Use of Private Hospitals

Department of Veterans' Affairs

Follow-up Audit

Tabled 6 March 1997

Audit Report No. 28 1996-97

Glossary

ACHS	Australian Council on Health Care Standards
accreditation	accreditation with the Australian Council on Healthcare Standards as evidenced by a certificate of accreditation issued by the Council
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
APHA	Australian Private Hospitals Association
benchmarking	the use of base rates as a guide for negotiating and to assist with the development of performance standards
casemix	an information classification system that focuses on building useful categories of patient care episodes and making good use of those categories to manage the outcomes, quality and cost of health
Commission	Repatriation Commission
CPI	Consumer Price Index
DC	Deputy Commissioner
Department	Department of Veterans' Affairs
discharge	the planning of post-hospitalisation treatment, care and welfare of a

planning	hospital patient
DMO	Departmental Medical Officer
DVA	Department of Veterans' Affairs
episodes of care	an information classification system that focuses on building useful categories of patient care episodes and making good use of those categories to manage the outcomes, quality and cost of health
HCVS	Hospital Claims Validation System
HSD	Hospital Services Deed
ICD	International Classification of Diseases
LMO	Local Medical Officer
moiety	contribution to care charged to individual patients by the hospital
NO	National Office
PARS	Prior Approval and Review System
PI	performance indicator
prior approval	approval from the Department required before veterans are admitted to a private hospital; prior approval is required under both the Treatment Principles and the Repatriation Private Patient Scheme
RGH	Repatriation General Hospital
RPPS	Repatriation Private Patient Scheme
separation	a measurement of the number of people hospitalised for treatment

stepdowns	accommodation fees which reduce after a certain number of days in hospital
TAS	Treatment Accounts System
TMC	Treatment Monitoring Committee
Treatment Principles	the Treatment Principles are prepared under section 90 of the *Veterans' Entitlements Act 1986* and set out the circumstances in which, and conditions subject to which, treatment may be provided to eligible persons under Act
VEA	*Veterans' Entitlements Act 1986*

Summary

1. Under the terms of Part V of the *Veterans' Entitlements Act 1986* (VEA) the Repatriation Commission provides for medical treatment to veterans and other eligible people in respect of incapacity due to war service and other specified circumstances.

2. This follow-up audit examined the actions taken by the Department of Veterans' Affairs to address the ANAO's recommendations made in Audit Report No.28 1993-94 regarding the use of private hospitals on behalf of the Repatriation Commission. The recommendations from that audit were aimed at improving the basis and consistency of contracts with the private sector for the use of private hospitals and providing added assurance that quality care was available to the veteran community.

3. Changes since the original audit have assisted with improving the performance of the program. These include:

- national implementation of the Repatriation Private Patient Scheme;
- changed arrangements for the planning and management framework within the Department;
- development of the Hospital Services Deed which introduces a measure of consistency across the private hospital framework;
- introduction of better arrangements for transition to the community following discharge from hospital;
- development of the Hospital Claims Validation System to ensure that accounts received from contracted hospitals are paid in accordance with their contracts;
- further research conducted on performance information; and
- approvals for admission to, or on the actual date of admission to private hospitals have improved.

Key findings

4. Twenty-eight of the 29 recommendations made in the original report were agreed to by the department. Of the 28 agreed recommendations at the time of concluding this audit:

- 15 recommendations were implemented;
- 12 recommendations were partially implemented and required further work; and
- one recommendation has been overtaken by events and no further action is required.

5. The partial implementation of the original recommendations and Departmental reforms resulted in efficiencies estimated at some $7 million per annum.

6. Departmental actions on each recommendation in the original report and a summary of the ANAO opinion are at Appendix 1.

7. As the remainder of the recommendations are implemented and casemix classifications are improved, the ANAO considers the Department will continue to achieve a higher quality and more cost effective outcome in terms of private hospital rates negotiated and a more robust payments process.

8. In addition to actions required against the original audit recommendations, further improvements are recommended in this report in the areas of:

- program management;
- contract negotiation;
- payments and quality assurance; and
- quality of care.

Program management

9. Since the original audit, administration of contracts has significantly improved through the development of the standard Hospital Services Deed (HSD) nationally for all private hospitals. The HSD provides a reasonable framework for the effective administration of services provided to the veteran community by the Department.

10. Devolution of particular responsibilities to the States has increased the need for broad strategic direction for hospital treatments to be enhanced by National Office. This is important to ensure common goals are achieved in the most efficient and effective manner.

Contract negotiation

11. Although some State Offices have developed a more commercial and rigorous approach to contract negotiations since 1993-94, there is still scope for improvements in this area through a more consistent approach, and promulgation and adoption of better practice.

Payments and quality assurance

12. The introduction of the Hospital Claims Validation System (HCVS) has the potential to improve the reliability of payments to private hospitals being processed through HCVS. Development of a risk management policy for payments is necessary however, particularly in the light of accounts processing being undertaken by the Health Insurance Commission from

1 July 1997.

13. Although prior approvals before hospitalisation have improved since the original audit, the Department is reviewing approvals occurring post admission in country Queensland and Victoria.

Quality of care

14. The number of Australian Council of Health Care Standards accredited private hospitals contracted has increased, however, the Department did not meet its stated aim of only using accredited hospitals by 1995. DVA has recognised this and is still seeking to increase the proportion of veterans receiving private hospital care in accredited versus non-accredited hospitals.

15. The collection and monitoring of statistics from non-accredited hospitals on the quality of clinical care could be improved in some States and referral of statistics on the quality of care to Treatment Monitoring Committees would assist in this regard.

Departmental response

16. The Department is generally pleased with the outcome of three years of work to achieve substantial reforms in the program. The Department has agreed to implement the further ANAO recommendations in this Follow-up audit.

Recommendations

Set out below are the ANAO's recommendations with Report paragraph reference and DVA's abbreviated responses. More detailed responses and any ANAO comments are shown in the body of the report.

Recommendation No. 1 Para. 3.12	The ANAO recommends DVA enhance its National Office role in assisting the State Offices to set strategic directions for the provision of hospital treatment and monitor reports on progress with implementation of strategies.
	Response: The Department agrees with this recommendation.
Recommendation No. 2 Para. 3.14	The ANAO recommends DVA identify better practice in relation to program administration (including data collection, analysis and reporting) throughout the State Office network and adopt it as standard practice.
	Response: The Department agrees with this recommendation.
Recommendation No. 3 Para. 3.25	The ANAO recommends that a standard format for documenting new contracts, or variations to existing contracts, between DVA and private hospitals be developed as a standard feature of every DVA private hospital file.

Response:
The Department agrees with this recommendation.

Recommendation No. 4 Para. 3.34	The ANAO recommends that DVA National Office develop, implement and monitor a risk management policy specifically for private hospital payments as part of their management approach.

Response:
The Department agrees with this recommendation.

Recommendation No. 5 Para. 3.39	The ANAO recommends that DVA undertake a more rigorous monitoring of non-accredited hospitals quality of care statistics and that these statistics be forwarded to Treatment Monitoring Committees on an ongoing basis to ensure quality of care outcomes for the veteran community in accordance with performance targets.

Response:
The Department agrees with this recommendation.

1. Introduction

This chapter outlines the background to the audit including the program's administration, original audit findings and audit methodology.

1.1 This is a follow-up audit of the actions taken by the Department of Veterans' Affairs on behalf of the Repatriation Commission in addressing the ANAO's recommendations made in Audit Report No.28 1993-94. Those recommendations included the need to improve the basis and consistency of contracts with the private sector for the use of private hospitals and provide assurance of quality care for the veteran community.

The administration of veterans' use of private hospitals [1]

1.2 Under the terms of Part V of the *Veterans' Entitlements Act 1986* (VEA) the Repatriation Commission (referred to as 'the Commission') provides for medical treatment to veterans and other eligible people in respect of incapacity due to war service and other specified circumstances.

1.3 Treatment in hospitals (both public and private) is provided under the Health Care Services Subprogram of the Health Program, in accordance with Treatment Principles issued by the Commission. This Subprogram is administered by the Health Care and Services Division of the Department.

1.4 Broadly under the arrangements that applied before the integration of the Repatriation General Hospitals (RGHs) into State Health systems, private hospital treatment was provided only after RGH and public hospitals had been considered, or in emergency situations.

1.5 In terms of addressing the original audit recommendations, an understanding of the broader policy framework is useful in administering the private hospital program, negotiating contracts and developing performance indicators.

1.6 Since the introduction of RPPS there has been a change in the use of hospitals by veterans and other eligible people. Patients previously treated in RGHs have been referred to public and private hospitals. Key statistics outlined in this chapter show this movement and provide

a comparison between RGH, private and public hospital treatments since the national implementation of RPPS.

1.7 When comparing costs between RGHs, public hospitals and private hospitals the following points should be considered:

- there are variations in the treatment of superannuation and capital works between hospitals and States;
- RGH costs include outpatients occasions of care unless specifically excluded;
- teaching roles vary and can affect overall and average costs.

1.8 Notwithstanding the above, there has been a significant increase in DVA expenditure on private hospitals over the four years to 1995-96 (refer to Table 1 and Figure 1).

Table 1. Expenditure on DVA Hospital Services

Hospital Services Expenditure	**1992-93 $m**	**1995-96 $m**	**Change in Nominal Terms %**
RGH	489	0	-100
Public	100	414	+314
Private	118	294	+149
Total	707	708	0

1.9 Usage of private hospital bed days is shown in Figure 2. DVA's private and public hospital utilisation increased. The reasons for the major changes over the period - that is, increased number of separations and bed days and increased total expenditure on public and private hospitals - relates directly to the introduction of the RPPS and the activity previously managed by RGHs applying to these sectors.

1.10 A comparison of the average cost per separation for public hospitals, private hospitals and RGHs is shown in Figure 3. A direct comparison between private and public hospitals bed day costs is shown in Figure 4. Bed day costs of RGHs have not been included due to the impact of additional day only services provided by these hospitals. The Department has advised that RGH average bed day costs ranged from $400 to $700 per day (excluding outpatients occasions of care) prior to their integration or sale.

1.11 The average cost per bed day for private hospitals increased by 26 per cent over the four-year period (Figure 4) compared with public hospital increases of 155 per cent in nominal terms. This compares with a 26 per cent increase in consumer price index over the same period (based on the eight capital cities for hospital and medical services, June 1992 to June 1996).

Figure 1. DVA Expenditure on Hospitals ($m)

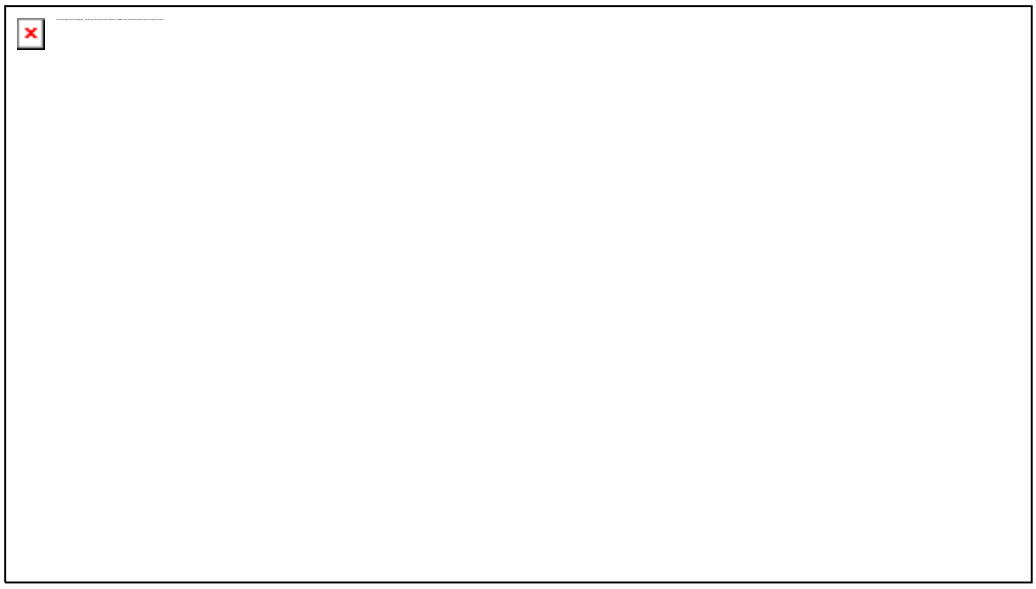


Figure 2. DVA Usage of Hospital Bed Days

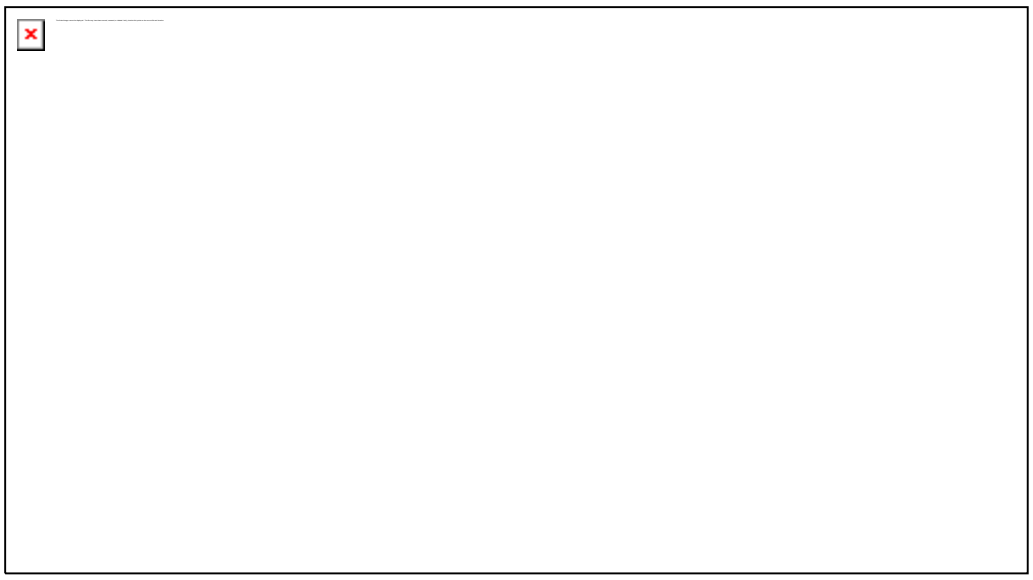


Figure 3. Average Cost of Hospital Service per Separation ($)

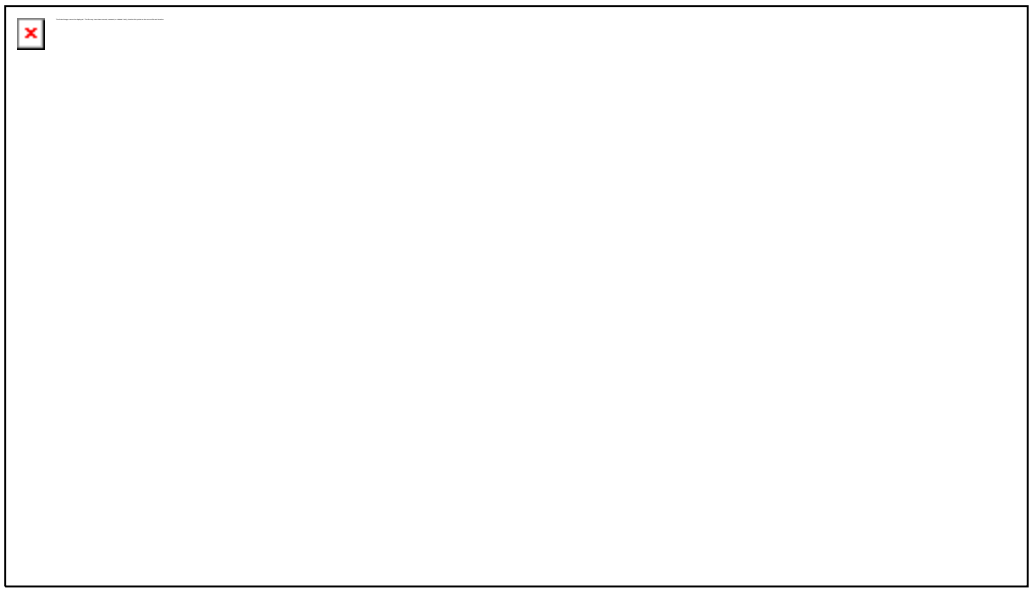
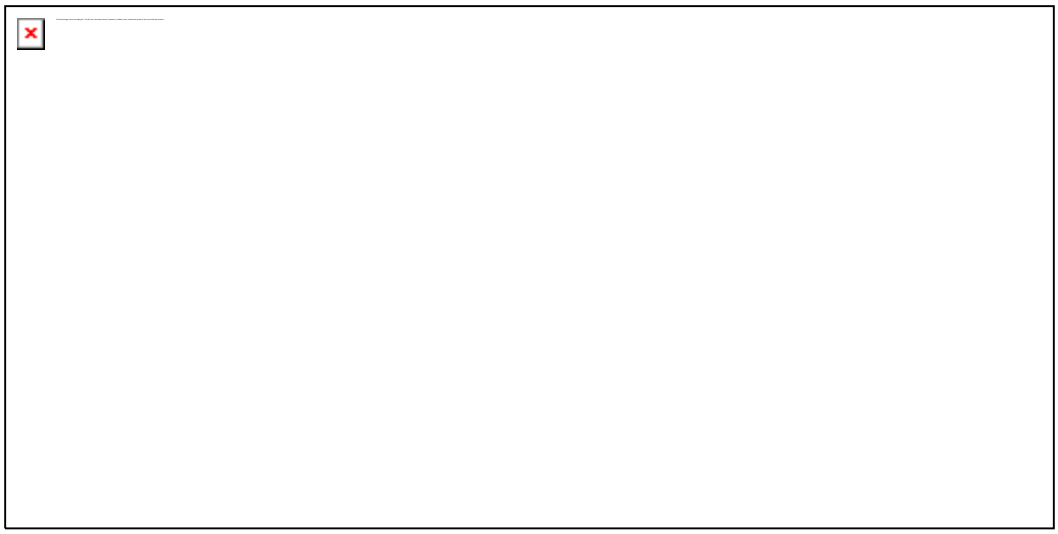


Figure 4. Average Cost per Bed Day for Public and Private Hospitals ($)



1.12 The reason for this trend which highlights a difference between the public and private hospitals (beyond the factors outlined in paragraph 1.7) is:

- the nature of agreements between DVA and those States which provided for the integration of former RGHs into the State health systems. These agreements generally guaranteed bulk payments over a number of years based on a given number of DVA separations, with adjustments if separations varied significantly. The out years generally reflect decreasing payments; and
- private hospital costs have continued to be based on individual contracts with private hospitals, with changes subject to an annual index based on average weekly earnings, wages and salaries for private hospitals and consumer price index movements or as negotiated annually.

1.13 Despite the large difference in the percentage increase over this period, the average cost per bed day in 1995-96 was $563 for public hospitals compared with $513 for private hospitals.

DVA developments to assist program administration

1.14 Identification of trend information is important for optimising opportunities to better serve clients, reduce costs and improve efficiency.

1.15 DVA is developing tools to improve its ability to classify and interpret data on trend information and the various costs of episodes of care. This is further discussed in Chapter 2. The trend in usage of private hospitals illustrates the importance of developing and using such predictive management tools.

The findings of Audit Report No.28 1993-94

1.16 The major findings reported in the Auditor-General's Report No.28 1993-94 were as follows:

- a more commercial and rigorous approach to contract negotiations would result in savings of approximately $4 million per annum over time;
- a more consistent negotiating framework was needed;
- the systems of contract administration and invoice processing were not effective and placed the Department and the Commonwealth at financial risk. Overpayments of up to $3 million per annum were possible;
- prior approval for admission to private hospitals required strengthening; and
- systems could be developed to improve assurance that a high quality of care had been provided to all veterans.

1.17 A full list of recommendations made in Report No.28 1993-94 is at Appendix 1.

Objectives and criteria for this follow-up audit

1.18 The objectives of this follow up audit were to:

- identify the changes made by the Department since 1994;
- ascertain the extent to which the agreed recommendations of the original audit have been implemented;
- assess the impact and effectiveness of the changes made; and
- identify the scope for further improvement.

Methodology

1.19 The follow-up audit built on results of fieldwork and research on private hospitals contracts, financial authorisation and payments conducted by DVA's Internal Audit earlier in the year. Internal working papers, including testing results, were reviewed in September 1996 to evaluate the basis of claims in the papers produced by Internal Audit. This was

supplemented by material provided by DVA National Office during October and November 1996.

1.20 The cost of this audit totalled $62 000. The audit was conducted in accordance with the ANAO Auditing Standards.

Report structure

1.21 As indicated in paragraph 1.13, the original audit report identified scope for enhancing departmental administration of the use of private hospitals.

1.22 A number of areas recommended for attention have been addressed in part or fully through reforms in departmental administration and improvements in administrative efficiency and effectiveness. These are discussed in Chapter 2.

1.23 In addition to actions required against the original audit recommendations, further improvements are recommended in the areas of:

- program management;
- contract negotiation;
- payments and quality assurance; and
- quality of care.

These are addressed in Chapter 3.

1.24 Departmental actions on the recommendations in the original report are summarised at Appendix 1.

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2. Reforms in Departmental Administration and Improvements in Administrative Efficiency and Effectiveness

This chapter outlines the changes that have taken place in DVA since the tabling of Audit Report No.28 in February 1994 and the extent to which the changes have addressed the original audit recommendations.

Summary of developments since Audit Report No.28 1993-94

2.1 Since Audit Report No 28 was tabled on 24 February 1994, developments relevant to the administration of private hospitals utilised by the Department include:

- changed arrangements for the planning and management framework within the Department;
- development of the Hospital Services Deed;
- introduction of better arrangements for transition to the community following discharge from hospital;

- development of the Hospital Claims Validation System;
- performance information research;
- approvals for admission to, or on the actual date of admission to private hospitals have improved; and
- savings achieved.

2.2 These changes and their impact on the original audit recommendations are outlined below.

The planning and management framework within the Department

2.3 DVA is comprised of National Office and six State Offices. In the last twelve to eighteen months, the State Offices have been given a greater level of responsibility and autonomy than was provided in the previous program-based structure. Under the previous arrangements, planning and management responsibilities for all DVA programs rested with the part of the Department now known as National Office. State Offices reported directly on their performance on particular functions (for example Health) to the area in National Office responsible for administering the particular program (in this example, the Health Program).

2.4 State Deputy Commissioners (DCs) under the changed arrangements have responsibility for all programs in their State. Managers, or Directors as they are known in the State Offices, report directly to the DC, but it is recognised by the Department that close liaison with National Office program staff is necessary for successful service delivery.

2.5 The changes were intended to give State Deputy Commissioners more responsibility to manage performance in their State in accordance with national guidelines, with a reporting line direct to the Secretary. Changes to the DVA structure and reporting relationships are outlined at Appendix 2.

2.6 The ANAO considers the effect of the structural change has increased the relative importance of original recommendations that were aimed at achieving consistency in administration within the program. These recommendations included:

- a consistent strategic framework (recommendation 1);
- consistent use of information (recommendation 4);
- consistent use of databases (recommendation 5);
- consistent negotiating framework (recommendations 6 to 10);
- improved utilisation of performance information and benchmarking tools (recommendations 11 to 15); and
- improved communication flows (recommendation 16).

2.7 As a result of the changes, the Health Care and Services Division within National Office has recently implemented six-monthly conferences with State Offices on private hospital matters to share information and as a platform for policy development and reform. This forum, in conjunction with the clarified roles, has assisted with improved communication

between the State Offices (recommendation 16). It is anticipated that more complete implementation of the other recommendations listed above will occur as a result of this improvement in communication. Consequently, they are shown as only partially implemented in Appendix 1.

2.8 Issues relating to the restructure are discussed further in Chapter 3 in the section 'Program management'.

The Hospital Services Deed

2.9 The Department introduced the standard Hospital Services Deed (HSD) for all contracted hospitals nationally as a result of recommendations in the original audit. Its use has been endorsed by the Attorney-General's Department and addresses issues such as:

- arrangements for billing private hospitals at negotiated rates;
- multiyear indexing arrangements based on movements in average weekly earnings, private hospital wages and salaries and consumer price index for that State;
- quality assurance;
- discharge planning;
- rights of inspection;
- patient records;
- provision of information (including regular International Classification of Diseases statistics);
- indemnity against claims arising from hospital negligence;
- prior approval requirements; and
- protection against veterans being charged a moiety.

2.10 The Department believes the use of the HSD and adherence to its quality monitoring requirements provides reasonable assurance that legally binding relationships exist with hospitals at guaranteed rates and clients are afforded quality of care. It also introduces a measure of consistency in administration across the private hospital framework.

2.11 This action addresses the intent of recommendation 2 in the original audit.

Discharge planning

2.12 In June 1996 the Department issued new guidelines on discharge planning and distributed discharge information to staff in hospitals and day surgery facilities and to veterans and war widow(er)s. These were intended to improve quality care outcomes for veterans following discharge from hospital and encourage greater participation in the discharge planning process by veterans and their carers.

2.13 A resource kit was issued to staff in hospitals and day surgery facilities setting out the Commission's expectations and requirements for discharge planning, including access to

information on additional support services available. The need to have discharge planning processes in place is reflected in the Hospital Services Deed.

2.14 This action addresses that part of recommendation 2 in the original audit that relates to discharge planning. The remainder of recommendation 2 was dealt with in the preceding section of this chapter.

Hospital Claims Validation System

2.15 The Hospital Claims Validation System (HCVS) was developed to ensure that accounts received from contracted hospitals are paid in accordance with their contracts. The system was introduced into DVA State Offices in New South Wales, Queensland and Victoria in late 1995 and matching of data from contracts to invoices assures the Department minimises the risk of overpayments.

2.16 The introduction of HCVS was intended to address concerns identified in the original audit and address recommendations 17 to 21. When fully implemented, the ANAO considers this will be the case. However, there are a number of issues relating to its usage in New South Wales that are discussed in Chapter 3 in the section 'Payments and quality assurance'. Notwithstanding these, however, the Department has confirmed that the HCVS system has achieved the reduction in the overpayments which were estimated at $3 million in the original audit.

Performance information

2.17 The Department has also been developing its capacity to analyse data on a casemix basis and thereby enhance its ability to better manage hospital and other health services. Casemix (also referred to as episode-based care) is an information classification system that focuses on building useful categories of patient care episodes and making good use of those categories to manage the outcomes, quality and cost of health care. It provides more meaningful information on patient care than has traditionally been available from health service providers.

2.18 Overall, the Department considers the greatest challenges to the management of contracts in hospital services have been the absence in methodologies to interpret information available from the hospitals and the imprecise nature of the data available. This has been an industry wide issue. The introduction of episode-based care information as a classification tool is expected to greatly assist contract managers in interpreting a hospital's performance.

2.19 The Department is working in conjunction with the Commonwealth Department of Health and Family Services and the Australian Institute of Health and Welfare and liaising with the Australian Private Hospitals Association on the development of an episode-based care information model.

2.20 The ANAO considers further development of performance information and benchmarks as recommended in the original audit (recommendations 11, 12 and 14) is important for effective program management. The Department has advised that development is dependent on the outcome of the above project.

2.21 Existing information systems within the Department capturing various data on hospital

details, separations, types of care, costs, validation of claims and payments are the subject of a review by the Department to provide for better integration and utilisation of information. This review (the Health Care Information System project) is intended to streamline and improve timeliness of access to information within DVA. The Department has advised this action is intended to address the intent of recommendation 5 in the original audit. The ANAO considers this is a significant project which has the potential to address the intent of recommendation 5 when implemented.

Prior approval

2.22 Under both the Treatment Principles and the RPPS, approval from the Department is generally required before veterans are admitted to a private hospital. In emergencies and other exceptional cases, approval is obtained after admission.

2.23 Since the original audit, approvals for admission prior to, or on the actual date of, admission to private hospitals have improved (increasing from approximately 42 per cent in 1992-93 to 54 per cent in 1996). An analysis of approvals for the six-month period 1 January to 30 June 1996 by State Office provided by DVA is at Figure 5. The Department could not provide accurate data for Victoria. The data in Figure 5 is estimated. Overall, Figure 5 shows that approvals beyond three days after admission (denoted as >3 days after and shown in the darkest shading on the graph) in Queensland and Victoria are relatively high. The Department has advised that in Queensland under contractual arrangements with country private hospitals, prior approvals are not required for medically approved procedures and the figures for Queensland are overstated by 59 per cent as a result.

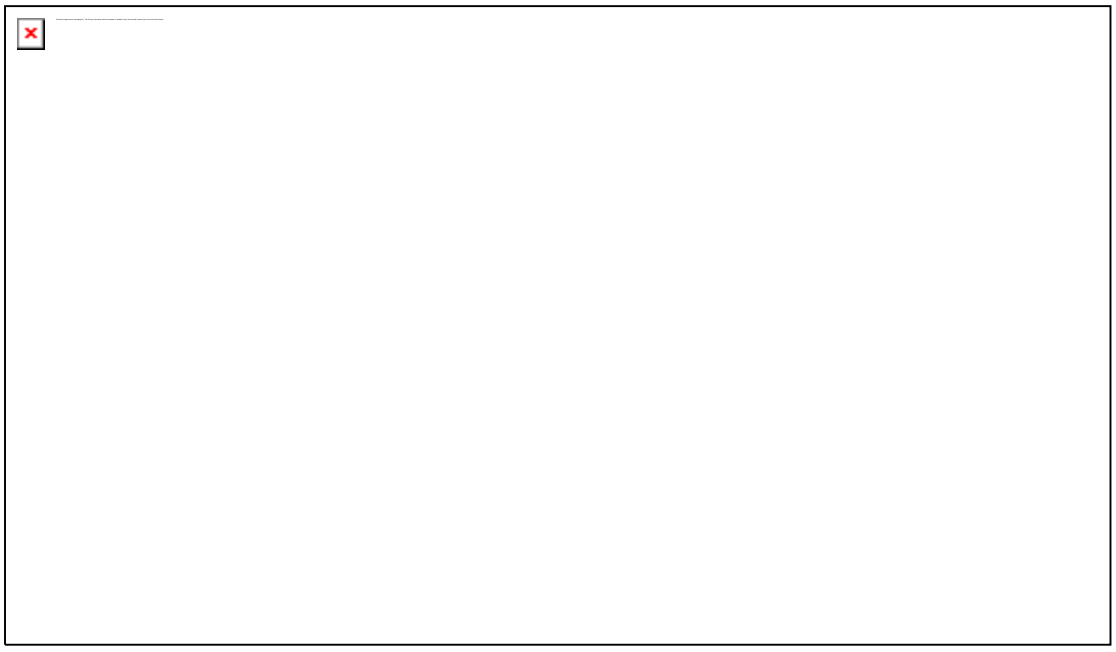
2.24 Further action by the Department on recommendation 24 of the original audit is required to improve approvals prior to treatment. National Office is currently working with the Victorian and Queensland Offices to review prior approvals procedures as a result of the audit.

Savings achieved

2.25 Savings specifically relating to the original audit recommendations can be measured only through comparison between and within States for constant characteristics. Actions by the Department since the original audit have resulted in an estimated $4 million savings per annum through a more commercial and rigorous approach to contract negotiations.

2.26 The Department considers that savings achieved are ultimately the province of the Private Hospital Negotiator in each State. To this end, information that they should take into account in setting or renegotiating case rates in private hospitals and the processes that they should follow are outlined in the Private Hospital Negotiators Kit. This kit was developed by DVA in 1991 as a resource for private hospital negotiators, explaining the background for negotiations and strategies for achieving the best outcomes for the program.

Figure 5. Decision of Approval for Admission to Private Hospital - 1 January to 30 June 1996



2.27 Practices in different State Offices for negotiating particular case rates continue to vary but more sophisticated uses of information systems and reference points have achieved savings. In Queensland, for example, Internal Audit testing assessed the improved utilisation of management information systems such as

- data from the Treatment Account System (TAS) expenditure reports;
- treatment demographic data; and
- the Private Hospital Terms of Evaluation System (TES) as instrumental in gaining better bed day rates for particular episodes of care from hospitals.

2.28 From the Department's own analysis, in one particular case an estimated projected $700 000 annual saving was attained based on projected veteran usage for the year on a large supplier's contracted rates with the Department, compared with its standard rate for other clients. This was a result of having information available to negotiate better rates.

2.29 The above is an indication of the potential benefits of fully implementing across State Offices recommendations from the original audit. As the remainder of the recommendations are fully implemented and casemix classifications improved, the ANAO considers the Department will continue to achieve a higher quality and more cost effective outcome in terms of private hospital rates negotiated.

Other developments resulting in savings

2.30 There were other savings options or efficiency measures recommended in the original audit. These included:

- national agreements with health organisations (recommendation 7);
- improved stepdown rates (recommendation 10);
- utilisation of multiyear contracts (recommendation 6); and
- competitive tender where alternative providers were available (recommendation 9).

National agreements with health organisations

2.31 Agreements with national health organisations are being pursued to the extent deemed appropriate by the Department, which considers that the scope will be improved as casemix information is more readily available. The ANAO is satisfied that progress is appropriate in the light of developments in the area. Recommendation 7 is shown as partially implemented in Appendix 1 as a result.

Step-down rates

2.32 This follow-up audit found that step-down rates have been negotiated in 255 of the 266 private hospital contracts. The length of step-downs continues to vary between States but is generally consistent with industry standards for the particular State. The only exception to this is New South Wales where 64 per cent of standard medical and surgical contract step downs exceed industry standards and 18 per cent of contract step-down rates fall below industry standards. Those contracts below industry standards are being progressively realigned over time to a basis consistent with industry standards.

2.33 As the Department has indicated that efforts to align rates will be completed during 1996-97, recommendation 10 is shown as completed at Appendix 1.

Multiyear contracts

2.34 This follow-up audit found that multiyear contracts are in place for 121 out of 266 contracts. This is a marked increase since the original audit.

2.35 There are a number of factors impacting on a hospital's ability to perform consistently at a profitable level. These include fluctuations in demand, the volatility of the environment comprising changes in work, facilities, technological developments, movement of doctors and the hospital's ability to attract and retain top line specialists.

2.36 The Department advised that through the contract negotiation process it has been ascertained that there is some resistance to the indexation formula and in particular the direct link to a CPI based indicator. The Department is currently investigating alternative methods of calculating the multiyear formula.

2.37 Action for recommendation 6 is shown as completed at Appendix 1.

Competitive tendering

2.38 Use of competitive tendering has been piloted in a number of States. DVA has reported that this will continue to be explored on a regional basis. In Appendix 1 action is shown as completed on recommendation 9.

Conclusion

2.39 The estimated $4 million savings identified in the original audit relating to contract negotiations have been achieved through the partial implementation of the original recommendations and Departmental reforms outlined above. The ANAO considers that additional savings can be achieved if a consistent approach to the negotiation framework is implemented and better practice in negotiations shared and adopted. Specific recommendations to this effect are in Chapter 3 (recommendations 1 and 2).

Extent to which the agreed recommendations of the original audit have been implemented

2.40 Individual recommendations from the original audit and actions taken are outlined at Appendix 1. A total of 28 of the 29 recommendations were agreed by DVA. Of the 28 agreed recommendations the ANAO considers:

- 15 recommendations have been implemented;
- 12 recommendations have been partially implemented but require further development; and
- one recommendation has been overtaken by events and no further action is required.

2.41 One recommendation was not agreed in the original audit concerning augmentation of ACHS accreditation with additional quality assurance procedures. The Department argued that ACHS accreditation was comprehensive enough without the Department devising additional quality assurance procedures. Nevertheless, the intent of this recommendation has been addressed through the Department requiring regular quality of care statistics to be provided by both accredited and non-accredited private hospitals under the HSD.

2.42 Appendix 1 provides details of specific actions taken by the Department and identifies where further work is required. Outstanding issues are discussed further in Chapter 3.

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3. Outstanding Issues

This chapter identifies issues arising from the original report which would benefit from further development work by the Department, including program management, contract negotiation, payments and quality assurance and quality of care.

3.1 As identified at paragraph 2.39 there are areas requiring further development identified during the follow-up audit. Areas with scope for improvement are outlined below.

Program management

3.2 As previously stated, the Department considers that the use of the HSD and adherence to its quality monitoring requirements provides reasonable assurance that legally binding relationships exist with hospitals at guaranteed rates and clients are afforded quality of care. The ANAO has concluded that it also introduces some measure of consistency in administration across the private hospital framework that did not previously exist. However, the audit has identified substantially different practices between States in strategic direction, administration and process. This is a product of changed responsibilities and priorities being set by individual States. Examples of these differences include:

- different objectives in business plans for each State Office for the year;
- variations in the planning processes undertaken in negotiating extensions of existing

contracts;

- development of new databases and reference material to assist with the renegotiation of contracts; and
- variations in the type of quality assurance activity undertaken.

3.3 These variations are discussed further below under the following headings: the outcomes of devolution, the implications for differing practices with respect to contract negotiation and scope to improve.

Outcomes of devolution of authority

3.4 Devolution of authority and responsibility for program delivery to the States was intended to recognise the differences in State practices with each State Office given the autonomy to manage within agreed national service standards and within national program guidelines. However, the effect of the above variations has resulted in an ad hoc approach to program development issues, duplication of effort by State Offices and an amelioration of the intent of national policy and strategy as discussed below.

3.5 An example of the effect of devolution is illustrated through the change in implementation of actions identified to address the original audit recommendations. There was initially a strong national focus reflected in national plans to address the issues raised in the original audit. These plans outlined the required national and State Offices' actions to identify strategies to address areas of responsibility relevant to each. However, such action in addressing the issues has varied between the State Offices. In at least one State Office there has been little action on implementing changes recommended and changes not taken up have not been reflected in subsequent State-based Business Plans. Furthermore, at the time of the audit, there was an ad hoc approach to setting increases for bed rates for private hospitals within and between regions with no reference to a specific State strategy. This is not consistent with the national policy which required States to identify particular strategies.

3.6 Another example is the data collection area where data presently being collected by the Department from private hospitals (the International Classification of Disease information, ICD9, requested under the HSD) will be overtaken by refinements and changes in definition and format. This data is being collected by the State Offices but is not being analysed nor trends monitored at this stage. This is due, according to the Department, to a lack of resources to analyse the data, an awareness that the data will be overtaken by new classification methods being developed and a slower than anticipated adoption by the industry of the data set.

Implications for differing practices with respect to contract negotiation

3.7 Differing practices do not promote a consistent, efficient and effective approach to negotiating contracts directed to achieving common goals. The follow up audit identified scope for further development in program administration (including data collection, analysis and reporting) between State Offices. These present a challenge to the overall efficiency and effectiveness of contract administration and analyses of national trends. These issues are particularly important in the current climate of resource constraint within the Department generally, and State Offices and Health Care and Services Division more specifically.

3.8 The Department has indicated that the inherent differences in the operation of private

hospitals in each State should not be overlooked. DVA considers the efficiency of the various State public systems and the buoyancy of individual State market places will impact on the way contracts are negotiated nationally. The ANAO accepts this and recognises that the continuation of RPPS workshops will help in understanding the issues faced in each State to assist in the development of a national strategy.

Scope to improve

3.9 The ANAO considers promulgation of better practice in contract administration and contract negotiations between State Offices is desirable. Where differences in practices or processes between states do exist the reasons for this should be fully justified and documented. Overall, the commitment of State Deputy Commissioners to improving their performance is consistent with the Department's charter 'we aim to be the best.... by doing the right thing, the first time.' With some changes in direction as suggested, the ANAO is of the opinion this aim has the potential to be achieved.

3.10 The ANAO found there is scope for significant improvement in the quality of performance reports from program areas and State Offices to senior management in National Office under the changed reporting arrangements. It is the ANAO's view that it would be difficult for senior management to draw conclusions on the performance of the Department with respect to particular indicators based on the management reports being provided to them at the time of the audit. The ANAO recognises that significant changes have occurred in the restructuring of program responsibilities and that development work on benchmarking, performance indicators and the cost of administration will eventually produce better and more timely information. It is essential, however, that clear and comprehensive information be provided to senior management regularly. Reference to the ANAO's Better Practice Guide on Performance Information may be of assistance in this regard.

3.11 The ANAO notes that the Department has recently committed itself to the development of Centres of Excellence. These Centres of Excellence are a good mechanism to identify and develop better practice processes and to promulgate and raise service standards. Action on this initiative is consistent with the following recommendations.

Recommendation No.1

3.12 The ANAO *recommends* DVA enhance its National Office role in assisting the State Offices to set strategic directions for the provision of hospital treatment and monitor reports on progress with implementation of strategies.

DVA comment

3.13 Agreed. As referred to in paragraphs 2.7 and 3.8, in the last 12 months the Department has commenced holding twice yearly workshops which are attended by representatives from each State and National Office. This provides an opportunity to discuss a variety of strategic issues and assists to achieve consistency in maintaining the RPPS. At the last meeting it was agreed that each State would provide quarterly reports including performance indicators to National Office and to each other State. In addition the RPPS is currently under review, and the conclusion of the review will provide a further opportunity for national Office, with State Office input, to determine specific strategies for the future directions of the RPPS.

Recommendation No.2

3.14 The ANAO *recommends* DVA identify better practice in relation to program administration (including data collection, analysis and reporting) throughout the State Office network and adopt it as standard practice.

DVA comment

3.15 Agreed. The regular RPPS workshops have provided an opportunity to identify and discuss ways to improve program administration of the RPPS. An important aspect of this is the Department's move to collect casemix information from private hospitals, most notably Hospital Casemix Protocol (HCP) data. A considerable amount of effort by both the State and National Offices is being provided to collect and analyse the HCP data. The Department is also working with the Department of Health and Family Services to provide casemix benchmarking information.

3.16 In addition, the Department is currently developing a Health Management Information System which will enable State and National Office staff to more quickly and accurately interpret data on any of the Department's systems.

3.17 Once these systems have been implemented, DVA will have access to a considerable amount of data that will assist not only with contract negotiation, but state by state and hospital by hospital comparisons. This will be a significant improvement on the current average bed day and by veteran comparisons and will assist to identify the true cost of the hospital care of veterans.

Contract negotiation

3.18 The HSD includes a standard schedule for indexing multiyear contracts. This is not, however, used by all States. For example, New South Wales and Queensland rate increases were negotiated for each bundled sets of medical benefit scheme items on an individual hospital basis annually. The original audit, the Department's Internal Audit and this follow-up audit have all noted poor documentation in files on the basis for setting initial and subsequent rates of care and a lack of consistency in approach in negotiating continuation of contracts in a number of States.

3.19 The ANAO found that different information on different databases between States continues to be used in negotiating existing and new contracts to varying extents. The implications of these variations in practice are inconsistencies in indexing rates between and within States. For example, in one State, information on comparative treatments within the region are not taken into account before agreement is reached in the setting of indexed rates for a private hospital within that particular region. Such variations can lead to inefficiencies and increased costs.

3.20 The ANAO considers that a standard format for data to be considered prior to extension or establishment of contracts would assist by:

- ensuring consistent use of databases and reference points; and
- through the above, providing a comprehensive understanding of the environment, thus allowing a better informed and higher quality outcome in terms of rates negotiated to be achieved.

3.21 This would also improve the justification and documentation for contract rates for individual hospitals and provide a transparent account on individual files of how decisions were arrived at.

3.22 The standard format for data to be considered could incorporate elements suggested for consideration outlined in the Private Hospital Negotiators Handbook such as:

- information on hospital characteristics;
- types of services offered;
- average length of stay data;
- comparable rates within the region, State and nationally;
- rates for individual casemix in previous agreements;
- comparison with State Health CPI and other increases within the State and nationally; and
- the basis of increase proposed.

3.23 It could also incorporate space for medical and administrative staff consultation and sign-off on the recommended rates.

3.24 The above measures would ensure that the intent of recommendations 4 to 8 in the original audit (covering awareness and use of available information and their context) is more adequately and consistently addressed by all State Offices.

Recommendation No 3

3.25 The ANAO *recommends* that a standard format for documenting extensions of existing or new contracts between DVA and private hospitals be developed as a standard feature of every DVA private hospital file.

DVA comment

3.26 Agreed. National Office staff have started discussions with State Offices to determine a standard format for documenting new contracts or variations to existing contracts. Each State Office has developed its own format to varying degrees and these discussions are intended to take these ideas and develop a standard format. It is intended to seek State Office agreement to this new format at the next RPPS workshop.

Payments and quality assurance

3.27 Internal Audit found in their testing of payments during an audit conducted in 1995 (reported in May 1996) that an unacceptably high level of incorrect payments were being made. Internal Audit also made several recommendations relating to timeliness of payments and the need to check the reason for returned cheques. They foreshadowed the imminent introduction of HCVS would improve payment accuracy and address the intent of original recommendations 17 to 23. HCVS was subsequently introduced in New South Wales, Victoria and Queensland in late 1995. Contract details are entered into the HCVS by National Office and matching against the invoices is undertaken by State Office payment areas.

3.28 The HCVS is a validation tool which is planned to form the basis of quality assurance and a large component of risk management for the Department when outsourcing of the payments function to the Health Insurance Commission occurs in July 1997.

3.29 The HCVS user manual developed by National Office presently stipulates that the system must be used to process claims received from contracted private hospitals in Victoria, Queensland and New South Wales. While 25% of invoices were being checked through HCVS in New South Wales at the time of this audit, invoices selected for checking through HCVS were not randomly selected, nor selected on the basis of specified risk criteria. The checking process of selected invoices was not being undertaken independently of the payments function. This increases the potential for incorrect payments and the risk for fraud.

3.30 Another issue identified as part of the follow-up audit was the inability of the HCVS system to track cumulative numbers of episodes of care. This capacity is required to register discounts for service providers who offer discounts once particular throughput thresholds have been reached. There are obvious implications for ensuring accuracy of payments against invoices and the integrity of the system for checking.

3.31 While the introduction of the HCVS has the potential to substantially reduce the risk of incorrect or inappropriate payments, the ANAO considers there is still some risk that overpayments are being made for those invoices that are not being checked through the system or where bulk discounts are provided. This risk is increased when reasons for overpayment are not being followed up.

3.32 As recommended by ANAO in the original audit and by Internal Audit in May 1996, a risk management approach whereby payments are selected for checking based on specified criteria and a risk management strategy would enhance current arrangements. The ANAO considers that this approach should be developed, implemented and monitored by National Office to ensure a consistent approach and that implementation actually occurs. This is also critical in light of the pending change to payment arrangements, whereby from 1 July 1997 the Health Insurance Commission will process accounts on behalf of the Department.

3.33 Recognising the current level of resources being applied to HCVS, the ANAO considers a systematic risk management policy would clarify the checking procedures within the processing of payments and could be implemented at minimal cost.

Recommendation No.4

3.34 The ANAO *recommends* that DVA National Office develop, implement and monitor a risk management policy specifically for private hospital payments as part of their management approach.

DVA comment

3.35 Agreed. The Department has initiated discussions with State Offices regarding the development of risk management approaches for private hospital payments. The Internal Audit area has already undertaken a comprehensive risk management identification and analysis exercise which covers all areas of the Department's operations including private hospital payments. In addition, the Health Care and Services Division has conducted its own risk assessment identification/analysis exercise. The information obtained is now being used as the basis for developing a comprehensive risk management policy.

Quality of care

3.36 The quality of private hospital services provided is managed in a number of ways:

- accreditation by the Australian Council on Health Care Standards which combines guidelines with an inspection process, is currently the only recognised industry method of assessing health care standards. DVA has a stated preference for contracting accredited private hospitals, except in exceptional circumstances such as emergency care or in the cases of geographically remote regions;

- information on indicators of clinical care is required to be provided to the Department on a quarterly basis where hospitals are not accredited. These indicators were developed by the ACHS in conjunction with the Royal Australian College of Medical Administrators and presently include statistics on the rate of unplanned hospital readmissions, return of patients to the operating room during the same hospital stay and the rate of incidents and accidents; and

- the establishment of Treatment Monitoring Committees in each State and nationally, comprised of representatives from the ex-service community, State Health departments and DVA. These committees provide an avenue for raising serious concerns about health care and for analysis of those concerns and their causes.

3.37 The ANAO notes that, while the number of ACHS accredited private hospitals contracted to the Department has increased, DVA was not able to meet its stated aim of using only accredited hospitals by 1995. This is due to smaller and more remote hospitals not having the means of attaining ACHS accreditation. The Department has recognised this goal is not attainable but is aiming to increase the proportion of veterans receiving private hospital care in accredited versus non-accredited hospitals by continuing to give preference to accredited private hospitals in negotiating new and continuing contracts.

3.38 The ANAO noted that the collection of statistics from non-accredited hospitals on the quality of clinical care was not being regularly monitored and irregularities were not being followed up in NSW prior to this follow-up audit. Monitoring is an important tool for ensuring the veteran community is properly cared for, particularly where there are significant numbers of unplanned admissions to the operating room, readmissions to hospital or incidents or accidents. Monitoring is required to identify quality issues which need to be addressed.

The ANAO considers that referral of quality of care information to the Treatment Monitoring Committees on an ongoing basis would assist with ensuring relevant information is collated and analysed in a timely manner.

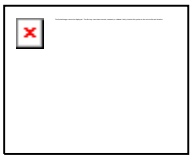
Recommendation No 5

3.39 The ANAO *recommends* that DVA undertake a more rigorous monitoring of non-accredited hospitals quality of care statistics and that these statistics be forwarded to Treatment Monitoring Committees on an ongoing basis to ensure quality of care outcomes for the veteran community in accordance with performance targets.

DVA comment

3.40 Agreed. The Department intends to forward exception report statistics to State Treatment

Monitoring Committees on the quality indicators for non-accredited hospitals. In addition, the Department has been liaising with the Department of Health and Family Services who are currently reviewing existing quality indicators. Once this review is completed, it is proposed to use these new quality indicators to provide more precise data on the quality of care which veterans are receiving at non-accredited facilities.



Canberra ACT — P. J. Barrett

5 March 1997 — Auditor-General

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The statistics used in this chapter have been provided by DVA, with bed days based on date of service data and costs based on actual financial year data. DVA has advised that data for 1995-96 is subject to change due to processing lags and reconciliations under block arrangements with States.

Appendix 1

DVA Private Hospitals - Action On Original Recommendations

Private Hospital Contracts. There were 194 private hospital contracts in 1993-94. Action on implementing the recommendations outlined below were estimated to provide $4 million per annum over time. DVA subsequent action and ANAO findings are also tabulated. In 1995-96 there were 266 private hospital contracts.

Recommendation	Intention of Recommendation	DVA Response	DVA Action	ANAO Comments
1. Refine objectives and strategies of private hospital contracting in order to provide greater consistency in the	There were a variety of negotiating approaches and strategies applied across the States. The proposed refinement would	Agreed. The objective and strategies will be reiterated to State Branches. The proposed refinement would provide the basis	State and National Business Plans set the broad objectives. Regular six monthly forums have been held and these will	Partially completed. Practices vary between State Offices. An enhanced National Office role in assisting State

strategies adopted in each State Office.	provide the basis for future development, a consistent negotiation framework across the State network and ensure consistency with the desired departmental objectives.	for future development, a consistent negotiation framework across the State network and ensure consistency with the desired departmental outcomes.	assist with setting directions, aided by joint working groups on specific issues.	Offices set strategic directions for the provision of hospital treatments and monitor reports on progress is recommended (3.12).
2. Review the clarity of its defined requirements regarding discharge planning, standard of care accreditation and rights of inspection in new contract.	It is important that contracts specify and define key departmental requirements to contracted private hospitals clearly and unambiguously in order to ensure that minimum departmental requirements are known and understood.	Agreed. The Department is already reviewing these provisions and a new standardised contract should be available early in 1994.	Standard Hospital Services Deed (HSD) developed. Modification for discharge planning developed.	Action completed.

Recommendation	**Intention of Recommendation**	**DVA Response**	**DVA Action**	**ANAO Comments**
3. Review present provisions regarding indemnity against new claims arising from hospital negligence.	Existing contracts contained an indemnity clause previously cleared by the Attorney-General's Department. However, the ANAO believes this clause may not adequately protect the Department against claims of negligence, particularly as its approval is	Agreed. The Department is consulting with its legal area about the appropriateness of the existing legal clause.	Received legal advice that existing indemnity clause is adequate.	Action completed.

	necessary before admission. This may be interpreted as indicating acceptance of liability by the Department.			
4. Ensure State Offices follow Departmental guidelines regarding types of information available and their effective use.	Although Departmental systems are able to produce relevant information on casemix and usage to assist negotiators in developing their negotiation framework with individual hospitals, there was no evidence that this information was used in a consistent and systematic manner.	Agreed. The Department will reiterate the importance of effectively using departmental databases, information systems and guidelines.	National Office (NO) reminded State Offices (SO) of requirements and negotiators urged to make full use of information available. Private Hospital Negotiators Kit is being updated by working group. IT systems being developed to assist SOs.	Partially completed. Inconsistent processes for negotiating contracts are still evident. The ANAO recommends identification of better practice in program administration is adopted throughout the State network (3.14).

Recommendation	**Intention of Recommendation**	**DVA Response**	**DVA Action**	**ANAO Comments**
5. Review existing information databases and develop appropriate models for use in the negotiation process.	The use of information on private hospital usage from departmental systems was on an ad hoc basis. There is scope for a more systematic use of information and the development of computer modelling to assist negotiators.	Agreed; see recommendation 4.	Integration of information planned through the Data Repository Project will assist with accessing relevant information in a timely manner.	Partially completed. Work to integrate information databases is ongoing. Development of a standard format for new contracts or variations to existing contracts across SOs is recommended (3.25).
6. Consider	The process of	Agreed. The	Being	Completed, 121 out

multi-year contracts.	negotiating individual contracts with all hospitals in each State each year was a relatively inefficient process that required the same amount of effort for new contracts and for contract renewals.	Department supports the extension of multi-year contracts where there are positive benefits. Major benefits are only expected to accrue in areas where larger or consistent volumes of private hospital usage can be used as negotiating points in the Department's favour.	implemented in most States - issues relating to negotiating annual hospital rates and applicability to particular hospitals are being reviewed by a working group.	of 266 contracts are multi-year with consideration provided for other contracts whenever appropriate.

Recommendation	**Intention of Recommendation**	**DVA Response**	**DVA Action**	**ANAO Comments**
7. Negotiate with national health groups where advantageous.	Where the negotiating involved hospitals owned by major health groups, greater efficiency could be achieved by negotiating directly with individual health groups as a whole, either on a state or national basis to gain bulk discounts.	Agreed. However, the Department believes it is important to retain the flexibility of dealing with individual hospitals or the group. This is required to produce the best outcome for the Commonwealth.	Pursued to the extent deemed effective - more information on casemix will permit negotiations on a broader scale.	Partially completed. DVA has agreed to review again after casemix information is available.
8. Input from both administrative and medical staff as part of the negotiation process.	There is a need to ensure that contracted hospitals had the capacity and facilities that they claimed during the negotiation process. Involvement of both	Agreed. The Department acknowledges the desirability of including input from both medical and administrative staff into the negotiation process.	Taking a multidisciplinary approach to negotiation preparations.	Partially completed. Development of a standard format for Private Hospital files with space for signatures of both medical and administrative staff would assist with ensuring this was

	administrative and medical staff would seem to cover the economic and medical requirements of the Department.			actually occurring (3.25).

Recommendation	Intention of Recommendation	DVA Response	DVA Action	ANAO Comments
9. Establish contracted provider arrangements through tendering of services In those States where the RGH has been integrated into the State health system.	There are opportunities available for the department to obtain discounts through a contracted provider arrangement.	Agreed to the extent possible. The Department will continue to explore tendering on a regional basis, taking account the range of services available.	DVA continue to explore opportunities on a regional basis with a number of pilot studies in various States.	Action completed - tendering continues to be evaluated.
10. Review stepdown arrangements	The use of reduced rates for longer periods of hospitalisation had the potential for significant savings, particularly where these stepdown rates were based on average lengths of stay	Agreed. The Department agreed to review its stepdown arrangements and ascertain if changes are required in terms of industry standards	Reviewed as contracts are renewed. Further research is being undertaken particularly in relation to industry standards.	Action completed.
11. Develop models to assist in the development of benchmark rates and assist with cost/benefit analysis, casemix and demand projections	There was little uniformity in the base from which States negotiated.	Agreed in part. Departmental strategies will ensure that States negotiators utilise appropriate information and that their performance is evaluated against agreed targets	Performance monitored against State Business Plans. Tasmanian pilot on casemix development /episodes of care will assist here	Partially completed - more development work required to ensure consistent and comprehensive base utilised by all SOs.

Recommendation	Intention of Recommendation	DVA Response	DVA Action	ANAO Comments
12. Develop performance indicators (e.g. discount and price objectives) to augment the development of benchmarks for its negotiation framework.	In view of the wide variations in State-based approaches, there is a need to develop performance indicators that, together with benchmarks, will improve consistency and comparability of results across the State network.	Agreed. The Department will give consideration to the development of performance information.	State Business Plans in some SOs include performance indicators relating to its negotiating framework. Development of casemix information will assist.	Partially completed - more development work required to ensure consistency across the State network.
13. Review methods of calculating savings including use of consistent methodologies and standard cost indices.	The methods adopted to calculate savings depend on somewhat loose assumptions, for example different rates of inflation adopted by each State, which do not provide the Department with a defensible methodology.	Agreed. The Department agreed to examine the scope to revise the calculation of savings.	Some development work on savings and cost indices was undertaken.	Action incomplete. However savings are no longer reported upon. No further action.
14. Develop performance indicators for monitoring administrative performance in respect of private hospital administration (costs, usage, procedure and length of stay).	Departmental systems are capable of providing substantially more information on administrative performance than was being obtained at the time of the audit. There is potential for the Department to introduce a regular and	Agreed. The Department will consider development of performance indicators for monitoring administrative performance.	Performance Indicators (PIs) and benchmarks planned to be developed in conjunction with casemix development.	Partially completed. Further development work on indicators required.

	systematic use of information systems for performance monitoring.			

Recommendation	Intention of Recommendation	DVA Response	DVA Action	ANAO Comments
15. Establish a performance monitoring group to be responsible for monitoring the performance of State offices.	In view of the different administrative practices adopted by the States, there is a need for close monitoring of performance to identify potential problems and best practice.	Agreed. The Department will ensure the performance of States is properly monitored.	The need to establish a performance monitoring group has been overtaken by the devolution of responsibility to State Deputy Commissioners. However, national performance indicators and benchmarks are being developed to assist in State Office self-monitoring. In addition, the Department is considering introducing Centres of Excellence, which would concentrate the knowledge and expertise of areas such as contract negotiation into one or two State Offices.	Partially completed - an enhanced national focus is required to ensure consistency of monitoring and identification, promulgation and implementation of better practice (3.14).

Recommendation	Intention of Recommendation	DVA Response	DVA Action	ANAO Comments
16. Review communication within the States to improve	Although informal networks had been established between the State	Agreed. There is scope for improvement in the level of	National Component Plan delineates National and State	Action completed.

interaction between various groups responsible for private hospitals.	Branches there was only limited formal communication and liaison. There was potential for improvement in the interaction between the various groups responsible for private hospital usage.	communication between all groups involved in private hospitals and the Department will undertake action to enhance communication between those involved.	Office responsibilities and communication channels.	

Recommendation	**Intention of Recommendation**	**DVA Response**	**DVA Action**	**ANAO Comments**
Contract Administration				
17. Expedite systems review for processing and payment of accounts.	In order to ensure that the rates charged by hospitals reflect the rates actually agreed the link between the system components needs to be improved.	Agreed. The Department will ensure that all private hospital accounts processing is subject to verification by the PC-based verification system, until such time as enhancements to Treatment Account Systems (TAS) have been implemented in early 1994.	The Hospital Claims Validation Systems (HCVS) was introduced on 6 March 1995.	Action completed.
18. Redevelopment of TAS utilising system flags for preventing incorrect coding.	The present systems do not provide a mechanism for ensuring that only accurate data is entered into the system used for processing private hospital accounts.	The current TAS enhancements incorporate these capabilities.	The HCVS was introduced on 6 March 1995 in Vic, NSW & Qld and has the capacity to flag incorrect coding.	Action completed.

Recommendation	Intention of Recommendation	DVA Response	DVA Action	ANAO Comments
19. Apply risk management approach to payment of hospital accounts.	Private hospital invoices can be very complex and require specialised knowledge of theatre and medical procedures. A random check of hospital accounts by trained medical personnel, in conjunction with accounts staff, would provide a mechanism for ensuring the medical correctness of the classification of technical theatre and medical procedures.	Agreed. However, checking the medical correctness of the classification of theatre procedures and medical bandings would normally require examination of the patient's medical record and could only feasibly be undertaken as a post-payment activity.	The HCVS incorporates the ability to monitor the administrative correctness of surgical claims and theatre bandings for procedures.	Partially completed. Only a non-random proportion of invoices is presently being processed through HCVS in NSW. Implementation of a risk management policy is recommended (3.34).
20. Conduct task-specific training courses for TAS personnel.	In some States, the processing of private hospital invoices was undertaken by staff on a part-time basis, notwithstanding the complexity and large volume of invoices to hand.	Agreed. The need for specialisation and training in the processing of private hospital accounts will be examined.	HCVS training ongoing.	Action completed.
21. Issue instructions on procedures to TAS personnel.	A large number of invoices examined were incorrect, with incorrect matching of accommodation or theatre bandings with the contracted rates.	Agreed. The Department agrees to reissue instructions to staff on these matters.	HCVS manual issued to all relevant staff.	Action completed.

Recommendation	Intention of Recommendation	DVA Response	DVA Action	ANAO Comments
22. Reinforce to private hospitals the need for accurate invoices.	This recommendation is aimed at ensuring the department pays only those invoices which have been correctly submitted and for which the accommodation bandings and theatre procedures are correctly transcribed, e.g. medical procedure numbers and theatre bandings.	Agreed. The Department will initiate a provider education program utilising material similar to that forwarded to contracted private hospitals in NSW following introduction of the RPPS from 1 July 1993.	All State Offices supply providers with information relating to the Department's administrative procedures.	Action completed-quality assurance process required for payments, however.
23. Ensure Department contractual obligations regarding the payment of private hospital invoices are met.	The process of verifying surgical and accommodation procedures and bandings claimed by hospitals against different types of classification structure (such as the Medibank Private classifications structure, the APHA classification structure and the international classification of diseases codes) required technical knowledge of complex medical procedures.	Agreed. The Department agrees to remind staff of the time allowed for payment of private hospital accounts.	Claims for payment processed within 28 days.	Action completed.

Recommendation	Intention of Recommendation	DVA Response	DVA Action	ANAO Comments
The Prior Approval and Financial Authorisations Process				
24. Review deficiencies in the current approval arrangements and remedy.	ANAO analysis of data showed that 58% of requests for prior approval were made after the veterans had been admitted to hospital and included admissions to certain country hospitals and emergency admissions for which prior approval was not required. There was scope for the system information to be improved as a management tool.	Agreed. The Department will reissue instructions to remind all delegates to strictly abide by the requirement for prior approval before admission. Amendments will be made to the Prior Approvals Recording System (PARS) to ensure that the actual date of entry is recorded.	New instructions issued and a procedural training package is to be developed.	Partially completed. While performance overall has improved, variations within States requires further review by the Department.
25. Ensure compliance/appropriate documentary evidence for prior approvals recorded on PARS.	Prior approval records, both computer and medical document files, were frequently incomplete and less than 10% of both types of records examined had adequate details of treatment and hospitalisation recorded.	Agreed. See Recommendation 24.	PARS system modified so actual date of entry is recorded.	Action completed.

Recommendation	Intention of Recommendation	DVA Response	DVA Action	ANAO Comments
26. Ensure approvals staff	In several States, administrative	Agreed. The Department	New protocols implemented for	Action completed.

work under medical guidance and all cases be referred to medical officers for decisions.	staff were responsible for giving approval for admission and consequently medical issues associated with the proposed hospitalisation may not have been adequately assessed.	requires that a Medical Officer's opinion must be obtained where a request is rejected.	processing prior approvals. Variations between States noted.	
Quality of Care				
27. Monitor non-accredited hospital performance against criteria set out in Departmental guidelines.	Although departmental guidelines outline the processes to be followed in ascertaining quality of care, these requirements were not implemented and consequently did not provide assurance that Departmental requirements for standard of care, particularly from non-accredited hospitals, had been satisfied.	Agreed. The need for documentation of the performance of non-accredited hospitals will be reinforced as per the Departmental guidelines.	State Offices presently collect and monitor information.	Partially completed. State Office activity on follow up differs - referral to Treatment Monitoring Committees to monitor is recommended (3.39).

Recommendation	**Intention of Recommendation**	**DVA Response**	**DVA Action**	**ANAO Comments**
28. Ensure quality of care criteria and requirements for accreditation are clearly specified in its new form of contract and are mandatory for all State contracts.	At the time of the audit, the Departmental preference for accreditation and quality care arrangements were not clearly specified in contracts. By	Agreed. The Department is considering the introduction of quality of care provisions in its new standardised contract. The development of separate contracts	The HSD includes quality care requirements. The Department has recognised that it is unable to meet its aim of only using accredited hospitals due to smaller and	Action completed

	including these requirements in contracts the department can provide guidance on its requirements and ensure its requirements are known and understood by private hospitals.	for accredited and non-accredited hospitals may be desirable. The Department has the stated aim of only using accredited hospitals by 1995.	remote hospitals not having the means of attaining ACHS accreditation. However the Department is still aiming to increase the proportion of veterans receiving care in accredited hospitals.	
29. Augment ACHS accreditation with relevant quality assurance procedures consistent with recommendations from its health consultant.	In developing its quality of care requirements for private hospitals the departmental consultant recommended the minimum requirement be ACHS standards augmented by other assurance mechanisms to ensure that quality of care requirements were satisfied. These additional mechanisms were not fully adopted by the department.	Not agreed. The Department considers that ACHS accreditation is a viable system for ensuring quality of care for veterans and war widows in private hospitals. The process has been strengthened by the introduction of clinical indicators as part of the accreditation system.	Actual experience is being monitored closely through the extensive National and State Monitoring Committee Network	The intent of the recommendation is satisfied through requirements in the HSD for quality of care information to be submitted by all hospitals not ACHS accredited.

Appendix 2

Changes to DVA Structure and Reporting

DVA is comprised of National Office and six State Offices. In the last 12 to 18 months, the State Offices have been given a greater level of responsibility and autonomy than was applied in the previous program-based structure. Under the previous arrangements, planning and management responsibilities for all DVA programs rested with the part of the department now known as National Office. State Offices reported directly on their performance on particular functions (for example Health) to the area in Central Office responsible for administering that particular program (in this example, the Health Program).

Changed arrangements to DVA were outlined in "A User's Guide to Planning" circulated within Department in August 1996 by the Corporate Development Division. Under changed arrangements Central Office was renamed National Office and took on a coordinating role:

- servicing the Minister and the Repatriation Commission;
- assisting State Offices with information and tools needed to provide high quality client service;
- taking a leading role in the development of appropriate policies, guidelines and standards;
- national accounts and budgets; and
- liaison with national ex service organisations.

The Health Care and Services Division is one of four divisions within National Office and is responsible, amongst other matters, for setting

- national program policies and objectives;
- policy review and evaluation;
- service level standards; and
- performance indicators.

State Offices are responsible for:

- delivery of service to clients (as their primary focus);
- joining with National Office, as partners in the development of policies;
- ensuring that national standards are met, and that policies and procedures are effective;
- State accounts and budgets; and
- liaison with State branches of ex- service organisations.

State Deputy Commissioners (DCs) under the changed arrangements have responsibility for all programs in their State. Managers, or Directors as they are known, in the State offices report directly to the DC, but close liaison with National Office program staff is necessary for successful service delivery.

The changes were intended to give State Deputy Commissioners more responsibility to manage holistic performance for their state in accordance with national guidelines with a reporting line direct to the Secretary (see Figure 6).

Figure 6. Structure and Reporting Relationships in DVA

Appendix 3

Performance Audits In The Veterans' Affairs Portfolio

Set out below are the titles of the reports of the main performance audits by the ANAO in the Veterans' Affairs Portfolio tabled in the Parliament in the past three years.

Audit Report No.28 1993-94

Department of Veterans' Affairs

Use of Private Hospitals

Audit Report No.7 1995-96

Financial Management

Department of Veterans' Affairs

Audit Report No.3 1996-97

Compensation Pensions to Veterans

and War Widows

Department of Veterans' Affairs

Audit Report No.6 1996-97

Commonwealth Guarantees, Indemnities

and Letters of Comfort

Audit Report No.16 1996-97

Payment of Accounts

Audit Report No.21 1996-97

Management of IT Outsourcing

Department of Veterans' Affairs