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Australian Government
Department of Veterans' Affairs

Department of Veterans' Affairs submission – Inquiry into Health Funding by the Standing Committee on Health and Ageing

Terms of Reference
The Committee shall inquire into and report on how the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.

The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.

The Committee shall give particular consideration to:

a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services;

b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;

c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and

e) while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

Purpose
This paper provides background information on the Repatriation Commission, the Military Rehabilitation and Compensation Commission and the Department of Veterans' Affairs' (DVA) roles in arranging the provision of treatment in the Australian health care system for entitled veterans, war widows/widowers and their eligible dependants according to the provisions of the *Veterans'*

Entitlement Act, 1986. In addition it provides background information on DVA's arrangements for the provision of health care for entitled persons under the *Safety Rehabilitation and Compensation Act, 1988* and the new *Military Rehabilitation and Compensation Act,* 2004 for both serving and former members of the Australian Defence Force. In doing so it addresses the terms of reference above.

Introduction

DVA seeks to be a discerning purchaser of services from both public and private health care providers. DVA's aim is to provide timely, high quality accessible services for veterans in their local communities and according to their clinical needs, and also, in relation to programs such as Veterans Home Care, social and personal needs. This is ensured in the main by DVA procuring necessary veteran services from both private and public sector providers in an informed and cost effective manner, meeting appropriate government procurement guidelines.

Background

The health needs of the veteran community are met by:

- Providing access to medical, hospital and allied health care services for entitled beneficiaries through arrangements with hospitals and health care providers in both the public and private sectors;
- Providing effective procurement and management of DVA's community support and residential care programs, including development and review of policy and operational guidelines and procedures, and assessment of program effectiveness; and
- Developing strategic directions in aged care for the veteran community and continuing to define DVA's role in ensuring veterans' aged care needs are met in a changing health and aged care environment, in cooperation with other key agencies.

DVA achieves this, not through direct service provision but through contracts, memorandums of understanding and standing offers with a wide range of service providers, including hospitals, doctors, specialists, community nursing providers and allied health professionals. The one exception to this is the Vietnam Veterans Counselling Service (VVCS), through which DVA provides highly specialised counselling and related services not readily available in the general community.

The role of the general practitioner (GP) is integral to the provision of health care services to veterans. Local Medical Officers (LMOs), that is those GPs who have registered to participate in the Department's Local Medical Officer arrangements, must have the capacity to be central to the care of eligible veterans. LMOs play a key role in the delivery of primary health care to veterans, through the coordination of their health care and by providing a support base for their patients. An example of this care coordination role is the requirement for the hospital to provide a report back to the LMO within two days of a veteran's hospital episode.

The Department is one of the largest single purchasers of health care services in Australia with an annual health care budget of $4.1 billion in the 2004/05 financial year, projected to increase to around $4.6 billion in 2005/06. Approximately $1.6 billion of the expenditure in 2004/05 was for public and private hospital services consisting of approximately 380,000 separations and nearly 2 million occupied bed days.

Table 1 gives a breakdown of the major DVA health expenditure items for 2004/05 by service type.

Health Service Type	Cost 2004/05 $ million
Private and public hospital treatment	1,642.876
Residential care	750.290
Consultations and medical practitioner services	687.453
Veterans' pharmaceutical services	471.533
Allied Health Services	119.094
Travel & subsistence	100.321
Rehabilitation Appliances Program	85.179
Veterans' Home Care	80.451
Community Nursing	73.192
Dental	73.157
Other (including VVCS)	35.753
Total	**4,119.299**

Table 1: Major health expenditure items in 2004/05

DVA also reimburses payments, at reasonable cost, made by entitled persons for health services, received through compensation entitlements under the *Safety Rehabilitation and Compensation Act, 1988*, totalling around $18 million in 2003/04.

Today our veterans and war widows account for 30% of the Australian population over the age of 75. The number of veterans entitled to DVA health coverage is showing a slow but steady decline due to ageing and mortality rates of the veteran population. However, the ageing of our population means that while we will have fewer veterans, overall they are requiring more services as they become frailer.

The gender mix of our population is also changing, with an increasing proportion of the population being made up of war widows (the wives of those veterans who died from war caused disabilities).

While the procurement of health services by DVA has to be set in the context of the Australian Health Care Agreements that the Australian Government has with each state/territory, DVA should not be looked on as a Commonwealth funder of public and private health care services. It is an important purchaser competing in the various markets for health care services, accountable to Parliament and highly conscious of the need to deliver acceptable and responsible financial outcomes. A recent independent review of the procurement of hospital services concluded that DVA showed a capacity to manage sensitive and complex issues with signal success, achieving financial outcomes equal to or less than private health insurance purchasers of like hospital services.

Eligibility

Eligible veterans and dependants are issued with Repatriation Health and pharmaceutical Cards that identify the level of health care coverage to which they are entitled.

These cards are:

- *Repatriation Health Card – for all conditions (Gold Card)*, which entitles eligible veterans, war widows/widowers and eligible dependants to treatment and care for all medical conditions, regardless of whether they are service-related.
- *Repatriation Health Card – for specific conditions (White Card)*, which entitles eligible veterans to treatment for medical conditions that are accepted as service-related. The White Card is also issued to all Australian veterans suffering from malignant neoplasia, pulmonary tuberculosis and post-traumatic stress disorder regardless of whether these conditions are service-related.
- *Repatriation Pharmaceutical Benefits Card (Orange Card)*, which gives eligible British, Commonwealth and Allied (BCAL) veterans access to Repatriation Pharmaceutical Benefits Scheme (RPBS) items at concessional rates. This card does not entitle the holder to treatment at Commission expense, other than access to subsidised pharmaceuticals.

At 30 June 2005 the total number of Repatriation Health Card holders was 334,207, comprising 260,864 Gold Card holders, 55,469 White Card holders and 17,874 Orange Card holders (2,958 of these Orange Card holders also hold a White Card).

The average and estimated costs per year of the Gold and White Card, for the years from 2002/03 to 2008/09, are summarised in Table 2 below.

Financial year	Av cost per Gold Card	Av cost per White Card
2002-03	$10,250	$1,100
2003-04	$11,450	$1,200
2004-05 (estimate)	$12,400	$1,300
2005-06 (estimate)	$13,900	$1,500
2006-07 (estimate)	$15,200	$1,600
2007/08 (estimate)	$16,800	$1,800
2008/09 (estimate)	$18,450	$1,950

Table 2: Average cost of a Gold Card and a White Card

The projected treatment population (Gold and White card holders only) for the years from 2005 to 2014, are at Table 3 below.

Year	Treatment Population (Gold & White Cards)
2005	317,000
2006	307,900
2007	298,700
2008	289,400
2009	280,000
2010	270,400
2011	260,600
2012	250,800
2013	240,900
2014	231,300

Table 3: Projected Treatment Population

The costs at Table 2 above **include** LMO/Specialist consultations and services; Hospitals; Community Nursing, Rehabilitation Appliances; Repatriation Pharmaceutical Benefits Scheme; Veterans Home Care; VVCS and **exclude** Residential Care Subsidy and various minor items not directly related to veteran health care (eg Health Research). It should also be noted that these figures are gross of any Medicare offsets.

As well as ensuring adequate treatment options are available through access to doctors, specialists and hospitals, the Department places a strong emphasis on preventive health initiatives, such as Veterans' Home Care, which provides low level care and assistance, aimed at enabling veterans to live independently in their local communities for as long as possible.

With the introduction of the Military Rehabilitation & Compensation Scheme in 2004 there is an increased focus on rehabilitation and greater recognition of the importance of vocational rehabilitation as a vital part of a comprehensive treatment plan.

Under the *Military Rehabilitation and Compensation Act, 2004* (MRCA), the Commonwealth meets the reasonable treatment costs for accepted short-term or acute conditions. If treatment is required for accepted long-term or chronic conditions clients are able to access treatment in a similar manner to the holder of a Repatriation Health Card – for specific conditions (White Card). In the case of more serious injury, the Commonwealth will allow similar access to treatment as that accessed by the holder of a Repatriation Health Card – for all conditions (Gold Card).

It is important to note that a recent comparison of veterans and war widows/ widowers with the rest of the community conducted by the Australian Institute of Health & Welfare showed that the patterns of health service use by the veteran community, after adjusting for disability and other key factors, shows similarity with the rest of the community.

DVA's procurement approach and philosophy

DVA has worked with the health industry over many years to improve access for veterans, establish and maintain quality care standards and to determine appropriate pricing regimes and structures for the services it procures for veterans and their eligible dependants. These long-standing relationships have ensured that veterans are able to receive the care they need, when they need it, and generally obtain services in their local environments. The arrangements that the Department has in place to procure the required services also generally reflect an approach that ensures that DVA's procurement arrangements are close to market rates, and they essentially ensure that cost-recovery is the main outcome for public sector providers. In the private sector, discounted market price is the objective, rather than profit per se.

In the hospital sector in particular, where DVA is a significant procurer, arrangements have been struck with private hospitals that are based on a fee for service, and which include step-down rates reflecting the changing nature of care for veterans as their hospital stay becomes longer. In the public sector, funding arrangements generally reflect throughput (ie number of veterans treated) and are based on that jurisdiction's application of casemix principles to the actual payment for the treatment provided. As DVA is seeking to provide a cost-recovery mechanism for the public hospital providers, DVA is careful, to the extent possible, not to provide funding or cross-subsidisation to the State health system in general through payments made on behalf of veterans receiving care in the public hospital system. Some further work in this regard is, however, still required as better data becomes available for analysis by DVA.

Health Care Services available to Veterans

Medical

The Repatriation Comprehensive Care Scheme, established in 1996, requires participating Local Medical Officers[1] (LMO)s to ensure that eligible veterans and war widows/widowers receive integrated care within the Repatriation Commission's treatment guidelines. The LMO is at the centre of care for veterans as a community case manager and are paid according to Cabinet-approved arrangements that are consistent across Australia. The Commission has contracts with LMOs for services to the veteran community but not with specialists. Commission has understandings with the specialist Colleges. Similarly for dental services provided to the veteran community we have understandings with dental providers as to the level of fees to be paid and the related limitations on the services to be provided.

These payments are below that paid by private health insurance funds, but above the Medicare Benefits Schedule (MBS) fees.

Prior to 1 January 2005, LMOs and medical specialists treating eligible veterans received 100% of the MBS fee. From 1 January 2005, the payment to eligible LMOs for the treatment of veterans increased from 100 per cent of the MBS fee to 115 per cent. Similarly, fees paid to most medical specialists also increased on 1 January 2005 to 115% of the MBS fee for consultations and 120% for procedures.

DVA-funded allied health and support services

Health and support services funded by DVA are mostly provided at no cost to the veteran. Access to services is dependent on the availability of the service in the community, and on the skills and specialisation of the local health practitioner. This is particularly evident in the allied health service area. There is a contractual relationship with each allied health provider, based on a national schedule of fees set by DVA, together with Guidelines issued by DVA on the services to be provided. DVA's payments are well below market rates.

While DVA generally procures allied health services available in the private sector, the veteran may need to access a service at a public hospital if it is not available privately, or if no private provider can deliver the type of service or level of expertise required by the veteran. A range of allied health services is available to veterans under Repatriation health care arrangements including:

- Chiropractic and osteopathic
- Occupational therapy
- Optometry
- Physiotherapy
- Podiatry
- Psychology
- Social work
- Speech pathology.

A number of other community-based health services can be accessed by veterans at DVA's expense, including community nursing, carer support and community support services, convalescent and respite care, dental services, hearing services, palliative care, pharmaceuticals (through the Repatriation Pharmaceutical Benefits Scheme), rehabilitation and rehabilitation aids, residential aged care, transport and travel assistance, Veterans' Home Care and the Vietnam Veterans Counselling Service (available to all veterans). More information is available, if required, on these services.

[1] Vocationally registered general practitioners.

Public Hospitals

Traditionally, DVA delivered hospital services to veterans and their eligible dependants through a network of departmental facilities, including a major Repatriation General Hospital (RGH) in each State capital city. The provision of hospitalisation through these facilities was complemented by arrangements whereby patients could be admitted to other public and private facilities when the RGH could not provide a service or it was impractical for the patient to be admitted to the RGH.

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. The Commonwealth transferred these hospitals and entered into 10-year contractual arrangements with the States for the provision of treatment for veterans.

In WA and QLD, the respective State governments declined the opportunity of integrating the Repatriation facility into their State health system and the RGHs in these States (Hollywood and Greenslopes Hospitals respectively) were sold, following tender, to the Ramsay Health Care Group Pty Ltd. In NSW the State Government also declined to integrate Repatriation Auxillary Hospital (RAH) Lady Davidson into the state health system and it was sold to Australian Hospital Care, which is now a part of the Affinity Health Ltd group of hospitals.

The dates when each hospital was transferred or sold are as follows:

- RGH Hobart - integrated into the Tasmanian state health system on 1 July 1992.
- RAH Macleod - closed 27 January 1993.
- RGH Concord (renamed Concord RGH) - integrated into the NSW State health system on 1 July 1993.
- RGH Hollywood (renamed Hollywood Private Hospital) - sold to Ramsay Health Care Group Pty Ltd (a private company) on 24 February 1994.
- RGH Heidelberg subsumed into the Austin and Repatriation Medical Centre and integrated into the VIC state health system on 1 January 1995.
- RGH Greenslopes (renamed Greenslopes Private Hospital) - sold to Ramsay Health Care Group Pty Ltd (a private company) on 6 January 1995.
- RGH Daw Park - integrated into the SA state health system on 9 March 1995.
- RAH Lady Davidson (renamed Lady Davidson Private Hospital) - sold on 1 October 1997 to Australian Hospital Care (a private company), now controlled by Affinity Health Ltd.

DVA sees the services provided by public and private hospitals as complementary, rather than as competitors, for veteran patients. DVA strives to ensure that veterans access clinically necessary care in the appropriate setting, whether that be for complex surgery in a major tertiary public hospital (such as an organ transplant) or for a minor procedure in a private day procedure centre (such as an endoscopy). The rates that DVA negotiates and pays the various private facilities take into account each facility's infrastructure, the different tax regimes, its casemix and the quality of the services provided. In the public sector, payment arrangements are based on a full cost recovery model. State and/or national morbidity and cost data is used to arrive at acceptable financial outcomes with individual State/Territory governments.

Private Hospitals

The Repatriation Private Patient Scheme (RPPS) provides acute hospital care for veterans or war widows/widowers in local facilities. Under the Scheme, a veteran or war widow/widower may be admitted directly to a local public hospital, as a private patient, former Repatriation Hospital (RH) or

a contracted private Tier 1 Veteran Partnering[2] (VP) hospital, as a private patient, in a shared ward, with the doctor of his or her choice.

In short, the RPPS has an order of preference for hospital admissions according to three Tiers:

- Tier 1 - all public hospitals, all former RHs and VP private hospitals;
- Tier 2 - contracted private hospitals; and
- Tier 3 - non-contracted private hospitals.

Financial responsibility for hospital and medical treatment in a public hospital, a former RH or a VP private hospital is accepted by the Department. Should a veteran require hospital care, the treating doctor would be able to arrange treatment at an appropriate local facility.

Whilst the aim of the RPPS is to use public hospitals, former RHs or VP private hospitals wherever possible, the Scheme also provides a safety net of contracted private hospitals and day surgery centres. If an admission to a Tier 1 hospital cannot be arranged within a reasonable time, the treating doctor may obtain financial authorisation from the Department for admission to a Tier 2 private hospital. The decision is made on the grounds of medical need after the circumstances of the individual case have been considered. In the unlikely event that a bed is not available in a Tier 1 or Tier 2 hospital, authorisation may be given for an admission to a Tier 3 private hospital.

On a state by state basis the Repatriation Commission sought tenders from private hospitals to be selected as VP hospitals, which allows the same access as public hospitals and former RHs (ie where no prior financial authorisation is required for admission, once eligibility is established).

These hospitals have been selected by the Department because they are conveniently located for most veterans, offer a full range of services at competitive rates, and perform consistently to industry approved standards. These arrangements, four year contracts with an option to extend for a further two years, have been successfully implemented commencing in Victoria in 1999, Tasmania, metropolitan South Australia, non-metropolitan Queensland, New South Wales, the Australian Capital Territory and most recently in Western Australia outer metropolitan and rural areas in 2003.

DVAs current expenditure on hospital services at $1.643 billion in 2004/05 represents 40% of the total DVA health care budget.

The diagram below shows DVAs expenditure on private hospital services as a percentage of the total market, for the most recently available year (2000-2001).

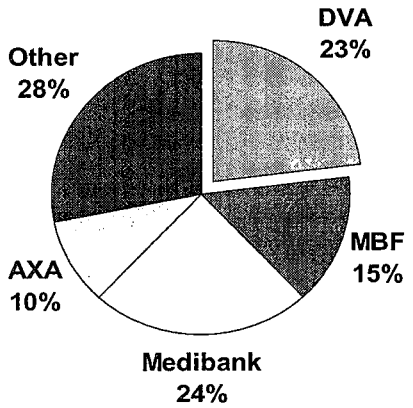

Diagram 1: Expenditure on hospital services by DVA and private health insurance funds in 2000/01.

[2] Veteran Partnering arrangements are explained in more detail on page 5.

DVA's Future

In general, the issues facing DVA now and in the immediate future are those that will be facing the wider Australian community in the medium to long-term future – an ageing population, improvements in medical technology that have the potential to add considerably to the cost of care, high community expectations as to the quality and timeliness of care and the need to provide that care in a cost effective manner and in the appropriate setting.

The age profile of the DVA treatment population is changing rapidly as the number of card holders from the World War II conflict, who currently make up around 70% of the overall treatment population, continues to decline. Table 4, at Attachment i, shows the current make-up of the treatment population by conflict as at 1 April 2005. Table 5 below shows the changing trend of the treatment population by conflict over the preceding year.

Conflict	Mar-04	Mar-05	% Change
1. World War I	941	805	-14.45%
2. World War II	233,305	221,865	-4.90%
3. Korea / Malaya	10,374	10,311	-0.61%
4. Far East Strategic Reserve	2,671	2,754	3.11%
5. Spec. O'seas Serv.(inc Vietnam)	28,606	29,294	2.41%
6. Defence/Peace Keeping	42,133	43,789	3.93%
7. Seamen's War Pension 1939	2,181	2,094	-3.99%
8. Gulf War	18	16	-11.11%
9. British Commonwealth & Allied	7,943	7,700	-3.06%

Table 5: Treatment population by conflict (total)

In 2000 the highest proportion of Gold and White card holders was in the 75-79 age group (36% of the treatment population), by the end of 2005 the 80-84 year age group will represent the highest proportion (34%) and by 2014, the highest proportion will be in the 85-89 age group (23%) followed by the 90+age group (21%). The overall treatment population is also projected to decline from 348,996 card holders in 2000 to 225,500 by 2014, a overall decrease of 35%. Table 6 at Attachment ii shows the changing age profile of the treatment population. Table 7 below shows the trend over the previous year.

Age	Mar-04	Mar-05	% Change
<55	30,570	28,458	-6.91%
55-64	34,759	37,384	7.55%
65-74	30,677	27,724	-9.63%
75-84	175,836	161,727	-8.02%
85>	56,265	63,275	12.46%
Total	328,172	318,628	-2.91%

Table 7: Treatment population by age group: Mar – 04 and Mar – 05; total and % change

Table 8 provides details of the DVA treatment population compared with the Australian population, as at April 2005.

Age Group	Males			Females			Persons		
	Total Pop. [1]	Treatment Pop.	% of Total Pop.	Total Pop.[1]	Treatment Pop.	% of Total Pop.	Total Pop. [1]	Treatment Pop.	% of Total Population
65-69	367,833	7,093	2%	377,414	3,395	1%	745,247	10,526	1%
70-74	300,211	7,839	3%	325,913	9,397	3%	626,124	17,836	3%
75-79	247,065	22,811	9%	301,772	30,272	10%	548,837	56,967	10%
80-84	155,521	65,933	42%	230,853	42,711	19%	386,374	108,373	28%
85 & over	94,832	33,881	36%	203,471	29,394	14%	298,303	61,187	21%

[1] Source: Australian Demographic Statistics June Quarter 2004 ABS Cat. No. 3101.0 (table 6)

Table 8 : DVA treatment population compared with Australian population by age group over 64 and sex, as at 1April 2005

The ageing veteran population will continue to place greater demand on health services for individual veterans, in particular in the area of aged care. However the overall decreasing veteran population will reduce DVA's purchasing power in the health care system due to the smaller volume of services required for the diminishing client base.

DVA is turning its attention to the areas of sub-acute and transitional care, building on the Pathways Home Programs built into the current Australian Health Care Agreements between the Australian Government and each State/Territory, as well as working with industry organisations and committees to define the various types of sub- and non-acute care, with the aim of improving the interface between acute and community care.

A recent review of the service delivery model[3], commissioned by DVA, identified the need for better care coordination and post-acute care management for older people to assist them to navigate through the array of health care services to prevent premature hospitalisations. The Report also recommended improved discharge planning for the elderly at risk, to prevent readmissions. This care coordination is aimed at ensuring improved health outcomes and return to a better quality of life. DVA has recently commenced trialling two alternative care coordination projects in response to the review.

It is also focussing on the quality of health care provided to veterans. For example the Medication Management program aims to improve the well-being of veterans through the quality use of medicines. The program focuses on reducing drug-related illness and adverse consequences (such as falls) and improving the management of costs of pharmaceuticals used by the veteran community.

DVA is also working on reforms to its arrangements for the provision of mental health care services. The proposed reforms will strengthen assessment, treatment and continuity of care and improve access to a broader range of mental health care for veterans. This will encourage providers to offer a better mix of hospital and community based mental health services and where clinically appropriate, use of community based alternatives to inpatient mental health services.

[3] Uniquest Pty Ltd & Academic Unit in Geriatric Medicine and the School of Population Health, Uni of Qld, *Review of the Service Delivery Model: Final Report* , June 2004.

In summary DVA is wanting to:

- Improve the understanding of mental health in the veteran community;
- Encourage a more positive approach to recovering mental health and wellbeing;
- Allow flexibility and innovation to tailor services to individual needs;
- Facilitate better targeting of acute inpatient psychiatric care;
- Encourage more effective assessment, treatment and discharge planning;
- Strengthen continuity of care and improved integration between specialist hospital based services and community based and primary mental health care services; and
- Encourage innovative programs and service delivery that strengthen community-based alternatives that will deliver prevention, early intervention, treatment, rehabilitation and relapse prevention services.

Conclusion

It can be seen that DVA plays an important role in the health care industry both as a procurer of health care services and as an innovator working with service providers to develop improved delivery of quality health services. DVA seeks to influence price as well as industry policy through the strength of its presence as a procurer. Whilst seeking to influence price, at the end of the day, DVA is, in a number of cases, a price-taker. With the ageing of the veteran population DVA can also be seen as a leader in the care of older people, dealing in the present with the problems that the wider Australian community will encounter in the future.

Sex	Card	CONFLICTS – AUSTRALIAN FORCES								
		World War I	World War II	Korea Malaya	Far East Strategic Reserve	Special Overseas Service (inc Vietnam)	Defence/ Peace Keeping	Seamen's War Pension 1939	Australian Gulf War	Total
(DVA) VETERANS										
MALE	GOLD	3	100,748	7,474	1,990	20,290	12,880	1,405	5	**144,795**
	WHITE	0	9,809	227	402	6,697	26,498	19	11	**43,663**
	TOTAL	**3**	**110,557**	**7,701**	**2,392**	**26,987**	**39,378**	**1,424**	**16**	**188,458**
FEMALE	GOLD	0	5,217	55	15	52	297	1	0	**5,637**
	WHITE	0	2,526	10	3	8	2,079	0	0	**4,626**
	TOTAL	**0**	**7,743**	**65**	**18**	**60**	**2,376**	**1**	**0**	**10,263**
TOTAL	GOLD	3	105,965	7,529	2,005	20,342	13,177	1,406	5	**150,432**
	WHITE	0	12,335	237	405	6,705	28,577	19	11	**48,289**
	TOTAL	3	118,300	7,766	2,410	27,047	41,754	1,425	16	**198,721**
(DVA) DEPENDENTS										
MALE	GOLD	23	247	8	2	80	83	2	0	**445**
	WHITE	0	0	0	0	0	0	0	0	**0**
	TOTAL	**23**	**247**	**8**	**2**	**80**	**83**	**2**	**0**	**445**
FEMALE	GOLD	779	103,316	2,537	342	2,167	1,952	667	0	**111,760**
	WHITE	0	2	0	0	0	0	0	0	**2**
	TOTAL	**779**	**103,318**	**2,537**	**342**	**2,167**	**1,952**	**667**	**0**	**111,762**
TOTAL	GOLD	802	103,563	2,545	344	2,247	2,035	669	0	**112,205**
	WHITE	0	2	0	0	0	0	0	0	**2**
	TOTAL	**802**	**103,565**	**2,545**	**344**	**2,247**	**2,035**	**669**	**0**	**112,207**
DVA TOTAL		**805**	**221,865**	**10,311**	**2,754**	**29,294**	**43,789**	**2,094**	**16**	**310,928**
OTHERS TOTAL		**BRITISH, NEW ZEALAND, OVERSEAS FORCES, MISCELLANEOUS AND COMMONWEALTH COUNTRIES FORCES**								
TOTAL	GOLD									**262**
	WHITE									**7,438**
	TOTAL									**7,700**
	TOTAL									**318,628**

Note: the conflict categories have been derived from the Client File Number. Because of this, the figures do not reflect the total number of veterans who served.

Table 4: Treatment population by conflict, card and sex, as at 1 April, 2005

	ACTUALS					PROJECTIONS									
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
CARD															
Gold	287,066	283,925	281,448	277,747	269,544	260,900	252,300	243,600	234,900	226,100	217,100	208,100	199,000	190,000	181,200
White	61,930	61,206	59,268	57,413	56,254	55,500	54,500	53,400	52,200	50,900	49,700	48,400	47,100	45,700	44,300
GENDER															
Male	233,427	227,093	218,798	212,370	202,925	193,800	184,500	175,200	166,100	157,200	148,600	140,400	132,800	125,800	119,500
Female	115,569	118,038	121,918	122,790	122,873	122,600	122,300	121,800	121,000	119,800	118,200	116,000	113,200	109,800	105,900
AVERAGE AGE															
Male	72.5	72.7	72.9	73.1	73.2	73.3	73.2	73.1	73.0	72.7	72.4	72.0	71.6	71.2	70.7
Female	76.8	77.4	78.1	78.7	79.3	80.0	80.6	81.1	81.6	82.1	82.5	82.9	83.2	83.5	83.7
GOLD AND WHITE CARDS															
AGE GROUP															
<55	41,516	39,685	36,514	33,139	29,931	28,300	27,200	26,400	25,800	25,100	24,400	23,700	22,900	22,000	21,100
55-59	9,948	13,569	17,987	22,269	25,517	25,000	22,300	19,400	16,500	14,100	12,700	11,900	11,400	11,100	11,000
60-64	8,144	8,855	9,328	9,628	10,103	12,900	17,400	21,700	25,700	28,900	28,800	26,700	24,200	21,900	19,600
65-69	13,171	11,926	11,240	10,638	10,490	10,700	10,900	11,100	11,300	11,900	14,900	19,100	23,200	27,000	30,400
70-74	45,187	32,672	25,588	22,934	19,391	16,600	14,600	13,500	13,000	12,800	12,800	13,000	13,200	13,300	13,900
75-79	125,965	118,326	103,081	84,890	66,122	49,500	37,500	29,800	24,200	19,800	16,500	14,400	13,400	13,000	12,800
80-84	70,891	80,938	91,303	100,221	106,438	107,100	101,300	90,100	76,600	62,800	50,000	39,300	31,200	24,400	18,900
85-89	26,409	30,366	35,421	39,793	44,189	50,400	57,400	64,300	70,400	75,000	76,500	73,900	67,800	60,100	51,600
90+	7,766	8,794	10,255	11,648	13,615	16,000	18,300	20,800	23,600	26,500	30,200	34,500	38,800	42,800	46,300
Total	**348,996**	**345,131**	**340,716**	**335,160**	**325,798**	**316,500**	**306,800**	**297,000**	**287,100**	**277,000**	**266,800**	**256,400**	**246,000**	**235,700**	**225,500**

Notes: .1 Projected client numbers may not add exactly to totals due to rounding.
2. All forecast figures are current as at 28 January 2005.

Table 6: Treatment Population Trends – Actual and Projections as at 30 June