Submission No. 158
AUTHORISED: 13/11/06

QUESTIONS ON NOTICE
House of Representatives
Standing Committee on Health and Ageing
4 September 2006

Travel for treatment

Q: How many veterans travelled interstate in 2005–06 to access treatment with specialists, and why? What was the cost of that travel in 2005–06? How does the cost of this travel compare with what the cost would be if the veterans were treated closer to home? What action, if any, is DVA taking to address the situation?

A: With the exception of Tasmania, DVA does not keep records of interstate travel brought about because of an unwillingness by local specialists to accept the Gold Card. Most interstate travel for treatment is believed to relate to the non-availability of treatment locally and is therefore unavoidable. Tasmania is a state where there has been an issue with availability in some specialties. In 2005/06, seven veterans travelled to Melbourne for treatment that specialists were unwilling to provide locally. The cost of this travel was $10,000.

The need for veterans to travel out of their local area to access specialist treatment has now been addressed by the recent funding package of more than $600 million over five years. This will allow arrangements with all provider groups to be strengthened.

Treatment for veterans and non-veterans

Q: What is the cost difference between providing health services for veterans compared to non-veterans, on the basis of the fee for an individual service and DVA pays compared to what is paid for an over–75 equivalent?

A: DVA's fee arrangements in relation to the provision of medical services to veterans are as follows:

- GPs who are registered as LMOs receive 115% of the Medicare Benefits Schedule (MBS) fee plus a Veteran Access Payment (VAP) of either $4.10 or $5.65 per item.
- Specialists are paid at 115% of the MBS fee for consultations and 120% for procedures.
- DVA pays the full cost for these services; there is no co-payment by the veteran.

In relation to the general community accessing services under Medicare, patients are required to pay the full fee set by the treating doctor and claim the applicable Medicare rebate. The patient pays the difference between the doctor's fee and the Medicare rebate.

From 1 November 2006, DVA fee arrangements will be as follows:

Specialists	Out of hospital	135% for consultations 140% for procedures
	In hospital	Fees similar to those paid by private health insurers
GPs		Move to align VAP with Medicare bulk billing
Allied Health		Alignment of relevant fees to Medicare GP fees

Dentists		Increase to near-market fees
Pathologists Optometrists		Move to 100% of MBS

In general, this will introduce a more market-based fee structure that will ensure the ongoing viability of the Gold and White card arrangements. The new arrangements are a result of the recently announced Government initiative that will inject an extra $600 million towards treatment costs over the next five years.

Co-payments

Q: What services have a co-payment and how much is each co-payment?

A: As indicated at the hearing, pharmaceuticals and Veterans' Home Care attract co-payments. In addition, there are arrangements around certain expensive dental treatments.

PHARMACEUTICALS

The current patient contribution charge (co-payment) for RPBS prescriptions is $4.70 an item until the safety net limit is reached. Prescriptions are then free for the rest of the calendar year although some particular brands of products may attract premiums.

For PBS prescriptions the co-payment is $4.70 at the concessional rate, or up to the general rate. Once the safety net limit is reached, prescriptions are then free for the rest of the calendar year for concessional beneficiaries.

A pharmaceutical allowance of $5.80 a fortnight, per family, is paid to eligible veterans to compensate them for the payment for each RPBS prescription item.

VETERANS' HOME CARE

Veterans are required to pay a small fee to service providers for home care services, other than respite care:

- Personal care: $5 per hour to a maximum of $10 per week
- Domestic assistance: $5 per hour to a maximum of $5 per week
- Home and garden maintenance: $5 per hour for each hour of service
- Respite care: no co-payment applies.

Services such as Meals on Wheels (delivered meals), community transport and social support are provided under arrangements with State and Territory governments and are subjected to separate co-payment arrangements.

EXPENSIVE DENTAL TREATMENTS

Certain expensive dental treatments, including crowns and bridges, are subject to an Annual Monetary Limit (AML). This means a set amount per calendar year is contributed towards these treatments. For the 2006 calendar year this amount is $2,118.

How this works in practice is that DVA pays the treatment fee, as set out in the DVA Dental Fee Schedule, or part thereof, until the AML is reached. Where the AML only covers part of the treatment fee, the veteran may be asked for a co-payment by the dentist. Once the AML is reached, DVA makes no further contribution towards the cost of treatment. Any further treatment undertaken in the calendar year must be paid for by the veteran.

However, a number of veterans are exempt from the AML, including:

- veterans whose Schedule C dental treatment is for a war-caused injury or disease (that is, an Accepted Disability)
- veterans whose Schedule C dental treatment is for a condition associated with malignant neoplasia; and
- former prisoners of war.

Veterans' Home Care

Q: Are some veterans having home care removed or having difficulty increasing home care hours? If so, what is the reason?

A: As indicated at the hearing, spending on Veterans' Home Care (VHC) increased from $80 million in 2004–05 to $92 million in 2005–06. This occurred at a time when veteran numbers were decreasing. The increase is designed to meet the service requirements for home care. (See Attachment A for additional background information on the VHC Program).

Hospital agreements

Q: Please provide a copy of the templates for private hospital contracts and public hospital agreements. Provide examples of how DVA uses these agreements to leverage improvements in health outcomes for the veteran community. Are there any provisions in the agreements for DVA to leverage improvements in mental health for the veteran community?

A: Templates for private and public hospital contracts include mechanisms for ensuring quality health outcomes for the veteran community, as indicated at the hearing. Excerpts from a contract template relating to quality assurance is at Attachment B and copies of the contract templates are also provided.

Specialists

Q: What is the total number of specialists to withdraw from the DVA system because of fees issues? Is specialist withdrawal more prevalent in any particular geographical or regional areas? If so, what is happening to ensure that veterans in those areas are still getting the health services they need? Regarding specialist fees, what is the scale of difference between what DVA pays and what specialists would want to charge?

A: The Department is aware of 388 specialists who have withdrawn or restricted services to veterans. Withdrawals have been patchy and have probably occurred most frequently as a proportion of total specialists in some rural and regional areas in Tasmania. This was outlined at the hearing.

This issue is being addressed by the recent funding package of more than $600 million over five years that will allow arrangements with specialists to be strengthened. Under these new arrangements, specialists will be paid at rates equivalent to those paid by the health funds for the same treatment.

Table at Attachment 1 of submission

Q: Please provide an update to the table at Attachment 1 of the submission showing the cost of major DVA health expenditure items by service type for 2004–05.

A: The cost of major DVA health expenditure items for 2005–06 is shown in the following updated table.

Health Service Type	Cost 2005–06 $ million
Private and public hospital treatment	1529.313
Residential care	806.489
Consultations and medical practitioner services	734.556
Veterans' pharmaceutical services	468.363
Allied Health Services	130.941
Travel and subsistence	101.959
Rehabilitation Appliances Program	89.035
Veterans' Home Care	91.351
Community nursing	79.847
Dental	83.520
Other (including VVCS)	37.358
Total	**4,152,732**

Aids and appliances including footwear

Q: What is the process involved in providing medical aids and appliances, including footwear? Are veterans being required to travel longer distances to get those things? If so, is DVA monitoring the cost of the travel and the impact it might have on frail veterans? How do current arrangements compare with the situation prior to the new arrangements coming into effect?

A: New contracts with footwear suppliers are now in place following a recent review and tender process for the supply of medical grade footwear (MGF) to eligible veterans. The new supply arrangements remove some anomalies previously present, such as incorrect supply of non-MGF footwear and inconsistency between providers. DVA now has in place a national register of approved footwear, which will ensure that technical criteria are met to a high standard and there is consistency across States and providers. The new arrangements mean that medical grade footwear products and services, and the footwear suppliers who are contracted to DVA to provide these services, all meet these high standards. There is no evidence that veterans have been required to travel longer distances as a result of the new arrangements.

As part of its footwear arrangements, DVA has developed criteria to differentiate MGF from normal, everyday footwear. MGF is treatment under DVA's health care arrangements and clinical need is determined by a footwear prescriber. If a veteran has no clinical need and can wear everyday footwear, they do not need MGF. In such cases, veterans are responsible for purchasing their own shoes.

There is no change to the policies surrounding provision of footwear nor to entitlements for eligible veterans. Veterans will not have to move to a new supplier if their current one is on the list of DVA-approved suppliers. This is the case for most veterans.

VETERANS' HOME CARE PROGRAM

- The Veterans' Home Care (VHC) program provides a range of low level home care services designed to support veterans to remain at home. VHC is not intended to meet medium or higher level long term support needs, however the program is able to cater for short term higher levels of care such as following discharge from hospital.

- There is no set, or pre-determined, level of service. VHC services are determined on the basis of assessed need by VHC assessment agencies, which are independent organisations specifically contracted by the Department for this purpose. DVA does however issue agencies with guidelines regarding the appropriate service levels.

- Where a veteran or war widow/widower has higher needs than can be accommodated by the VHC program in the longer term, the assessment agency may provide referrals (with the person's consent) to other DVA programs (e.g. community nursing) and / or other government programs and community agencies that are best placed to meet their needs. For example, the agency may refer a veteran with higher needs for an Aged Care Assessment Team (ACAT) assessment which is required for access to Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages or residential care. Veterans are identified as a special target group for access to many non-DVA programs.

VHC program funding, veteran numbers and services provided

- VHC program funding increased from approximately $79 million for 2004-05 to $92 million for 2005-06. The increase is due to the 2004 election funding commitment to provide additional funds to the VHC program of $13.1 million per year, which expires in 2007-08. As a result of this funding, the number of veterans provided with VHC services has increased from approximately 66,000 in 2004-05 to nearly 71,000 in 2005-06 and the number of services provided has increased from approximately 2.02 to 2.22 million. Also, during this period there was a 2.5 per cent increase in the average hours of domestic assistance provided and a 4.6 per cent increase in the average hours of personal care provided.

VHC program review

- The VHC program has been enormously successful since it was established in 2001, with over 143,000 veterans having been assessed for services during that period.
- However, the Government acknowledges that the veteran population is ageing and becoming more frail, and consequently requiring higher levels of service from the VHC program. To this end, the Government is proposing to conduct an independent review of the VHC program in 2007 to identify any changes necessary to ensure the program continues to meet the needs of veterans and war widows/widowers over the coming years.

BACKGROUND

Veterans' Home Care (VHC) is a Department of Veterans' Affairs (DVA) program that helps Australia's veterans, war widows/widowers with low care needs to remain in their own homes for longer. VHC is not an entitlement-based program like most other veterans' programs but a fixed budget program. It is similar to the Home and Community Care (HACC) program, and provides a range of home care services for eligible members of the veteran community. The

program is part of a broader DVA strategy to ensure veterans and war widows/widowers maintain optimal health, well being and independence.

VHC services are not intended to replace existing arrangements with family, friends and community-based groups or to substitute for other private service provision.

Services

Veterans' Home Care provides:

domestic assistance: assistance with domestic tasks such as household cleaning, dishwashing, clothes washing and ironing, shopping for the veteran and bill paying.

personal care: includes assistance with daily self-care tasks, such as eating, bathing, toileting, dressing, grooming, getting in and out of bed and moving about the house.

home and garden maintenance: may include tasks such as replacing light bulbs and tap washers or other tasks that you and the service provider agree upon. The focus of home and garden maintenance services is to assist in keeping the home safe and habitable by minimising environmental health and safety hazards that may impact on you in and around your home.

Home and garden maintenance does not include major home repairs such as gutter replacement, landscaping and garden tasks such as branch lopping, tree felling or tree removal. Nor does it include routine, cosmetic or ornamental gardening services such as maintenance of flowerbeds and pruning of roses, unless there is a safety hazard.

Veterans are responsible for the cost of materials required and any additional costs associated with providing the service, such as hire of special equipment or removal of large quantities of rubbish.

respite care: temporary relief provided to veterans who are carers or carers of veterans.

Meals on Wheels (delivered meals), community transport and other social support services are provided through arrangements with State and Territory governments.

Assessment for services

Access to services is *not* automatic. Eligible veterans must be assessed as needing home care assistance before receiving these services.

Who is eligible to be assessed to receive services?

To be assessed for Veterans' Home Care services a person must be:

- a veteran of the Australian defence forces, *or*
- a war widow or widower of a veteran of the Australian defence forces or an Australian mariner,

and have:

- a Repatriation Health Card—for All Conditions (Gold Card) or

- a Repatriation Health Card—for Specific Conditions (White Card).

Services for veterans of Commonwealth and Allied forces

Commonwealth or Allied veterans with a White Card may be eligible for respite care, but only where it relates to your war-caused disabilities. They are not eligible for other Veterans' Home Care services through DVA, but may receive similar services under the HACC program.

Services for partners and carers

Partners or carers of eligible veterans or war widows/widowers may receive respite care. They are not eligible for Veterans' Home Care services unless they have their own Gold or White Card. Services may have a flow-on benefit to partners and carers and assist them in their caring role. Partners and carers may also be eligible for HACC services.

Veterans who transferred from HACC

Veterans who transferred from the HACC program before 1 November 2002 continue to receive the same services and pay no more for those services. This applies while they remain in similar housing circumstances, or unless they agree to a change with their assessment agency. If their housing circumstance change, the assessment agency may negotiate new service levels with them.

VHC assessment, service and co-payment arrangements apply to all veterans who enter the program from 1 November 2002.

VHC services and co-payments

Veterans are required to pay a small fee to service providers for home care services, other than respite care:

- **Personal care**: $5 per hour to a maximum of $10 per week
- **Domestic assistance**: $5 per hour to a maximum of $5 per week
- **Home and garden maintenance**: $5 per hour for each hour of service
- **Respite care**: no co-payment applies

Services such as Meals on Wheels (delivered meals), community transport and social support are provided under arrangements with State and Territory governments and are subjected to separate co-payment arrangements.

Access to services

Assessments can be arranged by calling the Veterans' Home Care Agency on **1300 550 450.**

APPENDIX III: QUALITY STANDARDS

General

The Parties have agreed that quality management under this Agreement should be aimed at continuously improving the effectiveness of Entitled Persons' hospital care and health care in terms of its accessibility, appropriateness and efficiency, continuity, and Entitled Person satisfaction.
The Parties have agreed to the introduction of a Pay for Performance criteria which will be used to assess the Hospital's performance and will accordingly adjust the indexation offer made under clause 7. The details of these criteria are set out in clause 7.4. The Contracting Entity will incorporate relevant elements into its six monthly quality reports as outlined in clause 11.5.2.
The Contracting Entity agrees to ensure that staff involved in the delivery of care to Entitled Persons are made aware of DVA's Values and Service Charter and undertake to treat Entitled Persons with respect, courtesy and understanding.

Accessibility

Entitled Person access to the Hospital will be timely and in accordance with medical need, recognising established doctor/patient relationships.
The Contracting Entity will provide preferential access for Entitled Persons, provided care of other patients is not impaired.
The Contracting Entity shall provide Hospital Services to Entitled Persons that are not less in any material way than the services provided to other patients treated in the hospital.
While the Parties may agree to focus on other quality indicators from time to time, the Contracting Entity will develop, monitor and report to DVA (see clause) on agreed indicators.

Accreditation

Within twelve months of the Commencement Date of this Agreement, or such other period as agreed with DVA, the Hospital is to achieve formal quality accreditation or certification by an appropriate body acceptable to DVA, noting that hospitals that are currently accredited through the ACHS' Evaluation and Quality Improvement Program (EQuIP), will be deemed to have met this requirement. Consideration of other than ACHS accreditation will be conditional on the Contracting Entity also undertaking to purchase reporting facilities from the ACHS enabling the Hospital to report to both the ACHS and DVA against the ACHS "Australian Hospital-Wide Indicators". Where Rehabilitation and/or Sub- and Non-acute care is provided, additional reporting is required against the ACHS "Rehabilitation Medicine Indicators" and the ACHS "Internal Medicine Indicators".

Performance Monitoring

Responsibility for performance monitoring rests with the Hospital , which is to ensure that:

a) systems to monitor selected clinical indicators are in place and operating;

b) Entitled Persons are separately identified in the relevant data collection and analysis ie HCP data, complaints, discharge planning; and

c) results are reported regularly to DVA in accordance with clause of this Agreement.

Clinical Indicators (Applicable to all hospitals)

The Hospital will aim to achieve outcomes for the applicable clinical indicators based on whole of hospital population as is relevant to its casemix and listed below that are better than the average result (rate or number) reported by ACHS for the corresponding period and will report on the result in accordance with clause 11.5:

a) patient falls (Hospital Wide Indicator Area 5);

b) unplanned readmission (Hospital Wide Clinical Indicator Area 2);

c) unplanned returns to operating room (Hospital Wide Clinical Indicator Area 3);

d) hospital-acquired infections (Infection Control Indicator Areas 1-6);

e) medication prescription and drug monitoring, including adverse drug reactions *(Adverse Drug Reactions Indicator Areas 1-2* and Hospital Wide Indicator Area 1*)*; and

f) wound management/pressure ulcers (Hospital Wide Clinical Indicator Area 4).

The specific indicators are identified by number in the DVA quality report template and are sourced from the ACHS Clinical User Manual 2005.

Sub-acute and Non-acute Care Indicators

Additional Indicators applicable to hospitals that provide Rehabilitation Medicine Services, and/or Sub- and Non-acute Care
For Entitled Persons, the Contracting Entity will aim to develop outcomes for each of the Rehabilitation Medicine Indicator Areas 1 – 4 that are within the 95% confidence interval associated with the average result (rate or number) reported by ACHS for the corresponding period, and will report on the result in accordance with clause:
The Contracting Entity will monitor and report to DVA on further sub-acute indicators in the areas of:

g) geriatric care (Internal Medicine 1 Area 4 - Geriatric Medicine 1 and 2); and

h) any Entitled Person Rehabilitation length of stay greater than 35 days.

The specific indicators are identified by number in the DVA quality report template and are sourced from the ACHS Clinical User Manual 2005.

Continuity of Care

The Contracting Entity shall at all times in and about the provision of the Hospital Services promote continuity of care through linkages with other health services and LMOs.
The Contracting Entity agrees to use best endeavours to incorporate the Australian Pharmaceutical Advisory Council's Guiding Principles To Achieve Continuity in Medication Management July 2005 into the Hospital's quality regime and discharge planning processes.

Discharge Planning

The Hospital shall have in place for the term of the Agreement a comprehensive discharge planning program consistent with ACHS Equip standard "Continuum of Care Criterion 1.4.1" to facilitate the effective discharge from hospital of all Entitled Persons. The program shall:

a) be based on a multi-disciplinary approach, involving where appropriate, the treating doctor, nursing and other hospital staff, Local Medical Officer, allied health providers and community support service providers;

b) ensure that each Entitled Person and all involved health care providers have a documented discharge plan compiled with the assistance of the current version of the Discharge Planning Resource Kit (including the checklist) published by DVA at *http://www.dva.gov.au/media/publicat/2003/dprk/index.htm*; and

c) have an effective strategy in place to ensure the implementation of the discharge plan, including involvement and written notification of the patient's carers and LMO prior to the discharge.

On request, the Contracting Entity will make available to DVA a copy of its discharge planning protocols, together with copies of all discharge policy, planning and procedural documentation.

Entitled Person Satisfaction

The Contracting Entity will establish and maintain a complaints handling mechanism, under which Entitled Person patient comments are documented, addressed, retained and reported to DVA in accordance with clause **Error! Reference source not found.** and the Pay for Performance criteria in clause 7.4.

The Parties agree that, from time to time, DVA will appoint an independent agency to undertake random surveys of Entitled Persons, carers, relatives, and referring doctors or hospitals to establish the level of satisfaction with respect to quality, dignity, privacy, efficacy, and communication associated with the Hospital Services provided by the Contracting Entity.