Findings of the follow-up audit

2.31 DVA advised that there had been no more capital grants of the type to which this recommendation was specifically related. The 1999 Deed of Variation to the South Australian Arrangement contained an undertaking that South Australia was to expend fully the DVA contribution to the construction of the Rehabilitation Facility by 30 June 2001. DVA advised the ANAO that this facility had now been built.

2.32 Where possible, DVA has moved away from providing block funding for services towards a fee-for-service regime.

2.33 There remain areas, however, where DVA does provide block funding or grants for specific purposes. For example, DVA provides such payments under the Special Veterans' Services and Value-Added Veteran Services programs in New South Wales. The Arrangements provide for similar programs in South Australia and Victoria. The ANAO found that in New South Wales DVA had implemented mechanisms for monitoring and reporting on the progress and outcomes of such grants.

2.34 The ANAO considers that whenever DVA makes such grants for specific purposes it should implement a regime for monitoring the use of such funds.

Conclusion

2.35 DVA has implemented this recommendation. The ANAO found that there had been no more capital grants of the type to which this recommendation was specifically related.

2.36 In one State in which payments had been made for specific purposes, the ANAO found that DVA had established mechanisms to monitor the payments and report on their contribution to specified outcomes.

Value for money

Accounting for services – reconciliation

2.37 Establishing the number of treatment episodes that should be counted for payment purposes involves a reconciliation between (a) the episodes of care claimed by each State and (b) DVA eligibility and approval records. Any episodes of care outside the scope of the Arrangements are excluded for payment purposes.

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

2.39 The second step is to determine the veteran's level of eligibility. The majority of veterans have a Gold Repatriation Health Card, which entitles them to treatment for all conditions. Other veterans hold White Cards, which limit their entitlement for treatment to conditions accepted by the Repatriation Commission as war-caused or service-related. Before treating a White Card

patient, hospitals are required to seek confirmation by DVA that the treatment proposed relates to the condition for which the veteran is eligible.

2.40 At the time of the earlier audit, the Arrangements with the States specified the time frame within which DVA was to complete the reconciliations (that is, determine whether the episodes of care claimed by the State meet DVA eligibility criteria). The ANAO noted that DVA had not yet met those targets.

2.41 The ANAO noted that two main factors contributed to DVA's difficulties in conducting timely reconciliations and meeting agreed timetables for adjusting final payments:

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

Recommendation No. 3 of Audit Report No. 40, 1997–98

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

Findings of the follow-up audit

2.42 The steps required for each reconciliation are determined by the Arrangements, and the precise detail of the reconciliation process is specific to each State and Territory. In general, however, each treatment episode is assessed against eligibility and payment criteria. The payment checking depends on the payment terms in the Arrangement. Payment reconciliation involves determining the type of treatment administered and grouping treatment episodes according to the criteria in the Arrangement to determine a final amount payable.

2.43 The process is finalised with a financial adjustment, when DVA either makes payment to or recovers payment from the State or Territory. When the final amount payable (after reconciliation) is greater than the sum of any advance payments, DVA pays that amount. When the final amount payable is less than the sum of any advance payments, DVA recovers that amount from the State or Territory.

2.44 To facilitate reconciliations, the State or Territory provides data on each treatment episode. Each Arrangement specifies timetables for the provision of this data and completion of reconciliation. The Arrangements specify the type and format of data that the States must submit as well as the time frames within which it must be provided. They also specify the time frames within which DVA must reconcile the data.

2.45 In the follow-up audit the ANAO found that these time frames were not always observed by DVA. In two of the three States visited the ANAO found that although the Arrangements provided for reconciliations to be conducted quarterly, reconciliation had been conducted less frequently—annually in one State.

2.46 When the actual level of service provided falls substantially below that estimated, the amount recoverable by DVA increases. The ANAO notes the early difficulties experienced by DVA in conducting reconciliations. In one State it was agreed by DVA and the State to perform annual rather than quarterly reconciliations in the interim, while continuing to work towards the quarterly reconciliations specified in their Arrangement. However, one problem with that arrangement is that it is more difficult for DVA and the State to compare the actual and estimated levels of service throughout the year. If the reconciliation is conducted only annually, and monthly payments have not been adjusted according to actual levels of usage throughout the year, there is a greater risk that at the end of the financial year either DVA or the State Government will be left owing a considerable sum. This may cause difficulties for either party in meeting the payment obligation.

2.47 This problem is amplified when the final reconciliation is not completed until some time after the close of the financial year.

2.48 In one of the States conducting less frequent reconciliations, the State Government announced that the cost of any treatment episodes rejected by DVA as not payable would be borne by the treating hospital. This will mean that treating hospitals may not be reimbursed for these episodes of care. When the reconciliation process is not performed in a regular or timely fashion there will be a delay between the identification and communication of any potential problems with data submitted by a specific hospital. The greater the delay between the treatment episode and communication to the treating hospital of DVA's rejection, the less likely it will be that the hospital could rectify the data for that episode or prevent any more data errors. It is therefore in all parties' interest, including for accountability purposes, to conduct more frequent data reconciliations which could identify specific problems with data and communicate them to the treating hospital in a more timely fashion.

2.49 Also, an extended delay in finalising the financial reconciliation has the potential to interfere with individual hospitals' financial processes. If the DVA reconciliation is not finalised until 12 months after the close of the financial year, a specific hospital could have finalised its financial statements for that year by the time it received advice of rejection by DVA, and hence changes in its revenue. Likewise, when a hospital has provided more treatment than expected, a long delay in reconciliation could lead to a long delay in receiving payment for the extra services.

2.50 Despite the difficulties faced in these States, the ANAO found that, in the third State visited, data reconciliations were completed within the time frames specified. Financial adjustment—reimbursement or recovery of payments for additional or fewer services than estimated—was performed annually in accordance with the Arrangement.

2.51 The impending implementation of DVA's Hospital Purchasing System HOTSPUR (discussed below) is expected to enhance the reconciliation process in all States and Territories, with one of the expected benefits being a reduction in the time taken for reconciliations. Introduction of the system may provide an opportunity also for DVA to monitor more closely its data-reconciliation progress and timeliness.

Conclusion

2.52 DVA has made progress in implementing this recommendation. The ANAO found that it had been implemented in some States but not in others.

2.53 The ANAO would consider this recommendation fully implemented when DVA was performing all reconciliations of public-hospital separations data within the time frames specified in the Arrangements.

IT systems

2.54 In the earlier audit, the ANAO noted that the lack of appropriate reconciliation systems at the commencement of each Arrangement contributed to delays in completing reconciliations. The ANAO considered that the reconciliation process requires timely and appropriate IT support, and that DVA should work towards ensuring that appropriate IT systems were in place shortly after the commencement of new Arrangements.

Recommendation No. 4 of Audit Report No. 40, 1997–1998

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

Findings of the follow-up audit

2.55 At the time of the earlier audit, public hospitals in the Australian Capital Territory, the Northern Territory, Queensland and Tasmania providing veterans with services were reimbursed by the Commonwealth upon receipt of claim from the individual public hospital. These claims were processed by the Health Insurance Commission through the Treatment Accounts System (TAS). In general, with the commencement of Arrangements with these States and Territories and the corresponding change in the way payments are made, DVA no longer relies on TAS for these payments. There has been a need for the development of a specific IT system in response to these changes. Some of the DVA State Offices have developed local reconciliation systems to deal with the specific requirements arising from individual Arrangements while awaiting the development of HOTSPUR, DVA's national public hospital reconciliation and data system.

2.56 HOTSPUR is intended to enable DVA to:

- capture and collect public-hospital data from all State and Territory health departments;
- validate public-hospital data received and calculate payments;
- monitor the Arrangements; and
- provide quality management information.

2.57 The implementation and development of HOTSPUR has proved to be complex. Following commencement of the project in April 1999, there was a pause part of the way through the initial development stages until funding for further development was secured. Shortly after funding was provided in the 2000 Budget, a review of the project led to changes in the preferred approach. The revised development approach was agreed to in April 2001.

2.58 Initially, HOTSPUR will concentrate primarily on the process of reconciling treatment data. In the first phase of development, HOTSPUR will concentrate on admitted patient episodes, which DVA advises represent a majority of overall expenditure on hospital services. It is envisaged that the State reconciliation systems will be replaced upon the successful implementation of HOTSPUR, expected from 1 October 2002.

2.59 DVA has made progress already in securing a more standardised data set in its Arrangements with the States and Territories. DVA intends to link eventually the public-hospital data collected via HOTSPUR with private-hospital data collected by the Departmental Management Information System (DMIS). The collection of a more standardised data set will facilitate DVA's ability to compare public- and private-hospital treatment of veterans.

Conclusion

2.60 DVA has made progress towards the implementation of this recommendation. The expected implementation of HOTSPUR as envisaged by DVA will address this recommendation.

Responsibilities

2.61 In the earlier audit, the ANAO noted that there was scope for clearer ownership of and responsibility for the various stages of the reconciliation process. The earlier audit found that in the devolved management environment within which they operated, various DVA National and State Office staff suggested that their responsibility was limited to only certain aspects of the various stages of the reconciliation process. Nevertheless, the ANAO considered that there remained a responsibility to ensure that all the required reconciliation processes were performed.

Recommendation No. 5 of Audit Report No. 40, 1997–98

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

Findings of the follow-up audit

2.62 The ANAO found that DVA had established contract managers to manage the Arrangements with each State and Territory, each located in the appropriate DVA State Office (managers for the Australian Capital Territory and the Northern Territory located in New South Wales and South Australia respectively).

2.63 Although formal position descriptions of the roles of the contract managers did not exist for all the States visited, some Arrangements contained detailed descriptions of the roles and responsibilities of the contract managers.

2.64 Overall responsibility for daily management and operation of the Arrangements, including data reconciliation, rests with the DVA contract manager, who is responsible in turn to the State Office Deputy Commissioner. DVA National Office plays no direct role in the reconciliation process. With the implementation of HOTSPUR however, National Office will be better able to monitor the reconciliation process.

Conclusion

2.65 This recommendation has been implemented by DVA.

Cost-effectiveness

2.66 At the time of the earlier audit, the objective of the program under which public hospitals provided services to veterans was '*to provide access to quality, cost-effective health-care services to entitled persons*'. DVA still sees cost-effectiveness as a consideration in arranging for the delivery of these services. This is in line with the broader requirement that it employ Commonwealth resources efficiently, effectively and ethically.[10]

2.67 In the earlier audit, the ANAO noted that in the second phase of the Arrangements (encompassing the movement to Casemix-based payments), DVA would be more readily able to select the supplier offering the lowest cost or best value for money. It was noted that DVA would require more information from State and Territory Governments on the types and cost of services provided to make informed judgments on the cost of alternative suppliers. The ANAO concluded that if DVA were to use the lowest-priced supplier possible, consistent with the provision of quality services and the maintenance of veterans' access to hospital services, it would need better data on the cost of services than had been available so far from public-hospital systems.

2.68 At the time of the previous audit, the funding provided for the purchase of hospital services covered only the cost of buying private-patient status, not the full cost of the treatment. In 1998 the Commonwealth Government decided to move to a full-cost payment arrangement for the treatment of veterans from 1 July 1998. This resulted in the provision of an additional $150 million per annum in the new payment Arrangements. The Arrangements between DVA and the State and Territory Governments are based now on the principle of full cost recovery. This places DVA in a better position than at the time of the earlier audit in that it now understands better the full cost of treating veterans in public hospitals.

[10] Under s 44 of the *Financial Management and Accountability Act 1997*, a Departmental Secretary must 'manage the affairs of the Agency in a way that promotes proper use of the Commonwealth resources for which the Chief Executive is responsible', where the Act defines 'proper use' as 'efficient, effective and ethical use'.

Recommendation No. 6 of Audit Report No. 40, 1997–98

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

Findings of the follow-up audit

2.69 DVA has sought to establish a case-payment approach to buying hospital services. It has adopted the Casemix model[11], whereby each treatment episode is grouped according to the nature of care received and its relative cost.

2.70 The States and Territories provide DVA with a record of each eligible treatment episode, including the type of treatment provided and other clinical and related data. At present, Casemix payments are not made for all types of hospital services to veterans. In general, it is only admitted episodes of care that are purchased by Casemix payments.[12] Other services, such as non-admitted care, are paid by occasion of service.

2.71 Under most of the Arrangements, a State or Territory need provide DVA with Casemix data relating only to admitted episodes of care as part of the payment and reconciliation process. Most of the current Arrangements specify separate, non-Casemix based payment rates for non-admitted treatment episodes. As states are still developing the non-admitted Casemix models, DVA generally funds these services on an alternative basis, using per diem rates or block-funding formulae. These alternative methods require less complex data to calculate payment. The data supplied to DVA for processing and reconciling such episodes of care is therefore usually less comprehensive than that for admitted episodes.

2.72 To ensure that DVA receives adequate information to make informed purchasing decisions on admitted and non-admitted types of care, the current Arrangements specify that the State or Territory provide morbidity data on non-admitted episodes of care as well as the data required for payment for these

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[11] Discussed in Appendix A, pp. 38–39.

[12] An admitted patient is defined as a patient who has undergone a hospital's formal admission process. Admitted episodes of care are provided over a period of time and can occur in hospital and/or in the person's home. A non-admitted patient is defined as a patient who attends a functional unit of a hospital and receives care but is not admitted. Non-admitted services include Emergency Department services, outpatient services or other services provided by the hospital including community/outreach services.

types of service. The States and Territories collect and supply morbidity data already to the Australian Institute of Health and Welfare as part of the National Hospital Morbidity Database (NHMD). This data is based on the National Health Data Dictionary and is consistent with current International Classification of Disease (ICD) coding standards. Through the arrangements, DVA has sought to ensure that morbidity data supplied to the NHMD on all veterans' treatment is forwarded to DVA and that DVA receives similar data on non-admitted episodes of care.

2.73 The development of HOTSPUR (discussed earlier) will permit more effective use of this data to monitor and manage the arrangements and assist in informing decisions on the cost of alternative suppliers. Given the increased use of private-sector suppliers to deliver services to the veteran community, especially the introduction of Tier 1 private hospitals, there will be an increasing need for DVA to ensure that it receives the necessary data from its public and private suppliers. The implementation of HOTSPUR and its links with DMIS will also enable DVA to make informed comparisons between suppliers in the public and private sectors.

2.74 In some cases the Arrangements provide for the provision of quality data on the care provided by public hospitals. In the States and Territories visited in field work, the ANAO did not find any evidence that DVA was receiving and reporting routinely on this quality data. The ANAO considers that increased use of the provisions in its Arrangements for the supply of quality data will put DVA in a better position to assess the quality of its public-hospital service providers.

Conclusion

2.75 DVA has implemented this recommendation with respect to cost. The ANAO considers that DVA should focus greater attention now on the supply by State and Territory Governments of suitable data on service quality and ensure that such a requirement is specified in its Arrangements where this is not already the case.

3. Performance Assessment

This chapter deals with the methods used by DVA to assess its performance in buying hospital services from State Governments and its progress in implementing recommendations 7 and 8 of the earlier audit.

Performance indicators

Performance indicators for quality

3.1 At the time of the earlier audit, DVA had developed quality-related performance indicators for the purchase of hospital services. One of these indicators required 100 per cent of complaints to Treatment Monitoring Committees[13] to be investigated and strategies developed in a timely manner. DVA publishes information about its performance against this indicator in its annual report.

3.2 In the earlier audit the ANAO noted that the indicator did not include information on the number of complaints received, but only whether 100 per cent had been investigated. The ANAO considered that it would be useful if DVA published the number of complaints received, to better allow readers to understand the indicator.

Recommendation No. 7 of Audit Report No. 40, 1997–98

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

Findings of the follow-up audit

3.3 The Commonwealth's transition towards an output and outcome framework, including for measuring performance, has led to a change in the way DVA reports on its performance in buying hospital services from State Governments.[14] Veterans' health care falls now under Outcome 2 of the Department's output/outcome structure.[15] Buying such hospital services is part of DVA Output 2.1 – Arrangements for the delivery of services.

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[13] See Chapter 4 for further discussion of Treatment Monitoring Committees.

[14] The Department of Finance and Administration initially defined the requirements for the framework in '*Specifying outcomes and outputs*'. Finance has now updated these requirements with the revised arrangements being available on its web site www.finance.gov.au.

[15] See Appendix D for further discussion.

3.4 The balanced scorecard approach to performance management used by DVA attempts to measure DVA's performance in each operational area by reporting from the perspective of quantity, cost, timeliness, quality, and outcome. DVA has nine performance measures relating to the hospitals component of Output 2.1, none of which includes the performance indicator at which the earlier recommendation was aimed. However, DVA still includes in its annual report information on the number of complaints received by the State and Territory Treatment Monitoring Committees.

3.5 In 1997 DVA conducted its first survey of veterans' satisfaction. A follow-up survey was conducted in 1999. From September 2000, DVA has conducted quarterly cyclical veterans' satisfaction surveys. These surveys target key areas of the Department's activities. For example, in the September 2000 survey, the areas covered were income support, disability compensation, health and publications. DVA plans to ensure that each major area is surveyed twice a year. DVA plans to build the results into the Department's Balanced Scorecard.

Conclusion

3.6 DVA has implemented this recommendation. Although DVA no longer produces performance measures relating to complaints received by the Treatment Monitoring Committees, DVA nevertheless continues to include information on the number of complaints received in its annual report.

Performance in payment reconciliation

3.7 In the earlier audit the ANAO found that DVA was not performing payment reconciliations on claims submitted by the States in a timely fashion and recommended that it develop a performance indicator in this area. The ANAO considered that the development of such an indicator would help confirm that the reconciliations were being conducted and would enable DVA to monitor its performance in conducting reconciliations.

Recommendation No. 8 of Audit Report No. 40, 1997–98

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

Findings of the follow-up audit

3.8 All the Arrangements specify time frames for submission of data and completion of the reconciliation process.[16] The details of the reconciliation process and expected timetables depend on the specific Arrangement. In general, however, each Arrangement outlines the timetables for submission of data by the State or Territory to DVA and the time frames within which DVA is required to reconcile and raise with the State or Territory any issues for clarification.

3.9 As discussed in Chapter 2, during field work the ANAO found that the specified time frames were not consistently adhered to. In some cases, there was temporary agreement between DVA and the State or Territory concerned to vary the reconciliation timetable.

3.10 It was found that, in the States visited, the performance of the States and Territories in relation to their reconciliation obligations was monitored by the responsible DVA State Office. The ANAO found, however, that there was no formal mechanism by which DVA monitored its own performance in meeting the reconciliation timetable. Responsibility for that process rested with the DVA State Office Contract Manager concerned, who in turn was responsible to the Deputy Commissioner in the DVA State Office. The ANAO found that, in relation to reconciliation targets, neither the performances of the States and Territories nor those of the DVA State Offices concerned were reported routinely to National Office.

3.11 Despite DVA's Balanced Scorecard approach to measuring performance in the purchase of hospital services to eligible veterans, it had not developed a performance indicator to monitor its performance in relation to the discharge of its reconciliation commitments.

3.12 In the past, Balanced Scorecard measures relied on quarterly data from DVA State and Territory offices on the number of separations and level of expenditure occurring in a given quarter. When reconciliations are not conducted in a timely way, the data that informs the Balanced Scorecard may not give a true picture of the actual number of separations and level of expenditure on public hospital services for that quarter. This can lead to inconsistencies in the Balanced Scorecard data from quarter to quarter, as data for the previous quarters is reconciled and adjusted accordingly. Thus the lack of timely and accurate data because of delays in the reconciliation process can affect the Balanced Scorecard measures reported by DVA and in turn the reliable use of this data for planning. In recognition of this, DVA has recently begun reporting public hospital services for the Balanced Scorecard on an annual basis, reporting in the first quarter of each calendar year the data for the previous financial year.

[16] See Chapter 2 for further discussion.

3.13 As noted in Chapter 2, the implementation of HOTSPUR in all States and Territories will provide DVA with the data necessary to monitor its performance in reconciling its payments to the States and Territories.

Conclusion

3.14 This recommendation has not been implemented yet by DVA. The development of HOTSPUR is expected to provide DVA with the information it requires to monitor the progress of reconciliations.

3.15 The ANAO considers that DVA should develop a performance measure to allow an assessment of timeliness against performance targets in reconciling claims submitted by the States. It may be convenient for this measure to be incorporated into the Department's Balanced Scorecard for this output group.

4. Other Management Issues

This chapter deals with progress against recommendation 9 concerning staff knowledge and understanding of DVA's strategy for monitoring clinical standards in public hospitals. It comments also on other issues identified and investigated in the course of the audit.

Quality

Repatriation Private Patient Principles

4.1 The Repatriation Private Patient Principles (RPPPs) set out the circumstances in which veterans may be treated as private patients. The RPPPs are prepared under section 90A of the *Veterans' Entitlements Act 1986* and as disallowable instruments have the status of regulations. They state that '*the Commission will monitor the access to and quality of hospital care arranged for entitled persons. As part of the process, the Commission will establish and support a National Treatment Monitoring Committee and a Treatment Monitoring Committee in each State, the Australian Capital Territory and the Northern Territory*'. As a consequence, as well as quality being an output objective, there is a formal requirement for DVA to monitor quality.

Treatment Monitoring Committees

4.2 DVA has established a Treatment Monitoring Committee in each State and Territory. These are overseen by the National Treatment Monitoring Committee (NATMOC). Treatment Monitoring Committees play an important role in monitoring the quality of health care in both public and private hospitals.

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

4.4 The ANAO noted in the earlier audit that the use of Treatment Monitoring Committees seemed to be an effective means of monitoring quality for some of the aspects of health-care services provided by hospitals.

Clinical standards

4.5 In the earlier audit the ANAO noted that Treatment Monitoring Committees also have a role to play in monitoring clinical standards, particularly through their role in investigating complaints involving apparent lapses in clinical standards.

4.6 The ANAO also noted however, that there were other ways in which DVA was able to monitor clinical standards. The ANAO found in the earlier audit that although DVA staff were able to articulate clearly the methods used to monitor clinical-care quality in private hospitals, staff were less able to do so with respect to public hospitals. The ANAO considered that DVA should ensure that its staff has a clear knowledge of DVA's strategy for monitoring the quality of clinical care in public hospitals.

Recommendation No. 9 of Audit Report No. 40, 1997–98

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

Findings of the follow-up audit

4.7 Some of the current Arrangements with the States and Territories specify the quality requirements with which their public hospitals must comply. Where such provisions existed, the ANAO found that DVA did not monitor directly an individual public hospital's compliance. However, DVA staff in the States and Territories understood the quality strategy by which DVA ensured quality of clinical treatment. In Victoria, for example, DVA staff were aware of the Victorian State Government's general quality strategy and received copies of relevant reports on State public hospital quality investigations.

4.8 The ANAO considers, however, that there remains greater scope for monitoring clinical standards by DVA. The ANAO considers that DVA should ensure that quality provisions are incorporated in and, where possible, consistent across, all its Arrangements with States and Territories. The ANAO considers also that DVA should make better use of provisions in the Arrangements for the supply of clinical quality performance information by the public hospitals concerned and monitor more actively the clinical quality in public hospitals treating veterans.

4.9 The ANAO found that some of the Arrangements provided for periodic customer-satisfaction surveys of veterans treated in public hospitals. These surveys are in addition to those conducted quarterly by DVA and discussed in Chapter 3. In one of two States in which provision for such surveys existed, such a survey had been conducted by the State Government.

Conclusion

4.10 DVA has implemented this recommendation.

Other issues

Access clauses

4.11 Access to hospital records and facilities enhance the ability of DVA to assure itself that the services provided by specific public hospitals to veterans meet its quality, efficiency and effectiveness requirements. The presence of access clauses in its Arrangements with the States and Territories provides an additional mechanism by which it can so assure itself. The ANAO found that most, but not all, of the Arrangements provided for such access to clinical records and in some cases to hospital facilities.

4.12 In June 2001, the Auditor-General advised all heads of Commonwealth agencies of the revised standard access clauses for use in appropriate Commonwealth contracts. These clauses were designed to provide access by both agencies and the ANAO to records, information and assets associated with contractors' responsibilities for the delivery of services. Although it is expected that the need for ANAO access will be minimal, the presence of access clauses facilitates Commonwealth agencies' execution of accountability obligations.

4.13 The ANAO considers that DVA should investigate whether there is a need to ensure that access clauses are standardised in all its Arrangements. The revised standard access clauses developed by the Auditor-General and approved by the Minister for Finance as part of the Commonwealth Procurement Guidelines provide a useful guide in this respect.

Canberra ACT
15 March 2002

P. J. Barrett
Auditor-General

Appendices

Appendix A

Overview of the Provision of Hospital Services for Veterans

1. For more than 80 years the Commonwealth has provided eligible veterans with repatriation benefits, the first provision for medical treatment and the payment of war pensions having gone into operation on 21 December 1914.[17] Medical treatment for veterans was provided originally through a network of military hospitals that the Commonwealth had established across Australia at the time of the First World War. In 1921 their control was transferred to the Repatriation Commission, which thus became a direct provider of hospital care for veterans.

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

Divestment of Repatriation General Hospitals

3. Various Commonwealth Governments have reviewed the repatriation hospital system. Most significant in recent times was the Review of the Repatriation Hospital System, chaired by Dr Ian Brand. The Review report was published in June 1985,[18] and recommended that the existing network of RGHs be integrated into State hospital systems. It noted concerns about veterans' access to appropriate hospital services, evidence having shown that veterans and their spouses were experiencing difficulties in getting to the centralised RGHs.

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[17] *Repatriation* is defined as assistance given to ex-service personnel returning to civilian life, in the form of pensions, medical care, allowances for dependants, etc.

[18] *Review of the Repatriation Hospital System: Final Report*, (the "Brand Report"), Department of Veterans' Affairs, Melbourne, June 1985.

4. All the RGHs were general teaching hospitals and had established themselves as centres of excellence. However, the Brand Report commented that the RGHs were *'increasingly gaining the reputation of being hospitals for geriatric care and were losing their attractiveness to top-level specialist professional staff'*.[19] It commented that without community patients the RGHs would not have been able to operate effectively as acute and general teaching hospitals.

5. The Report noted also that more investment in the RGHs would affect, and needed to be coordinated with, State hospital systems. It discussed rationalising hospital resources in metropolitan areas and noted the then view of the Department of Finance that it was a long-term Government objective that management and development of the Repatriation system should involve rationalising Repatriation hospital activities with those of State authorities with a view to eventual integration with the State hospital systems, consistent with the effective use of resources and overall policy objectives.[20]

6. The Commonwealth Government accepted the report's findings and decided in 1989 to divest itself of the RGHs.

7. That decision was predicated on the Commonwealth's entering into Arrangements with State Governments to:

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

8. The decision to divest resulted in significant but unquantified savings to the Commonwealth.[21]

The DVA purchasing model

9. The Department of Veterans' Affairs no longer provides veterans with hospital services directly. In broad terms, it acts as both a buyer and financer of hospital services (see Diagram A1). It is a direct buyer when purchasing services from a private hospital and an indirect buyer, through State health departments, when obtaining services from public hospitals.

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[19] *ibid*, p. 43.

[20] *ibid*, p. 25.

[21] ANAO Report No 40 1997-98, DVA *Purchase of Hospital Services from State Governments*, AGPS, Canberra, 1998.

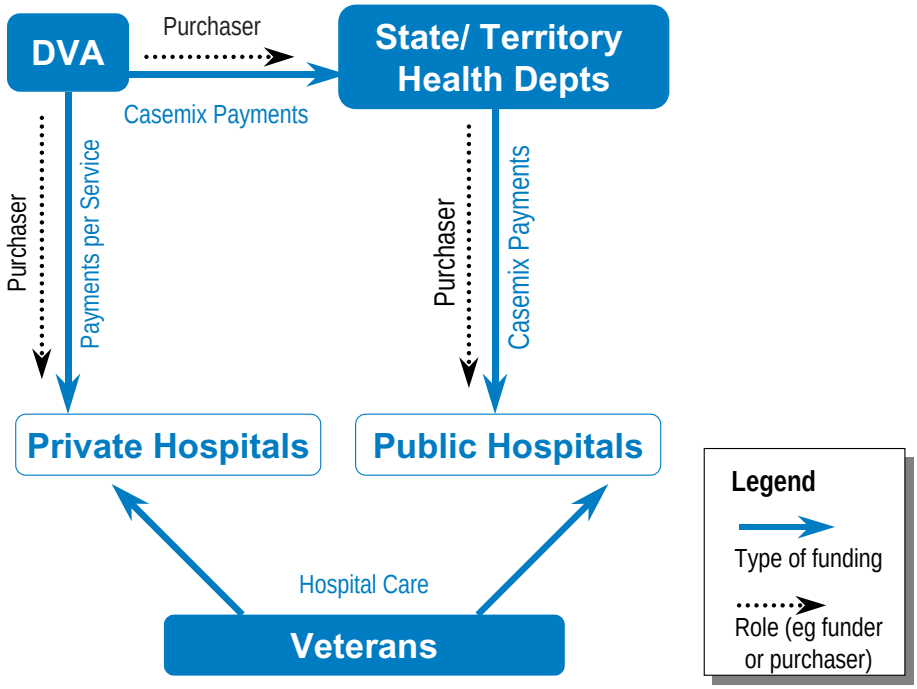
10. There are significant differences from State to State in the funding of public hospitals. In New South Wales, NSW Health funds individual health areas on a broadly demographic basis. These in turn fund and buy services from hospitals. In Victoria, South Australia and Tasmania the hospitals are funded directly, using variations of a Casemix formula (see below for further discussion).

11. The Victorian formula differentiates between funding of veterans' treatment in public hospitals, which is not capped, and that for the treatment of the general public, which is.

12. In 1998 the Commonwealth Government decided to move to a full-cost arrangement for veterans' hospital treatment in all States and Territories from 1 July that year. Before that, funding by DVA of State and Territory Governments to buy hospital services covered only the cost of buying private-patient status for veterans, not the full cost of the treatment. The remainder of the cost was covered by the Commonwealth through the Medicare Agreements (now Australian Health Care Agreements) with the States and Territories, and other offsetting arrangements.

Diagram A1

DVA's hospital services purchasing model



Arrangements with State Governments

13. The Commonwealth's preference was that the RGHs be integrated with the State health systems. The Commonwealth entered into 10–year Arrangements with New South Wales, South Australia, Tasmania and Victoria to incorporate them into their health systems.

14. The Arrangements were split into two phases, the first phase lasting between four and five years. The first phase was based on the Commonwealth's providing 'block funding' to the State Governments for providing veterans with hospital services through their public hospital networks, except Tasmania, to which payments were made on a fee-for-service basis. The second was to involve a shift to payments for actual services provided, based on a Casemix funding model. In Western Australia an interim Arrangement based on block funding existed in various forms from 1994 to 2001.

15. In the Australian Capital Territory, the Northern Territory, Queensland and Tasmania, individual public hospitals providing veterans with services were reimbursed by the Commonwealth upon receipt of claims, which were processed by the Health Insurance Commission through the Treatment Accounts System (TAS).

16. Under these early Arrangements with New South Wales, South Australia and Victoria, there was an agreed level of funding for each year of the first phase corresponding with an agreed number of separations to be provided by each State. When the number of separations exceeded the agreed level, the Commonwealth provided more funds.

17. DVA has Arrangements now with each State and Territory to buy public-hospital services for veterans. They provide for a mixture of fee-for-service and block-funded payments and are based generally on an adaptation of the hospital Casemix funding model already used in that State or Territory for funding its own public hospitals.

Casemix

18. In July 1993, the Victorian Government became the first in Australia to introduce Casemix funding of hospitals. Casemix is a classification system that attempts to categorise the work performed in hospitals into episodes of care; each episode of care is grouped according to its nature and relative consumption of hospital resources.

19. Under Casemix, each 'episode of care' is identified as falling within a Diagnosis Related Group (DRG). DRGs are a patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by a hospital. DRGs provide a summary of the varied

reasons for hospitalisation and the complexity of cases a hospital treats.[22] They are based on a patient's diagnosis, which identifies the decision reached, after assessment, of the nature and identity of the disease or condition of a patient[23]. Diagnoses are recorded according to the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification* (ICD-10-AM).

20. In Australia, the Australian Refined Diagnosis Related Groups (AR-DRGs) are used to group episodes of care. The AR-DRG classification categorises the episode using the diagnostic information recorded in the hospital record.

21. The AR-DRG classification is partly hierarchical, each DRG falling within one of 23 Major Diagnostic Categories (MDCs), defined by the organ system of the body or disease type. Individual DRGs further group and categorise the episode of care within these MDCs according to the procedures performed or the specific diagnoses made.

22. The Casemix system allows an estimation of the relative cost and hospital resources used in treating different patients by assigning cost weights to each DRG. The cost weights reflect the different level of resources required to deliver different episodes of care. For example, AR-DRG A01Z (Liver Transplant) is assigned a costweight of 40.31; AR-DRG D11Z (Tonsillectomy, Adenoidectomy) has a weight of 0.71. The former requires an average of 57 times the resources required by the latter. Each State and Territory uses its own version of cost weights, reflecting variations in the cost of delivering hospital care.[24]

23. By classifying episodes using Casemix, a hospital can determine the types of patients and complexity of conditions it treats. Grouping treatment episodes into DRGs enables also some comparisons between hospitals, such as the average length of stay, for specific DRGs.

24. Together with the use of cost weights for DRGs, Casemix can be used as a model to fund hospitals according to the mixture of patients the hospital treats. A buyer of hospital services could determine a benchmark price that it would pay per cost-weighted separation—say, $2500. Using the previous examples, that buyer would pay, on average, $100 775 ($2500 x 40.31) for a patient requiring a liver transplant, and $1775 ($2500 x 0.71) for one having a tonsillectomy.

25. In its current Arrangements, DVA has adopted the Casemix model for buying acute hospital services.

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[22] Australian Institute of Health and Welfare, *National Health Data Dictionary - Version 10*. Canberra, 2001, p. 148.

[23] ibid, p. 147.

[24] Some States and Territories use national cost weights developed by the Commonwealth Department of Health and Ageing.

Funding

26. Funding for the purchase of hospital services for veterans is a component of output group 2.1 (Arrangements for the delivery of services) of the Veterans' Affairs portfolio. In 2001–02, $2.2 billion was budgeted for veterans' hospital and health services, $1.2 billion of that amount allocated for treatment in public and private hospitals.[25] Access to hospital services is an entitlement of eligible veterans under the *Veterans' Entitlement Act 1986*.

27. Hospital services for eligible veterans are an entitlement. That is, the funding of hospital services varies with veterans' demand for hospital treatment. Table A1 shows DVA's expenditure on hospital services for the last five years by sector.

Table A1

DVA hospital expenditure by sector – in current and constant prices

Year	Public hospitals (inc. RGHs)			Private Hospitals			Total DVA hospital expenditure	
	Expenditure $ 000	1999-2000 prices $ 000	% of DVA total hospital expen.	Expenditure $ 000	1999-2000 prices $ 000	% of DVA total hospital expen.	Expenditure	1999-2000 prices
1996-97	406 950	421 834	53.5	354 228	367 184	46.5	761 178	789 018
1997-98	382 572	396 565	47.7	419 753	435 106	52.3	802 325	831 670
1998-99*	500 688	512 609	49.9	503 462	515 449	50.1	1 004 150	1 028 058
1999-00	496 022	496 022	44.6	615 309	615 309	55.4	1 111 331	1 111 331

Note (a) In 1998-99 DVA changed the basis of accommodation payment from the State public hospital default rate to full cost recovery
Source: Department of Veterans' Affairs

28. Table A1 shows that in 1996–97, public-hospital expenditure represented 53.5 per cent of overall hospital expenditure. By 1999–2000, it represented only 44.6 per cent. The sharp increase in 1998–99 is explained by the Commonwealth's decision to fund public-hospital services on the basis of paying for full cost, as well as its decision to extend eligibility for the Gold Card.

29. Table A2 shows DVA expenditure on services provided by privately owned hospitals, separated into privately owned former RGHs and other private hospitals.

[25] Portfolio Budget Statement 2001–02, Veterans' Affairs Portfolio Budget Related Paper No. 1.4B.

Table A2

DVA private sector hospital expenditure – current prices

Year	Privately owned former RGHs		Other private hospitals		Total private sector expend.	Total DVA hospital expend.
	$ 000	% of DVA total hospital expend.	$ 000	% of DVA total hospital expend.	$ 000	$ 000
1996-97	100 221	13.2	254 007	33.4	354 228	761 178
1997-98	112 437	14.0	307 316	38.3	419 753	802 325
1998-99	123 040	12.3	380 422	37.9	503 462	1 004 150
1999-00	138 733	12.5	476 576	42.9	615 309	1 111 331

Source: Department of Veterans' Affairs

30. As the table indicates, there has been an increase in expenditure on services provided by other private hospitals from $254 million (33.4 per cent of total expenditure) in 1996–97 to $477 million (42.9 per cent of total expenditure) in 1999–2000. Reasons for the trend towards the private sector include:

- admission of some veterans to private hospitals because of resource constraints and waiting lists in the public sector. Waiting times increase in importance with the ageing of the veteran community;
- the increase in the number of private day-surgery facilities with the advent of new technology;
- the gradual shift of veterans away from the former RGHs, to benefit from public- and private-hospital services closer to their place of residence and support;
- the impact of the sale of former Repatriation Hospitals to the private sector; and
- the introduction of Tier 1 private hospitals as a result of veteran partnering (see below 'Repatriation Private Patient Scheme' for further discussion).

31. Table A3 shows the average cost of separations in the public sector in the last four years.

Table A3

Public hospital separations – in current and constant prices

Year	Separations	Expend. (current prices)	Cost per Separation	
		$ 000	(current prices) $	(1999-2000 prices) $
1996-97	115 024	406 950	3 538	3 667
1997-98	107 984	382 572	3 543	3 672
1998-99	122 177	500 688	4 098	4 196
1999-00	129 486	496 022	3 831	3 831

Source: Department of Veterans' Affairs

32. The cost per separation increased by 4.5 per cent from 1996–97 until 1999–2000. The Commonwealth began to buy hospital services on the basis of full cost recovery in 1998–99, which may be a partial explanation of the increase in cost per separation in that year.

33. Table A4 shows total separations in all States and Territories in the public and private sectors.

Table A4

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

Year	Public sector	Private sector	Total
1996-97	115 024	131 023	246 047
1997-98	107 984	153 306	261 290
1998-99	122 177	172 752	294 929
1999-00	129 486	204 326	333 812

Source: Department of Veterans' Affairs

34. As Table A4 shows, there has been an increase of 36 per cent in the total number of separations, from 246 047 in 1996–97 to 333 812 in 1999–00, which was partly due to improvements in the hospitals' identification of veterans. Separations in the public sector increased by 13 per cent from 115 024 in 1996–97 to 129 486 in 1999–00, and in the private sector by 56 per cent from 131 023 to 204 326. Those in the public sector represented 47 per cent of total separations in 1996–97 and only 39 per cent in 1999–00. Note, however, that expenditure on public hospitals was 45 per cent of total expenditure. There are numerous reasons that this has been occurring. It can be partly explained by the greater complexity of procedures performed in public-sector hospitals, and to the generally wider range of services provided by public hospitals.

The eligible veteran population

35. The majority of veterans are eligible for treatment by virtue of Part V of the *Veterans' Entitlement Act 1986*. Sections 85–89 of the Act outline the criteria under which a veteran or dependent can be become eligible for treatment.[26]

36. With the ageing of the veteran population, the number of veterans eligible for health care under the repatriation system is in long-term decline. At 30 June 2001, the total veteran treatment population was 345 131.[27] DVA estimates that that population will have declined by 17 per cent between 1997 and 2007, by which time 42 per cent of male Gold Card holders and 56 per cent of female

[26] The Repatriation Private Patient Principles indicate, in general terms, those persons eligible for hospital treatment. The Repatriation Private Patient Principles are reproduced in Appendix C.

[27] Department of Veterans' Affairs, *Annual Report 2000-01*, AGPS, Canberra, 2001, p. 154.

Gold Card holders will be 80 and over. Table A5 shows the treatment population by age group at 30 June 2001.

37. Although the total number of eligible veterans is in decline, DVA has seen an increasing demand for hospital services caused by an increase in the proportion of those aged 80 and more. It forecasts that demand for health and aged-care services will peak in the next 10 years.

Table A5

Treatment population by age group as at 30 June 2001

Age	New South Wales	Victoria	Queensland	South Australia	Western Australia	Tasmania	Unknown	Australia
<55	11 914	6 278	11 981	3 743	4 433	1 305	7	**39 661**
55-59	4 191	2 153	4 191	1 172	1 404	446	7	**13 564**
60-64	2 829	1 233	2 887	605	1 005	288	5	**8 852**
65-69	4 249	2 139	3 126	799	1 181	428	0	**11 922**
70-74	12 170	7 465	6 664	2 513	2 594	1 249	5	**32 660**
75-79	43 736	28 932	21 990	10 231	9 177	4 216	17	**118 299**
80-84	29 467	19 987	15 442	7 158	6 292	2 565	9	**80 920**
85+	13 666	10 237	7 060	3 426	3 516	1 241	3	**39 149**
Unknown	25	24	30	12	11	2	0	**104**
Total	**122 247**	**78 448**	**73 371**	**29 659**	**29 613**	**11 740**	**53**	**345 131**

Source: Department of Veterans' Affairs

Repatriation Private Patient Scheme

38. The Repatriation Private Patient Scheme (RPPS) was established after the RGHs were transferred from the Commonwealth to the State Governments. It provides eligible veterans and dependants with free treatment at any public hospital or privatised Repatriation Hospital, as private patients, in shared wards, with the choice of their own doctors. The Repatriation Private Patient Principles (prepared under section 90A of the *Veterans' Entitlement Act 1986*) require that access to and the quality of hospital care be monitored. As a consequence, the Repatriation Commission established a National Treatment Monitoring Committee (NATMOC) and a Treatment Monitoring Committee (SATMOC) in each State and Territory.

39. The primary objective of the RPPS is to ensure that eligible veterans obtain access to the nearest suitable hospital to receive treatment. However, the Repatriation Commission has established an order of preference for veterans' admission to a hospital. There are three tiers:

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[28] The veteran partnering arrangements allow veterans access to services provided by private hospitals without requiring prior approval. In the past, Tier 1 treatment was provided only by public hospitals or former Repatriation General Hospitals. As a result of the veteran partnering initiative, veterans now have access to participating contracted private hospitals on the same terms as the Tier 1 facilities.

- Tier 1, public hospitals, privatised former Repatriation General Hospitals, and contracted veteran partnering private hospitals;[28]
- Tier 2, contracted private hospitals; and
- Tier 3, other private hospitals.

40. Under the scheme, an entitled veteran may be admitted directly to a local public hospital, former Repatriation General Hospital or a contracted veteran partnering private hospital as a private patient, in a shared ward, with the doctor of choice. No prior approval from DVA is required for admission to Tier 1 hospitals.

41. When treatment cannot be provided in a reasonable time from one of the Tier 1 hospitals, a veteran may be admitted to one of the Tier 2 hospitals with the prior authorisation of DVA.

42. Where a service is not available from either of a Tier 1 or Tier 2 hospital, a veteran may be admitted to a Tier 3 non-contracted private hospital. Again, admission to a Tier 3 hospital requires the prior authorisation of DVA.[29]

[29] In an emergency, a veteran may be admitted to the nearest hospital, public or private, provided that DVA is notified of the admission at the earliest opportunity.

Appendix B

Recommendations of Audit Report No. 40 of 1997–98

Earlier Audit		
	Recommendation	**Response from DVA**
Defined penalties and incentives	1. The ANAO recommends that the Department seek the introduction of a more comprehensive penalty regime, and additional incentives to encourage superior performance in all future DVA Arrangements with the States, to strengthen the Commonwealth's capacity to achieve its objectives. Para. 3.24	**Agreed.** The Department is actively working towards the aim. The exact mix of penalties and incentives achieved will be a consequence of negotiations with State governments. Para. 3.25
Capital funding	2. The ANAO recommends that where possible, in instances where Commonwealth money is paid to a State for particular purposes, such as for capital programs, the Arrangement and/or the supporting documentation should include details of: • the purpose for which the payment is made; • the time frame in which the money is expected to be spent; and • the consequences if the purpose or time frame is not met. Para. 3.30.	**Agreed**
Value for money — accounting for services	3. The ANAO recommends that, where accurate and timely data is received, DVA complete reconciliations of public hospital separations data within the time frames specified by the Arrangements with the States, to ensure that the Commonwealth pays the correct amounts to State governments for the provision of their services. Para. 3.43.	**Agreed** The Department has had repeated discussions with State stakeholders regarding the format and timing of separation data transmissions, and is hopeful that the difficulties identified will be overcome in 1998. Para. 3.44

Earlier Audit		
	Recommendation	**Response from DVA**
Value for money — IT systems	4. The ANAO recommends that DVA, to facilitate reconciliations, ensure that appropriate IT systems are in place at the latest shortly after the commencement of new Arrangements with the States. Para. 3.49	**Agreed**
Value for money — responsibilities	5. The ANAO recommends that DVA review its current allocation of responsibilities for the reconciliation of Commonwealth and State data. Para. 3.53	**Agreed.** The Department will review the allocation of responsibilities for the reconciliation process and clarify the roles of all relevant managers. Para. 3.54
Value for money — cost-effectiveness	6. The ANAO recommends that future Arrangements with the States should include provisions to ensure the supply of the public hospital data required by DVA to make informed judgements on the cost and quality of alternate suppliers of hospital services. Para. 3.60	**Agreed .**
Performance indicators for quality	7. The ANAO recommends that DVA include in its annual report the number of complaints received by Treatment Monitoring Committees, to allow readers to more fully understand DVA's performance indicator on the investigation of these complaints. Para. 4.9	**Agreed.**
Performance indicators for entitlement	8. The ANAO recommends that DVA ensure that it has adequate systems in place to monitor progress in data reconciliation, and develop a performance indicator to allow an assessment of the timeliness of its performance in reconciling claims submitted by the States. Para. 4.17	**Agreed.**
Quality — clinical standards	9. The ANAO recommends that DVA ensure that staff have a sound knowledge and understanding of DVA's strategy for monitoring clinical standards in public hospitals. Para. 5.27	**Agreed.**

Appendix C

Repatriation Private Patient Principles

REPATRIATION COMMISSION

Section 90A Veterans' Entitlements Act 1986

Repatriation Private Patient Principles

Introduction

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

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

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

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

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

- Australian veterans (section 85 of the Act) including:
  - a veteran with a war or Defence-caused injury or disease;
  - a veteran with a malignant neoplasm or pulmonary tuberculosis;
  - a veteran who receives a disability pension at or above the 100 per cent

general rate;

- a veteran who receives a disability pension at or above 50 per cent of the general rate and who also receives a service pension;
- a veteran who receives a service pension and is permanently blinded in both eyes or meets an income or assets test;
- a veteran who served in World War I;
- a veteran (including any person who during World War 2 was an eligible civilian) who was detained by the enemy;
- a Vietnam veteran in need of urgent treatment;
- a female veteran who rendered qualifying service in World War 2;
- dependants of Australian veterans (section 86 of the Act) including:
- a war or a defence widow or widower and her or his dependant children;
- the child of a deceased veteran who had operational service, if the child is not being cared for by a remaining parent;
- a dependant of a Vietnam veteran in need of urgent treatment;

6. Treatment for eligible persons may be provided:

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

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

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

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

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

Part A — Definitions

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

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

"Commission" means the Repatriation Commission;

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

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

"Department" means the Department of Veterans' Affairs;

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

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

"Entitled person" means a person who is:

(a) an entitled veteran;

(b) an entitled widow or widower; or

(c) a child eligible for treatment under section 86, except for a child eligible only under sub-section 86(5) of the Act;

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

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

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

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

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

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

Part B — Repatriation Private Patient Principles

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

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

(i) public hospitals and former Repatriation Hospitals

(ii) contracted private hospitals

(iii) other private hospitals

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

3. Under these Principles, entitled persons will have direct referral, for treatment as a private patient, to a hospital specified in Principle 2(i) of their choice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix D

DVA Output and Outcomes Framework

1. Veteran health care now falls under Outcome 2 of the Department's Output/Outcome structure. DVA Outcome 2 provides:

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

2. Performance information for Outcome 2 consists of the measures shown in Table A6. The purchase of hospital services from State Governments is part of DVA Output 2.1 – Arrangements for the delivery of services.

Table A6

Performance information and level of achievement 2001–02

Performance information and level of achievement 2001–02	
Effectiveness – Overall achievement of the outcome Veteran satisfaction with the choices they have and the quality of the care they receive, as well as the lifestyle choices and levels of independence available to them.	
Performance information for administered items	
Target is a high percentage of cardholders who report satisfaction with the standard of health care received through DVA arrangements.	
Performance information for Output Group 2 (Provide quality cost-effective health care and support services)	
Output 2.1: Arrangements for delivery of services.	**Quantity:** The treatment population (gold and white cards) is 344 950.
	Price: $208 per cardholder
	Quality: High level of veteran satisfaction
Hospitals	**Price:** Cost per cardholder of $26
	Quality: High level of veteran satisfaction
Non-hospital care	**Price:** Cost per cardholder of $182
	Quality: High level of veteran satisfaction

3. The DVA Corporate Plan for 2001–02 sets performance standards for measuring performance against the Departmental Outcomes. The Corporate Plan provides:

> **Our Performance Standards**
>
> *We have set the following performance criteria for these outcomes as:*
>
> - *High level of satisfaction among the veteran and defence force communities*
> - *Achievement of international and Australian benchmarks for DVA service standards, administrative arrangements and policy frameworks*
> - *Evidence of public awareness, particularly by young people, of the contributions that veterans have made to the Australian nation*
>
> *We will examine our performance using timeliness, quality, quantity and cost indicators that are measured quarterly and reported in a Balanced Scorecard.*

4. The Balanced Scorecard approach to performance management attempts to measure DVA's performance in each operational area by reporting from the perspective of quantity, cost, timeliness, quality, and outcome.

5. DVA currently has nine performance measures relating to the Hospitals component of Output 2.1. These measures are:

2105.01 — Number of public hospital separations
2105.02 — Number of private hospital separations
2105.08 — Departmental cost as a percentage of program costs
2105.16 — Program cost per public hospital separation
2106.17 — Program cost per private hospital separation
2105.18 — Departmental cost per public and private hospital separation (combined)
2105.19' — Combined number of private and public hospital separations
2105.20 — Combined program cost per private and public hospital separation (average)
2105.23 — Combined total program cost for public and private hospital separations

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