The Auditor-General
Audit Report No.41 2003–04
Performance Audit

Management of Repatriation Health Cards

Department of Veterans' Affairs

Australian National Audit Office

ISSN 1036–7632

ISBN 0 642 80772 8

Australian National
Audit Office

Canberra ACT
15 April 2004

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in the Department of Veterans' Affairs in accordance with the authority contained in the *Auditor-General Act 1997*. Pursuant to Senate Standing Order 166 relating to the presentation of documents when the Senate is not sitting, I present the report of this audit and the accompanying brochure. The report is titled *Management of Repatriation Health Cards.*

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

P. J. Barrett
Auditor-General

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

AUDITING FOR AUSTRALIA

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Abbreviations

AIS2000	Ad hoc Inquiry System (2000)
AMA	Australian Medical Association
ANAO	Australian National Audit Office
ARIA	Accessibility/Remoteness Index of Australia
Card DB	Card Database
CDB	Client Database
COAST	Change of Address and Simplified Transfers
DMIS	Departmental Management Information System
DVA	Department of Veterans' Affairs
ESO	Ex-Service Organisation
HIC	Health Insurance Commission
HIPS	Health Information and Payments Section
IMS	Information Management System
IT	Information Technology
LMO	Local Medical Officer
MBS	Medicare Benefits Schedule
MoU	Memorandum of Understanding
NTEL	Not Eligible (a code used in processing pharmaceutical claims)
PBS	Pharmaceutical Benefits Scheme
PCC	Pensioner Concession Card
RCCS	Repatriation Comprehensive Care Scheme
RGH	Repatriation General Hospital
RPBS	Repatriation Pharmaceutical Benefits Scheme
RPPS	Repatriation Private Patient Scheme
RSL	Returned & Services League of Australia
TEC	Treatment Eligibility Code
TP RARA	Treatment Population Statistics in Rural and Remote Areas

TPS	Treatment Population Statistics
UIN	Unique Identification Number
VEA	*Veterans' Entitlements Act 1986*
VIEW	Veterans' Information Enquiry Window

Glossary

Department of Veterans' Affairs	The Department of Veterans' Affairs (DVA) provides administrative support to the Repatriation Commission in discharging its responsibilities to veterans and other entitled people. DVA's Internet site can be found at http://www.dva.gov.au.
Ex-Service Organisations	DVA maintains a policy of partnership with the Ex-Service Organisations (ESOs). Deputy Commissioners in the State Offices are encouraged to develop close relationships with the local ESOs. This close liaison with the veteran community is essential to ensure that the views of veterans and their dependants are heard and their needs met.
Local Medical Officer	A Local Medical Officer is a general practitioner who is registered with DVA, and who participates in the Repatriation Comprehensive Care Scheme to provide and coordinate medical services for eligible veterans.
Repatriation Commission	The Repatriation Commission is responsible under the *Veterans' Entitlements Act 1986* (VEA) for granting pensions, allowances and other benefits, and providing treatment and other services through community facilities to veterans, their dependants and other eligible persons. The Commission also provides advice to the Minister on matters relating to the Act's operation and, subject to the Minister's control, generally administers the Act.
Unique Identification Number	The department allocates a Unique Identification Number (UIN) to clearly distinguish between clients.
Client file number	The department organises client information within a State-based file number system. A separate file is commenced each time a veteran makes a claim under the VEA. As the file numbers incorporate a State identification code, a new file number is issued whenever a client moves interstate.

Data integrity

In this audit the term 'data integrity' is used to refer to the consistency and accuracy of information across client records. DVA clients may have more than one file number. Often the client information is duplicated across these records and the different file numbers for a client should be cross-referenced.

Clients should have only one UIN. If client information is fragmented across two or more unrelated records, this reduces the integrity of the data holdings and introduces risks to the efficient and effective administration of the health card system.

Summary and Recommendations

Summary

1. The Department of Veterans' Affairs (DVA) administers the Repatriation health card system. This audit considered DVA's administration of the cards and the arrangements under which veterans have access to primary health care services. It also examined the accuracy and integrity of extensive electronic data holdings that support DVA's management of the card system. As a result of this audit, the ANAO made five recommendations designed to assist DVA to improve the efficiency and effectiveness of the Repatriation health card system.

2. Over 330 000 veterans, war widows and widowers and eligible dependants are entitled to a range of health services and medical treatment under the *Veterans' Entitlements Act 1986* (VEA). DVA has implemented a system of health cards—Gold, White and Orange Cards, which:

- identify the clients and the level of health care coverage to which they are entitled; and
- serve as a primary vehicle for health providers to claim for the services delivered to veterans—in much the same way as a Medicare Card.

3. DVA has established the Local Medical Officer (LMO) Scheme, within which participating general practitioners provide primary health care services to entitled DVA clients. Similarly, a set of treatment arrangements applies to medical specialists and allied health providers, who agree to treat DVA clients. DVA has also devised a three-tier arrangement with a significant number of public and private hospitals throughout Australia, for the treatment of DVA clients.

4. If a client is deemed eligible under the VEA, he or she is issued with a Repatriation health card, along with information about how to use the card to access health services. Participating health care providers then use the information embossed on the card to claim payment for services delivered to the DVA client. The Health Insurance Commission (HIC) processes claims for medical and pharmaceutical services, on behalf of DVA. HIC also produces and distributes the cards.

5. DVA and HIC employ a number of sophisticated Information Technology (IT) systems in support of the Repatriation health card system. DVA maintains an extensive database of client information and, through the HIC's processing systems, collects a considerable amount of data on card usage. The aggregated data is used by DVA to monitor expenditure; plan future expenditure; predict trends in the DVA treatment population; and to generally monitor the operation of the health card system.

6. Over 12 million medical services were provided to the treatment population in 2002–03, along with around 15 million pharmaceutical items and some 380 000 hospital separations.[1] The total administered expenditure for these services in that year was approximately $2.5 billion.

7. The objective of the audit was to examine DVA's implementation of the Repatriation health card system, which aims to ensure that veterans can obtain health care through community-based providers and facilities.

8. The audit addressed two major administrative criteria. These were, that:

- DVA effectively administers the system of Gold, White and Orange Repatriation health cards; and
- DVA's LMO arrangements facilitate access to primary health care services for Gold and White Card holders.

[1] 'Hospital separations' refers to the number of distinct episodes of hospitalisation. For example, a patient might be admitted to hospital on three separate occasions during the year. The figures include services delivered in Day Procedure Centres.

Key Findings

Administration of health cards

The issue, replacement and cancellation of Repatriation health cards are generally well managed by DVA. A sound set of administrative controls is in place. However, ANAO identified some scope for DVA to improve the controls associated with claims processing and, thereby, improve the efficiency of card administration.

9. Within DVA's IT systems, determinations made on compensation or pension matters for a client trigger the issue of a health card where eligibility criteria are met. The process is automated and results in HIC producing a batch of health cards on a weekly basis.

10. ANAO found that DVA managed the bulk replacement of expired Repatriation health cards well. DVA's quality assurance activities in this regard were sound and appropriate, as was the sensitivity demonstrated by manually extracting replacement cards for recently deceased veterans, prior to the bulk mailing of cards.

11. DVA had implemented effective controls in relation to the cancellation of health cards. A Treatment Eligibility Code (TEC) and date of death indicator were used to convey important information to HIC about the processing of claims against such cards.

DVA should consider the introduction of additional controls on the use of White Cards to obtain pharmaceutical benefits, as ANAO found the current lack of system level controls exposes the Commonwealth to a slight risk—although the amounts involved are likely to be small.

12. ANAO found that a combination of administrative and IT system level controls help to ensure that only appropriate health and medical services are claimed against White Cards.[2] However, in the case of the claim processing systems for pharmaceutical benefits, only administrative controls exist. ANAO found that this situation exposes DVA to a risk of having some administered expenditure recorded against the Repatriation Pharmaceutical Benefits Scheme (RPBS), when it should more appropriately be recorded against the Pharmaceutical Benefits Scheme (PBS). ANAO also found a slight risk that some White Card holders may gain a financial benefit to which they are not entitled.

The processing of pharmaceutical benefits claims, using Pensioner Concession Cards (PCCs) issued by DVA—which are not a type of Repatriation health card—results in

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[2] Unlike Gold Cards, which provide access to medical treatment for all conditions, White Cards entitle the card holders to treatment for specific illnesses or conditions, accepted by DVA as being service-related.

DVA incurring expenditure that is recorded against the RPBS, whereas the expenditure should, more properly, be recorded against the PBS.

13. ANAO confirmed DVA's analysis that pharmaceutical benefits paid against PCCs could amount to some two per cent of annual RPBS expenditure. Once again, ANAO found that such expenditure should be recorded against the PBS, rather than the RPBS.

Performance information on health cards

DVA generates and publishes a wide range of statistics relating to the veteran population and uses this information to administer the health card system and inform decision-making within the department.

14. DVA regularly compiled statistics on the treatment population—its composition, geographic distribution, age profile and use of health services—and employed these in its business management activities. ANAO identified a small error in the procedures used to generate the Treatment Population Statistics, which DVA promptly rectified.

Data integrity

DVA uses a Unique Identification Number (UIN) to distinguish between clients on its electronic databases. ANAO found that up to two per cent of clients in the treatment population had been issued with more than one UIN, either replicating or fragmenting the client's information across multiple records.

15. ANAO's analysis of DVA's data revealed that some 6222 health card holders, out of a treatment population of around 330 000, had been issued with two or more UINs. Furthermore, 94 of these people had been issued with two health cards and one person had been issued with three health cards. ANAO considers this situation represents a risk to the integrity of performance information on the health card system, although it is unlikely to impact significantly on client service.

Some DVA clients with multiple UINs were receiving two pharmacy allowance payments. ANAO identified a risk to the efficient administration of payments to veterans, caused by the fragmentation of client information across two UINs or two unlinked files.

16. Although the number of duplicate payments was small, these cases point to another inherent weakness of the card system, that is, when clients' information is fragmented. While this audit only considered the payment of pharmaceutical allowances, ANAO encouraged DVA to investigate possible duplicate pension payments.

The situation where clients have multiple UINs introduces the risk of recording inconsistent information across client records. ANAO found that the date of a client's death had been inconsistently recorded in up to 4582 cases.

17. ANAO's analysis identified over 4500 cases of clients with a date of death entered on their record under one UIN, but no date of death entered on their record under another UIN. Of these, ANAO identified 23 clients who had been issued with two health cards—under two different UINs—and had a date of death entered on one record only. With one UIN still active, a replacement health card would be sent to those deceased veterans when the previous card expired. DVA has indicated that, as part of its long term data clean-up process, it will institute additional measures to avoid sending replacement health cards to deceased veterans.

ANAO found that a relatively small number of DVA clients have been issued with both Gold and Orange Cards.

18. The Gold Card affords the card holder access to the full range of medical and pharmaceutical benefits under the RPBS. The Orange Card provides access to pharmaceutical benefits only. Therefore, the Orange Card is of no additional value to a Gold Card holder; the practice of issuing both cards to eligible clients introduces an administrative inefficiency. ANAO identified 63 DVA clients in this category. DVA has agreed to implement measures to prevent a Gold Card holder being issued with an Orange Card.

ANAO's analysis of DVA's client data revealed a number of errors and anomalies in the recording of dates of birth and death. These anomalies have the potential to impact adversely on DVA's statistical analyses and any decisions based on, or reliant on, these data.

19. Analysis of date of birth and date of death data revealed examples of erroneous entries—such as eight clients with the same date recorded for both their date of birth and date of death; 66 veterans who would have been over the age of 150 years at the time of their death, according to their recorded dates of birth and death; and 54 veterans who were identified as having served in World War 1 or World War 2, but with date of death recorded prior to 1914. ANAO considers that, while the obvious errors are relatively easy to identify and rectify, the existence of these anomalies points to a potentially more extensive problem with the integrity of date of birth and date of death data, stored on DVA's client database.

DVA conducts a series of regular checks on data integrity. However, these tend to concentrate on client records that have recently been amended. ANAO found that DVA had not conducted a comprehensive analysis of data integrity across its entire client database.

20. ANAO found that DVA regularly conducted up to 40 separate checks on specific aspects of data integrity, searching for anomalies in client entitlements or treatment eligibility. These often concentrated on client records affected by a reassessment of pension entitlements or focussed on clients whose multiple UIN records had recently been merged.

21. ANAO also noted that DVA had undertaken some work to merge suspected multiple UINs identified by HIC.

State-based file numbers

DVA's implementation of a State-based file number system was less than ideal and had contributed to many of the data anomalies identified in this audit.

22. In addition to UINs, DVA organises client information according to a State-based file number system. Each time a client lodges a new claim or moves interstate, he or she is issued with a new file number. File numbers, not UINs, are embossed on the clients' health cards. In the case of interstate transfers, the old health card is recalled and a replacement card, bearing the new file number, is issued.

23. ANAO found that, until recently, the manner in which the transfer of client data was handled contributed to the creation of multiple UINs for clients moving from State to State. ANAO also found that, even when a client was correctly identified under his or her UIN, client information was still inconsistently recorded across records, under different file numbers.

24. In 2002, DVA introduced a series of enhancements to simplify the interstate transfer process and improve the quality of data exchanged across a client's various file numbers. ANAO found that the COAST[3] project had significantly reduced the opportunity for issuing clients with multiple UINs.

Access to Local Medical Officers

DVA's LMO arrangements facilitate a good level of access, for entitled veterans and their dependants, to general practitioner services.

25. According to DVA, there were 14 481 LMOs registered with the department, at 7 November 2003. DVA maintained a good level of awareness of the geographic distribution of its treatment population, LMOs and of other medical service providers. Statistical reports, such as the Treatment Population Statistics—Rural and Remote Areas, provide valuable information to DVA managers. These enable them to provide timely support to veterans experiencing difficulty in accessing health services.

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[3] Change of Address and Simplified Transfers.

Access to specialists

Veterans and their entitled dependants had a reasonable level of access to medical specialist services, although the proportion of specialists prepared to accept the Repatriation health cards has decreased by approximately four per cent over the past twelve to eighteen months.

26. ANAO found that DVA maintained a good level of awareness of the shortage of particular specialist services in some States. ANAO also observed that, whenever DVA became aware of veterans experiencing difficulty in accessing specialist services, it had acted appropriately to support veterans in locating alternative providers, including the provision of transport when necessary.

27. DVA also acted properly whenever it became aware of specialists planning to charge veterans a co-payment. DVA reminded the specialists concerned that such practice is not permitted under DVA's treatment arrangements. That is, a condition of accepting the Repatriation health card is that no co-payment is levied on the patient.

28. DVA advised ANAO that the task of providing specialist services to veterans in regional areas, where specialist numbers are smaller and alternative specialists harder to find, will become increasingly difficult if many more specialists withdraw their services to veterans.

Access to hospitals

DVA's arrangements with a range of public and private hospitals, including Veteran Partnering hospitals, afforded a good level of access for veterans requiring hospitalisation.

29. Veterans are able to access around 750 public hospitals across Australia. In addition, DVA has contracted over 400 private hospitals and day procedure centres, and organised these within a three-tier structure. Treating doctors do not require prior approval to admit Repatriation health card holders to Tier 1 (public, Veteran Partnering and former Repatriation General) hospitals. If considered necessary, doctors may seek prior approval to admit DVA patients to Tier 2 (contracted private) hospitals or Tier 3 (non-contracted private) hospitals.

Monitoring client satisfaction

DVA maintains a productive and consultative relationship with a number of Ex-Service Organisations (ESOs). ANAO found that ESOs were generally supportive of DVA and the Repatriation health card system.

30. DVA regularly conducts a client satisfaction survey and, in 2002–03, reported a 99 per cent client satisfaction level. ANAO surveyed 24 ESOs

during this audit and found that, while some ESOs reported examples of members experiencing difficulty in accessing LMO or specialist services, most were satisfied that DVA had acted to support the veterans and to achieve an appropriate health care outcome for those concerned.

Reliability of LMO numbers

DVA could improve its capacity for providing accurate and reliable counts of the number of LMOs registered at any one time.

31. ANAO experienced difficulty in obtaining accurate and reliable information on LMO participation rates. LMO information is stored on a range of different databases. This in itself is not a problem, as they are used for different purposes. However, ANAO noted a lack of consistency across these, as well as errors in the processes used to extract summary figures.

32. Although difficult to verify, the number of registered LMOs appears to have remained relatively stable over the past five years. However, some variation in the participation rate occurred in 2002–03.

Overall audit conclusion

33. DVA's administration of the Repatriation health card system is generally sound. The cards readily identify a level of health care to which individuals are entitled under the VEA. They facilitate veterans' access to community-based health services and serve as a means by which health care providers can claim for services delivered to veterans. Most of the controls associated with health card administration and claims processing are well defined and consistently implemented. However, ANAO identified a number of areas in which controls should be strengthened.

34. Extensive electronic information holdings support DVA's administration of the health card system. ANAO identified a number of weaknesses in DVA's current data management activities. The fragmentation of clients' information across unrelated electronic records introduces a risk to the efficient administration of the card system. ANAO found that this situation applied to approximately two per cent of the treatment population. The audit revealed scope to improve the accuracy and integrity of DVA's data holdings, necessary for sound performance.

35. Repatriation health card holders enjoy a good level of access to medical and hospital services. DVA's arrangements with LMOs, public and many private hospitals provide entitled veterans with a relatively straightforward means of obtaining necessary health services. Health card holders also enjoy a reasonable level of access to medical specialist services. Where required, DVA assists veterans to locate alternative providers and arranges necessary transport.

DVA's response (summary)

36. DVA's full response to the audit may be found at Appendix 3. DVA also provided a summary of the full response. This summary appears below.

37. *DVA agrees with the overall ANAO finding that the administration of the Repatriation health card system is generally sound. DVA believes that this conclusion highlights our ongoing success in one of our key result areas—effective business performance, as stated in DVA's Corporate Plan.*

38. *As a general comment on the report, DVA agrees with the findings and broadly agrees with the recommendations made in the report. Four of the five recommendations focus on data integrity issues at the corporate level. DVA is of the view that the data supporting the payment of veterans' entitlements is complete and ensures accurate service delivery. DVA acknowledges that data cleansing would address the data integrity issues in legacy systems, but given the significance of the work required believes this can best be accommodated, as legacy systems are removed/redeveloped.*

Recommendations

Recommendation No.1 Para 2.44

The ANAO recommends that DVA develop a service level agreement with HIC for the processing of RPBS claims. The service level agreement should facilitate a claims processing environment that establishes adequate controls over the payment of RPBS benefits to eligible clients. In particular, the agreement should include reference to appropriate controls over RPBS claims made against White Cards and Pensioner Concession Cards issued by DVA.

***DVA's response**: Agreed.*

Recommendation No.2 Para 4.77

The ANAO recommends that DVA conduct a thorough assessment of the integrity and accuracy of data held on the Client Database and Card Database, with a view to:

- identifying and merging records for clients with multiple UINs;
- resolving anomalies in date of birth and date of death data entries; and
- identifying and eliminating inappropriate duplicate payments to clients, whether under multiple UINs or inadequately cross-referenced file numbers.

***DVA's response**: Agreed.*

Recommendation No.3 Para 4.79

The ANAO recommends that DVA implement appropriate measures to prevent Commonwealth and Allied veterans being issued with both Orange and Gold Cards.

***DVA's response**: Agreed.*

Recommendation No.4 Para 4.81

The ANAO recommends that DVA re-assess its various methods of client identification, with a view to eliminating the current State-based file number system in favour of a truly unique client identification system, capable of managing comprehensive client information effectively.

***DVA's response**: Agreed in principle.*

Recommendation No.5 Para 5.46

The ANAO recommends that DVA improve its capacity to report accurate and reliable information relating to the number of LMOs registered at any given time.

***DVA's response**: Agreed.*

Audit Findings and Conclusions

1. Introduction

This Chapter describes some of the main features of the Repatriation health card system, which is administered by DVA. It also outlines the arrangements DVA has implemented to help ensure that entitled veterans and their dependants have access to necessary health services. The Chapter concludes with a brief description of the audit approach.

Background

1.1 Australia has a proud tradition of caring for its war veterans. Since its establishment under the *Australian Soldiers' Repatriation Act 1920,* the Repatriation Commission has provided services to Australian veterans, war widows and widowers and their dependants.[4]

1.2 Today, the Repatriation Commission is responsible for the general administration of the VEA. The functions of the Repatriation Commission include the granting of pensions, allowances and other benefits, arranging for the provision of treatment and other services, and providing advice to the responsible Minister on matters relating to the Act's operation.[5]

1.3 DVA provides administrative support to the Repatriation Commission in discharging its responsibilities to veterans and other entitled people.[6] Within DVA's Outcomes/Outputs framework, Outcome 2 states:

> Eligible veterans, their war widows and widowers and dependants have access to health and other care services that promote and maintain self-sufficiency, well-being and quality of life.[7]

1.4 Under the VEA, eligible veterans and their dependants may be entitled to receive certain health care services. To administer these entitlements, and to provide a mechanism for veterans to access these services, DVA has established a system of health cards. This is supported by complex IT systems, containing personal information on clients, controlling the issue and cancellation of cards and processing the payment of claims against the cards.

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4 When this Act and several other related Acts were replaced in 1986 by the *Veterans' Entitlements Act 1986*, the Repatriation Commission was retained.

5 Department of Veterans' Affairs, Annual Report 2002–03, p. 1.

6 ibid. For a more detailed description of the relationship between the Repatriation Commission and DVA refer to the relevant annual reports. These are published in the one volume, along with the annual report of the National Treatment Monitoring Committee.

7 ibid., p. 63.

Repatriation health cards

1.5 Three types of health card identify the level of health care coverage to which a card holder is entitled. These are usually referred to as the Gold, White and Orange Cards. Appendix 1 outlines the eligibility criteria for the three health cards.

1.6 The Gold Card—Repatriation Health Card For All Conditions—entitles eligible veterans and dependants to treatment and care for all medical conditions, regardless of whether they are service-related.[8]

1.7 The White Card—Repatriation Health Card For Specific Conditions—entitles eligible veterans to treatment and care for conditions that are accepted as service-related.[9]

1.8 The Orange Card—Repatriation Pharmaceutical Benefits Card—provides eligible British, Commonwealth and Allied veterans with access to RPBS items at concessional rates.[10]

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[8] On 1 January 1996, the Personal Treatment Entitlement Card, Service Pensioner Benefits Card and the Dependant Treatment Entitlement Card were amalgamated into the Gold Card.

[9] On 1 January 1996 the Specific Treatment Entitlement Card was replaced with the White Card. The White Card is also issued to all Australian veterans suffering from malignant neoplasia, pulmonary tuberculosis, post-traumatic stress disorder and anxiety disorder (Vietnam veterans only), regardless of whether these conditions are service-related.

[10] The Orange Card was introduced on 1 January 2002. It is available to British, Commonwealth and Allied veterans who have qualifying service from World War 1 or World War 2, are 70 years of age and over and have been resident in Australia for at least 10 years. Section 5C(1) of the VEA defines 'Commonwealth country' to mean a country (other than Australia) that is, or was at the relevant time, a part of the Dominions of the Crown.

Figure 1.1

Number of Repatriation health card holders as at 30 June 2003

227 747 Gold Cardholders 57 413 White Cardholders

Giving a total treatment population of 335 160

20 672 Orange Cardholders
(pharmaceutical benefits only)

Source: DVA Annual Report 2002–03.

1.9 Some 12.4 million medical services were provided to the treatment population in 2002–03, an increase of 4.2 per cent on the number in the previous year. The cost of medical services for 2002–03 was $630 million, up 5.7 per cent on the previous year's figure. The average cost per medical service was $50.68, up 1 per cent on the previous year's cost.

1.10 In 2002–03, DVA spent $1.45 billion on private and public hospital services for the treatment population, an increase of some 10 per cent on the expenditure in 2001–02. Private hospital separations increased 5.5 per cent to 237 090, while public hospital separations remained relatively steady at 143 360.

1.11 Some 15.4 million pharmaceutical items were dispensed to entitled veterans during 2002–03, accounting for a total expenditure of $417 million, with an average cost per pharmaceutical service of $27.16. Compared to the 2001–02 results, this represents an increase of 7.9 per cent for items dispensed

and 10.8 per cent for total expenditure. The statistics for pharmaceutical services relate to all cards.[11]

Local Medical Officers

1.12 The LMO Scheme was established in 1918 to provide local general practitioner services to eligible veterans, war widows and widowers and their dependants. The purpose of this scheme was to recognise the important role that general practitioners played in coordinating care for veterans.

1.13 General practitioners wishing to participate in the scheme must apply to register as LMOs. The terms and conditions of registration are outlined in the DVA publication *Notes for Local Medical Officers*.[12] Following consultation with the Australian Medical Association (AMA) and a review of the LMO Scheme in 1995, DVA introduced the Repatriation Comprehensive Care Scheme (RCCS) from January 1996.

1.14 The RCCS was supported by a Memorandum of Understanding (MoU) between the AMA and the Repatriation Commission. The RCCS introduced a number of initiatives including an increased fee loading for registered LMOs.

1.15 The initial MoU operated for a period of three years and was then renewed, to expire in December 2002. The MoU was not renewed at this time, although the arrangements were extended, with the agreement of LMOs, until 30 June 2003.

1.16 In May 2003, a new three-year agreement, to take effect from 1 July 2003, was offered to LMOs. The new agreement included increased remuneration for LMOs treating members of the veteran community.[13] Chapter 5 of this report considers LMO participation rates since the introduction of the RCCS.

1.17 The *Notes for Local Medical Officers* outline the LMO's obligations under the RCCS. Key among these are for an LMO to:

- demonstrate a commitment to multidisciplinary integrated hospital discharge planning for the care of veterans;

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[11] While Orange Cards provide access to pharmaceutical benefits only, the Gold and White Cards provide card holders with access to medical services and pharmaceutical benefits under the RPBS.

[12] Available at DVA's Internet site: <www.dva.gov.au/health/provider/lmo/notes>.

[13] A 2003–04 Budget initiative provided $61.7 million over four years to fund the introduction of a veteran access payment of $3 for each service, provided by LMOs, to eligible veterans and dependants. Source: Portfolio Budget Statements 2003–04, Department of Veterans' Affairs (Defence Portfolio), Budget Related Paper No. 1.4B, p. 44.

- prepare multidisciplinary care plans, health assessments and case conferences for veterans identified as having chronic and/or complex conditions;
- demonstrate a commitment to medication reviews for veterans who are at risk of medication related problems;
- arrange transport for appointments through DVA, at the request of a veteran, and issue taxi vouchers when required;
- accept DVA fees as full payment for services provided and levy no additional fees; and
- where clinically appropriate, refer veterans to specialists who accept DVA arrangements, including fees, and do not levy additional fees on the veteran.

1.18 LMOs play an important role in ensuring that veterans have access to necessary medical specialist and hospital services. LMOs may refer veterans to medical specialists who accept DVA's payment arrangements. When necessary, and in accordance with guidelines contained in the Repatriation Private Patient Scheme (RPPS), LMOs and/or specialists may admit veterans to hospital.

1.19 DVA has established a comprehensive set of arrangements, under the RPPS, with a large number of private and public hospitals across Australia. These arrangements are explained in more detail in Chapter 5 of this report.

The audit

Audit objective

1.20 The objective of the audit was to examine DVA's implementation of the Repatriation health card system, which aims to ensure that veterans can obtain health care through community-based providers and facilities.

1.21 The audit addressed two major administrative criteria. These were, that:

- DVA effectively administers the system of Gold, White and Orange Repatriation health cards; and
- DVA's LMO arrangements facilitate access to primary health care services for Gold and White Card holders.

Audit scope

1.22 The audit examined DVA's procedures and controls associated with the issue, maintenance and cancellation of health cards. We also tested the

accuracy and integrity of DVA's information holdings, and examined the use made of performance information on health cards. We then considered the likely impact of inaccurate or anomalous data on the various uses to which the data is put by DVA.

1.23 The audit also examined how arrangements under the RCCS and the RPPS facilitated access to health care services for entitled veterans and their dependants. In this regard, the audit concentrated on the LMO Scheme for general practitioner services and referrals to medical specialists, and DVA's arrangements with public and private hospitals.

1.24 The audit did not assess the policy or procedures for determining eligibility for health cards, nor did it consider the quality or appropriateness of health services provided to veterans. Rather, it concentrated on the administration of health cards, once they had been issued to veterans, and the levels of access to health services afforded by the cards.

1.25 DVA issues Pensioner Concession Cards to all service pensioners, age pensioners who receive their pension through DVA and war widows and widowers receiving an income support supplement. A PCC issued by DVA has the same status as a PCC issued by Centrelink. It is proof that the card holder receives a means tested pension and is eligible to receive certain concessions. A PCC is **not** a type of Repatriation health card, although it does entitle the card holder to pharmaceuticals under the PBS (but not the RPBS) at the concessional rate. The audit considered the matter of some pharmaceutical benefits processed against PCCs resulting in administered expenditure being recorded against the RPBS, rather than the PBS.

Audit methodology

1.26 The audit team collected evidence from a variety of sources, including:

- a scan of relevant legislation, in particular the VEA;
- DVA policy documentation relating to health card administration, sourced from the DVA Intranet;
- additional policy and procedural documents sourced from DVA staff;
- selected departmental files;
- selected reports on card administration provided to DVA by HIC;
- a visit to HIC to witness a card production run and DVA quality assurance procedures in practice;
- documentation of IT systems architecture relating to DVA's Card Database;

- interviews with around 35 to 40 DVA staff in National Office and 10 to 15 in each of the Victorian and Queensland State Offices;
- interviews with members of ESOs, such as the Returned & Services League of Australia (RSL) and the War Widows' Guild of Australia; and
- written comments from a number of other ESOs, including the Naval Association of Australia, Australian Commando Association, Submarines Association, National Association of Extremely Disabled War Veterans, Regular Defence Force Welfare Association, Korea and South East Asia Forces Association of Australia and the Rats of Tobruk Association.

1.27 In addition, we took a number of reports and extracts of data from DVA's Client Database (CDB). These were sourced through the department's Ad hoc Inquiry System (AIS2000). We then conducted a series of analyses to test the completeness, consistency and integrity of data held on the CDB.

1.28 Audit fieldwork was conducted over the period August to November 2003. The audit was conducted in accordance with ANAO auditing standards at a cost of $290 000.

Other relevant audits

1.29 Previous audit reports containing information relevant to DVA's management of veterans' health services include:

- ANAO Audit Report No.37 2001–02, *Purchase of Hospital Services from State Governments Follow Up Audit*;
- ANAO Audit Report No.29 1999–2000, *Administration of Veterans' Health Care*;
- ANAO Audit Report No.40 1997–1998, *Purchase of Hospital Services from State Governments*;
- ANAO Audit Report No.28 1996–1997, *Use of Private Hospitals*; and
- ANAO Audit Report No.6 2002–03, *Fraud Control Arrangements in the Department of Veterans' Affairs.*

Structure of this report

1.30 This Chapter provides some general background to the health card system, LMO Scheme and the conduct of the audit.

1.31 Chapter 2 examines DVA's administration of the card system, in particular, controls associated with the issue, maintenance and cancellation of

health cards and DVA's management of some controls surrounding the payment of claims against the health cards.

1.32 Chapter 3 examines performance information on the treatment population and card usage patterns, and DVA's use of this information.

1.33 Chapter 4 reports on ANAO's examination of the integrity of data held on DVA's clients. It then explores the likely impact of data integrity problems on DVA's business, in particular, the administration of the health card system.

1.34 Chapter 5 reports on DVA's arrangements for facilitating veterans' access to primary health care services—LMOs, specialists and hospitals. It also examines the reliability of LMO statistics.

1.35 Appendices include information on card eligibility criteria and a listing of DVA's statistical publications. DVA's response to the audit is also included as an appendix.

2. Issue, Maintenance and Cancellation of Health Cards

This Chapter discusses the systems supporting DVA's automated issue and replacement of health cards, including the four-year cycle for the bulk replacement of cards. It also discusses the cancellation of cards and the controls associated with the payment of claims against the cards—particularly the payment of pharmaceutical claims against White Cards and Pensioner Concession Cards.

Automated issue/replacement of health cards

2.1 If a veteran or dependant meets the eligibility criteria, DVA issues him or her with a health card. The criteria are contained within the VEA and associated legislation. Appendix 1 describes the eligibility criteria for Repatriation health cards.

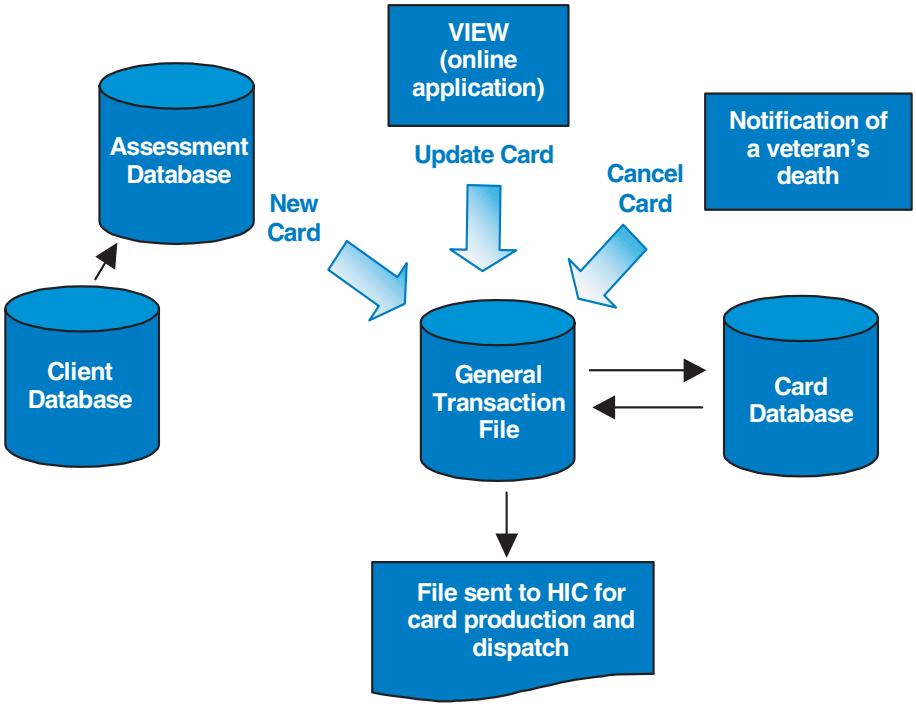
2.2 DVA's IT systems support the various functional areas within the department, for example, compensation and income support, and health services. These IT systems are linked and share information about DVA's clients.[14] When a client applies for a service pension, compensation pension or other entitlement, DVA staff assess these applications and make a series of determinations under the VEA. The IT systems use the results of these determinations to test for eligibility for a health card. When a client is deemed eligible, a process is initiated to generate the appropriate health card.

2.3 Figure 2.1 illustrates the major elements of the card generation process.

[14] DVA uses the term client to refer to a veteran, war widow, war widower, spouse, de facto, child or parent of a veteran whose information is stored in a record on the CDB. Their relationship to the veteran is noted within the record.

Figure 2.1

Health card generation



Source: Material provided by DVA Health Applications Projects Section.

2.4 If DVA's Compensation Claims Processing System results in a determination, this sets an electronic flag on the client's record in the Client Database. Information is then passed to the Assessment Database, where eligibility for a health card is determined. A successful assessment sends a 'new card' transaction to the General Transaction File.

2.5 DVA staff use a corporate application, called VIEW, to search, retrieve and update client details.[15] VIEW permits DVA staff to enter or amend data, for example, to change a client's address. DVA staff can also use VIEW to request a replacement card should the client's card be lost or stolen. Whenever this occurs, a 'card update' is posted to the General Transaction File.

2.6 Whenever DVA is notified of the death of a veteran, relevant information is passed to the General Transaction File in order to 'cancel' the card. This also stops the payment of medical claims, which might be lodged against the card of a deceased veteran.

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[15] VIEW stands for Veterans' Information Enquiry Window.

2.7 The General Transaction File exchanges information with the Card Database and then generates a number of electronic files that are transmitted to HIC on a weekly basis. These contain the data to be embossed on the cards—card holder's name, file number and expiry date—along with information for use in the postal carrier that will receive the card, such as the name and postal address of the card holder.

2.8 HIC dispatches cards directly to clients. HIC also sends regular reports to DVA, detailing the number of cards produced and dispatched in each run. These reports are received in the Health Information and Payments Section (HIPS) of DVA.[16]

2.9 DVA relies on HIC's quality assurance procedures to reconcile the number of cards produced with those dispatched. Indeed, this is one of the services specified in the *Services Agreement* between the two organisations. Consequently, DVA does not conduct a detailed reconciliation of cards requested—using the data sent from the DVA General Transaction File—and those reported as issued by HIC. DVA conducts a visual inspection of the total number of cards reported to have been produced by HIC and the number of cards for which HIC invoices DVA each month.[17]

Bulk replacement of health cards

2.10 DVA health cards have an expiry date printed on them and are reissued every four years. Rather than attempting to replace all health cards at the one time, DVA reissues cards for each State, about a month apart, over a period of six months. This practice also affords DVA and HIC the opportunity to schedule the procedures to fit in with other system and processing activities.

2.11 The procedure for the bulk replacement of cards varies from that employed on a week-to-week basis. For bulk reissues, HIC requires advance notification of an upcoming high volume run.[18] DVA provides HIC with a set of data files containing details for the replacement cards. Processing a bulk run takes more time than the usual weekly card production run, in some cases up to two to three weeks from the time DVA extracts the data from its IT systems to the cards being dispatched from HIC. After the cards have been produced by HIC, but before they are dispatched, DVA retrieves information on veterans who have died in the intervening two or three weeks.

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[16] For example, the DVA Run (No.) Card Issue Control Report—incorporating a Card Issue Extract Control Report, a Card Issue Format Control Report and a Search/Card Number Checklist.

[17] While it may be reasonable for DVA to rely, to a large extent, on HIC's quality assurance procedures, it is also reasonable for DVA to conduct an occasional reconciliation of cards requested (sourced from DVA's own electronic records) and cards produced (as reported by HIC).

[18] Advance notice is required to ensure that sufficient blank cards and postal carriers are on hand for a bulk reissue. HIC also needs to allocate sufficient time and resources for the extraordinary production run.

2.12 A DVA staff member visits the card production facility at HIC and manually extracts the replacement cards for these deceased veterans. There may be up to 20 or so replacement cards, for one of the larger States, extracted in this process. At the same time, he or she performs a quality control check, by selecting envelopes at random to ensure the name on the card matches the name on the postal carrier and that the card holder's details are correctly recorded on the card.

2.13 ANAO found the quality assurance procedures, in connection with the bulk reissue of health cards, to be sound and appropriate. ANAO also notes the sensitivity employed in efforts to manually extract cards for recently deceased veterans.

Cancellation of health cards

2.14 A client's eligibility for a health card may change due to a change in his or her circumstances. When such a change results in the client no longer having an entitlement to a health card, staff in the relevant DVA State Office may initiate a card recall process. This involves writing to the veteran requesting the destruction or return of the card. At an IT systems level, DVA staff update the client's record, modifying the eligibility status, and thereby cancelling the card.

2.15 When DVA is notified of the death of a veteran, a date of death is entered on the veteran's record in the CDB. DVA staff also amend the records to cancel any health card issued to the veteran, and request the family of the veteran to destroy or return the card.

2.16 Regardless of the destruction or return of a card, HIC and DVA rely on a series of IT system controls to ensure that claims for payment against a particular card are not processed. The two key controls are the Treatment Eligibility Code and date of death.

2.17 As an example of the first control, a client's TEC might be changed to 'Not Eligible' on a certain date, resulting in HIC rejecting all claims pertaining to that card after that date. With the second control, HIC's claims processing systems reject claims against a card with a date of death appearing on the client's record.

2.18 These claim rejections are notified to DVA for appropriate follow-up action. This involves a manual intervention on the part of DVA staff. For example, a claim might legitimately be paid for a doctor issuing a certificate of death, but perhaps not doing so until the day after the veteran died.

Expiry dates

2.19 As noted earlier, each health card incorporates an expiry date. This date is embossed on the face of the card and stored as part of the client's record on the CDB. However, the expiry date is not employed as a control for the payment of claims. That is, HIC will continue to process claims against a card which has passed its expiry date, provided the client's record includes a valid TEC and does not contain a date of death.

2.20 During the audit, ANAO discussed the matter of veterans' use of out of date health cards with DVA staff involved in the administration of cards. However, we did not conduct a detailed analysis of claims paid against out of date cards. ANAO considers that knowledge of the use of out of date cards would prove valuable to DVA in a number of respects. Firstly, as the approach of an expiry date triggers a replacement card, the continued use of an expired card may be an indicator that a veteran has changed address or not received the replacement card. DVA would then be aware of the need to update the client's records or initiate appropriate follow-up action.

2.21 If both the expired card and the replacement card were being used to access health services but in separate localities, identified using the postcode of the service providers, it may indicate that one of the cards has been passed to a third party. There is then a risk of fraudulent use of the health card.

2.22 Given the current level of controls associated with TEC and date of death, ANAO is not suggesting additional IT controls to prevent claims processing against cards that have passed their expiry date. Nevertheless, ANAO encourages DVA to investigate the matter of veterans using out of date cards, to ascertain the scale and nature of any such use and so determine DVA's risk exposure.

Pharmaceutical benefits and White Cards

2.23 A veteran who successfully claims a war or defence related disability may be granted a White Card—a Repatriation Health Card for Specific Conditions. This type of health card entitles the veteran to health and pharmaceutical services directly related to his or her accepted disabilities only. DVA relies on two different control structures to ensure that claims against White Cards are appropriately processed.

2.24 In relation to health and medical services, a doctor treating a White Card holder should ensure that services claimed against the White Card are directly related to the veteran's accepted conditions. The doctor should not claim against the White Card for providing other services to the veteran. The doctor may claim from Medicare or bill the veteran as a private patient for providing services outside the scope of the DVA accepted conditions.

2.25 When a doctor submits a claim to HIC, the services claimed for are compared to a list of accepted conditions for the particular veteran. This IT systems level control helps to ensure that only appropriate health and medical services are claimed against White Cards.

2.26 In the case of pharmaceutical services claimed against White Cards, once again the doctor is expected to serve as an administrative control when writing prescriptions for White Card holders. The doctor is expected to indicate the prescription is to be processed in accordance with the RPBS, rather than the PBS. The doctor should also ensure that only pharmaceutical products and services relating to the veteran's accepted conditions are included on a prescription marked for the RPBS. A separate prescription should be written for pharmaceuticals unrelated to the accepted conditions. These should be processed through the PBS.

2.27 When a pharmacist lodges a claim with HIC under the RPBS, unlike the system for processing medical claims, there are no IT system controls to ensure that the pharmaceutical products relate to the veteran's accepted disabilities. Claims are processed according to the standard rules for the RPBS system, which do not distinguish between White and Gold Card holders.

2.28 The cost to the RPBS of pharmaceutical services inappropriately claimed against White Cards is difficult to estimate. The DVA client may not receive a monetary benefit by using the White Card to obtain pharmaceuticals unrelated to his or her accepted condition. Using the White Card, the client could expect to be charged at the concessional rate of $3.80 for a prescription, and the dispensing pharmacist would claim the RPBS subsidy through HIC.[19] If the client holds a PCC, as many of DVA's clients do, the same $3.80 charge applies to the client. The pharmacist would then claim the PBS subsidy through HIC.

2.29 The issue is then whether the expenditure of government funds should be recorded against the RPBS or the PBS. If the pharmaceutical service is not related to a DVA accepted (White Card) condition, ANAO considers the expenditure should be recorded against the PBS.

2.30 Should the client not hold a PCC, he or she could normally expect to be charged at the non-concessional rate of $23.70 for a prescription.[20] Using a White Card in these circumstances would result in a monetary benefit to the client, to which he or she is not entitled. Once again, the pharmacist's subsidy would be incorrectly recorded against the RPBS and not the PBS.

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[19] The concessional rate of $3.80 and the non-concessional rate of $23.70 were correct at 1 January 2004. Source: Department of Health and Ageing Internet site <www.health.gov.au/pbs/general>.

[20] Unless he or she has reached the PBS Safety Net threshold, when the concessional rate would apply.

2.31 ANAO considers the lack of an appropriate IT system level control for processing RPBS claims against White Cards, to be a weakness in DVA's administration of the health card system. Having said that, ANAO notes that the introduction of such controls presents a significant practical problem for DVA and HIC. It is difficult, if not impossible to map pharmaceutical treatment against a list of accepted conditions. For example, a veteran may have a leg injury accepted by DVA as being service–related. If the veteran was prescribed an anti-inflammatory drug, it is not possible for the pharmacist or a claims processing system to determine, with certainty, whether the drug was prescribed as part of a treatment plan for the veteran's leg, or a more recent elbow injury that is not service-related.

2.32 ANAO notes that DVA has given some consideration to the matter and encourages the department to pursue a workable solution.[21] If an appropriate technical control is not achievable, DVA should monitor the effectiveness of the administrative level control, which relies on doctors only indicating RPBS on prescriptions relating to a White Card holder's accepted conditions.

2.33 The current *Services Agreement* between DVA and HIC relates to Treatment Account Processing—it does not extend to RPBS processing.[22] The *Services Agreement* contains a number of references to HIC and DVA cooperating to ensure that all processing rules reflect policy and business requirements. The absence of similar arrangements, in relation to RPBS claims processing, represents a risk to DVA's ability to effectively and efficiently administer the Repatriation health card system.

2.34 In December 2003, ANAO was provided with a copy of a *draft Services Agreement* for upgrading the RPBS authority processing system. The *draft Services Agreement* does not address the issue of claims processing controls for RPBS claims against White Cards.[23] ANAO considers that in developing a *Services Agreement* for RPBS, DVA and HIC should explore options for implementing a systems level control in relation to the payment of pharmaceutical claims against White Cards. This matter is addressed in a recommendation at the end of this Chapter.

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[21] In its annual report for 2002–03, DVA reported on a Smartcard trial. Smartcards may provide the scope for DVA to introduce appropriate controls for White Card pharmaceutical claims.

[22] RPBS processing is covered in a separate Deed of Arrangement.

[23] Although it does include a provision, in later phases of the project, for HIC and DVA to investigate and possibly implement additional requirements including an ability to improve compliance across PBS and RPBS in relation to processing authority requests.

Pharmaceutical benefits and Pensioner Concession Cards

2.35 During the audit, ANAO found that DVA was aware of another anomaly in RPBS payment processing. DVA issues Pensioner Concession Cards to all service pensioners, age pensioners who receive their pension through DVA and war widows and widowers receiving an income support supplement. A PCC issued by DVA has the same status as a PCC issued by Centrelink. It is proof that the card holder receives a means tested pension and is eligible to receive certain concessions. A PCC is **not** a type of Repatriation health card, although it does entitle the card holder to pharmaceuticals under the PBS (but not the RPBS) at the concessional rate.

2.36 DVA has investigated the matter of pharmaceutical payments made against a card type designated NTEL (not eligible) and concluded that most NTEL clients hold PCCs issued by DVA.[24] Usually the ineligible client was found to be the spouse of an entitled veteran.

2.37 The RPBS should only be charged for claims against Gold, White and Orange Repatriation health cards. However, the processing system permits payments against a card type NTEL. Some clients who do not hold a Repatriation health card have PCCs issued by DVA. Doctors and/or pharmacists may inappropriately indicate the RPBS rather than the PBS when writing or dispensing prescriptions. This results in a level of pharmaceutical benefit expenditure incorrectly recorded against the RPBS.

2.38 Using DVA's *Pharmscan* system, the June 2003 report on payments to ineligible clients concluded that RPBS payments to ineligible clients could amount to $7.2 million per annum. This represents approximately two per cent of the $417 million administered expenditure for RPBS in 2002–03. ANAO is sensitive to the measurement difficulties involved, yet encourages DVA to undertake further analysis of RPBS payments to NTEL clients, with a view to improving the accuracy of RPBS expenditure estimates and health card performance information.

2.39 ANAO understands that DVA is not in a position to act unilaterally to address this situation, as HIC actually processes and pays the claims. ANAO recognises that certain aspects of the problem are IT systems based, and that the rectification of the problem will, at least partially, involve an IT system solution.

2.40 The recommendation at the end of this Chapter goes to the development of a service level agreement specifically relating to RPBS claims

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[24] DVA, *RPBS Payments to Ineligible Clients*, produced in the Victorian State Office, June 2003.

processing. Such an agreement could also incorporate procedures and controls to address the NTEL issue.

Conclusion

2.41 ANAO concluded that, overall, DVA has implemented a sound set of administrative and system level controls in connection with the issue, maintenance and cancellation of Repatriation health cards. The bulk replacement of some 300 000 health cards, spread over a six month period, is particularly well managed.

2.42 ANAO considers there is a need for additional controls to be implemented in relation to the payment of claims for pharmaceutical benefits against White Cards. In the absence of such controls, we believe that some White Card holders may receive pharmaceutical benefits to which they are not entitled. ANAO was not able to estimate the costs involved, although we believe it to represent a relatively small amount in relation to total RPBS expenditure.

2.43 The payment of pharmaceutical benefits against PCCs issued by DVA, could also benefit from further investigation and the introduction of additional claims processing controls. ANAO has concluded that, under the current arrangements, an unknown amount of administered expenditure is inappropriately recorded against the RPBS, whereas it should be recorded against the PBS. ANAO further notes DVA's estimate for the amount of approximately two per cent of annual RPBS expenditure.

Recommendation No.1

2.44 The ANAO recommends that DVA develop a service level agreement with HIC for the processing of RPBS claims. The service level agreement should facilitate a claims processing environment that establishes adequate controls over the payment of RPBS benefits to eligible clients. In particular, the agreement should include reference to appropriate controls over RPBS claims made against White Cards and Pensioner Concession Cards issued by DVA.

DVA's response

2.45 DVA agrees with the recommendation. A schedule addressing the processing of RPBS claims has been drafted for inclusion in the next service agreement with HIC. The Schedule incorporates a requirement for HIC to comply with processing rules as defined by DVA. Over the next 12 months the processing rules will include improved checking procedures to determine eligibility of White cardholders for treatment for specific disabilities.

3. Performance Information on Cards

This Chapter discusses DVA's use of performance information on cards and examines some of the statistical publications prepared by DVA, in particular, the Treatment Population Statistics and the Treatment Population Statistics in Rural and Remote Areas.

Collection and use of information

3.1 DVA collects and uses a large amount of information relevant to the Repatriation health card system. An extensive and complex IT environment supports staff in DVA's National Office and State Offices in the day-to-day administration of the system.

3.2 Significant data holdings include the:

- Client Database (CDB), which is actually a composite of a number of databases. The CDB holds personal information about each of DVA's clients, such as the client's name, address, date of birth and death, a UIN, various numbers relating to the client's paper files and information about a spouse, de facto or child. It also stores records of claims and the results of claims processing for pensions and allowances;
- Provider Database, which contains information on health service providers, such as name, practice address, billing address, provider numbers and a series of codes to indicate the status of a provider. In order to facilitate the processing of treatment accounts, DVA exchanges information with HIC on a regular basis;[25] and
- Repatriation Health Card Database (Card DB). Linked to the CDB, the Card DB contains information on the client's treatment entitlements and card details, such as card type, card issue date, expiry date, reasons for card issue or recall and a history of previous cards issued to the client.

3.3 Major IT applications include:

- Departmental Management Information System (DMIS)—a tool that enables an integrated view of the department's health related information. Information is organised into 'data marts', such as those

[25] DVA also issues providers with a Provider Card. Once again, HIC produces the plastic cards using information supplied by DVA. While this audit did not consider the administration of Provider Cards, ANAO noted that similar arrangements were in place between HIC and DVA in terms of card production reports. For example, we sighted the *DVA Provider Card Issue Control Report* for a production run in September 2003.

introduced in 2002–03 – veterans' home care, pharmacy, private hospitals, DOLARS (financial reporting from DVA's financial management system) and a prototype for a health executive decision support system;[26]

- AIS2000—a tool used to interrogate the CDB and produce detailed and summary reports. AIS2000 is used by various business areas within DVA to generate statistics for inclusion in a range of publications. It is also the tool ANAO used to extract various DVA data sets for detailed analysis during this audit;
- Treatment Account System, which is operated by HIC with input from DVA. HIC provides DVA with line item data about all claims processed on behalf of DVA; and
- RPBS processing system, also operated by HIC with input from DVA. Again, line item data is provided by HIC to DVA.

3.4 In addition to including an extensive array of statistics and performance information in its annual report each year,[27] DVA produces a number of regular statistical publications, including:

- Treatment Population Statistics (TPS)—quarterly report;
- DVA Fact File—annual report produced each June;
- Treatment Population Statistics in Rural and Remote Areas (TP RARA)—quarterly report;
- DVA Pensioner Summary—with some tables showing yearly and quarterly time series; and
- DVA Executive Summary—showing actual and projected beneficiaries numbers up to a decade out from publication date.

3.5 Some of these statistical publications are available to members of the public, through DVA's Internet site, while others are available to DVA staff through the DVA Intranet.

3.6 DVA employs this information in its business management activities and relies on the information to support decision-making within the department, as is evident from the following entry in the department's annual report.

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[26] DVA Annual Report 2002–03, p. 81.

[27] Appendix 2 illustrates the range of client and treatment population related statistics included in DVA's annual report for 2002–03.

> The availability of information to support decision-making was enhanced during the year by the introduction of a range of reporting and monitoring tools. Data marts were developed to improve information management for several programs and to facilitate modelling and reporting to support decision-making. …this has led to improved performance of contracts, more informed negotiations with providers, more effective monitoring of claims, reduced effort in data analysis and development of evidence-based policy development and monitoring.[28]

Treatment Population Statistics

3.7 DVA's use of health card data, such as the TPS, illustrates many aspects of the richness of DVA's data holdings and the extent to which the organisation relies upon its data holdings and supporting IT systems.

3.8 The TPS are sourced from the department's various databases and, in particular, they draw on data held in the CDB and the Card DB. The TPS are produced using AIS2000.

3.9 The TPS report comprises a number of graphs and tables—typically some 22 pages—presenting information on the number of veterans and dependants entitled to medical and other treatment at DVA's expense. The information is aggregated according to various combinations of clients' age, sex, State/postcode, conflict and card type. One table presents statistics on prisoners of war with a Gold Card, by prisoner of war country and State of residence. Another compares the treatment population aged 64 years and over with their counterparts in the Australian population.

3.10 Also included are actual and projected figures for the treatment population, in the case of the March 2003 TPS, spanning the years 2000 to 2012. The information is cross tabulated by card type, sex, age and State of residence.

3.11 DVA uses these statistics, along with other sources of expenditure information, to formulate forward estimates of expenditure on veteran health care and to plan the delivery of its health programs.

Minor error in the generation of TPS

3.12 As noted above, the TPS are generated using AIS2000. A standard query is run each quarter and this generates a report file, which is refined and used as the basis for calculating the statistics included in the TPS.

3.13 ANAO found an error in the construction of the standard AIS2000 query. TPS reports produced prior to September 2003 included records of cards returned to DVA.[29] Logically, the query should filter only those cards

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[28] DVA Annual Report 2002–03, p. 65.

[29] A client may be requested to return a card if his or her treatment eligibility changes.

which are current. As such, the TPS reports overstated the number of Gold and White Card holders by some 0.15 per cent.[30]

3.14 The error is slightly more significant in the case of calculating the number of White Card holders—an error of 0.6 per cent for that population as opposed to 0.05 per cent for the population of Gold Card holders.

3.15 DVA has now modified the standard AIS2000 query to rectify this error.

Treatment Population Statistics in Rural and Remote Areas

3.16 The TP RARA is published quarterly on DVA's Intranet, with a separate file relating to each State. Therefore, it is available to DVA staff in a format that permits a State by State analysis.

3.17 DVA's Business Information Section produces the TP RARA report, which extracts data from the Treatment Accounts System and the CDB, using AIS2000. In addition to the types of cross tabulation contained in the TPS, the TP RARA includes an analysis of population groups by postcode/town and suburb, with RARA[31] and ARIA[32] classifications. Other tables present information on the number of health care providers (LMOs, specialists and allied health) and the ratio of treatment population to the number of providers by postcode, RARA/ARIA classification.

3.18 ANAO found that these tables provide a valuable insight into the geographical distribution of the treatment population and the coverage of health services experienced by those people. Because the data used to prepare

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30 ANAO's calculation of the treatment population at 23 August 2003 was 332 833, while the standard AIS2000 query would have yielded 333 329—a discrepancy of 496 card holders, or 0.15 per cent of the treatment population.

31 The RARA (Rural and Remote Area) classification system was developed in 1991 by the Commonwealth Department of Primary Industries and Energy and the Commonwealth Department of Human Services and Health. It was revised in 1994 to include classifications of 'capital city' and 'other metropolitan area' and is now known as the Rural, Remote and Metropolitan Area (RRMA) classification. This classification system categorises all statistical local areas (SLA) in Australia according to their remoteness. Source: DVA TP RARA, December 2002, which further acknowledges the source as Department of Human Services and Health.

32 The ARIA (Accessibility/Remoteness Index of Australia) grew out of a 1998 Department of Health and Aged Care project to measure and classify the remoteness of populated localities in relation to 'service centres' of various sizes based on the 1996 census. The ARIA Index was developed by the National Key Centre for Social Applications of Geographical Information Systems, and calculates remoteness as accessibility to some 201 service centres based on road distances. ARIA values are grouped into five categories: Highly accessible, Accessible, Moderately Accessible, Remote and Very Remote. Source: DVA TP RARA, December 2002, which further acknowledges the source as *Measuring Remoteness: Accessibility/Remoteness index of Australia (ARIA)*, Department of Health and Aged Care and the National Key Centre for Social Applications of Geographical Information Systems at the University of Adelaide, October 2001.

tables relating to providers are drawn from the Treatment Accounts System, the figures relate to claims for health services—lodged with and paid by HIC—rather than the actual number of providers within any particular area or postcode. For example, in a particular postcode, four doctors may have registered with DVA as LMOs, yet only three may have submitted a claim for treating a veteran within the TP RARA reporting period. In this case, the TP RARA would only report data relating to those three LMOs.

3.19 ANAO also found that, in preparing estimates for annual expenditure on health care, DVA uses a variety of statistical information including data on the average cost of particular medical and hospital services to veterans. A relatively sophisticated trend analysis model is employed, rather than simple per capita calculations based on the treatment population numbers, so the estimates produced are unlikely to suffer from errors identified in the TPS.

3.20 DVA's Resources Branch compares actual against estimated expenditure on a monthly basis and provides regular reports to the department's executive management group.

Conclusion

3.21 ANAO found that DVA applies performance information on health card usage to a variety of purposes. A standard suite of regular statistical reports supports DVA managers and staff to maintain an awareness of trends within the treatment population, their use of health services and the geographical coverage of health services. DVA also effectively uses performance information to calculate budget estimates and to monitor expenditure.

4. Data Integrity

This Chapter considers data integrity issues. It examines the way in which clients are identified on DVA's databases, in particular, the use of UINs and client file numbers. The analysis also addresses the integrity of date of birth and date of death information, as these are recorded on the various databases. It highlights and explores the implications of some anomalies identified in DVA's data holdings, many arising from the fragmentation of client information across two or more unrelated electronic records.

Data analysis

Client identification

4.1 DVA employs a number of different IT environments and applications to store and retrieve client data. The CDB stores basic information such as the client's file number, name, address, date of birth, date of death, service history, and a record of claims processing for service and/or disability pensions. It also identifies any links between veterans and their dependants.

4.2 The information is stored on a mainframe computer, in an (Information Management System) IMS database. This is essentially a legacy system, implemented some decades ago. Many of the data structures in the IMS database are now redundant, various business functions having moved to an ObjectStar environment.[33] Some of the same client information is stored on ObjectStar, such as date of birth or date of death, along with additional information relating to pension payments and the results of claims assessments.

4.3 Information from IMS and ObjectStar is brought together in DMIS, in a series of data marts. These data marts serve as a repository for information. The VIEW application draws information from both IMS and ObjectStar databases, in order to display a comprehensive set of client information.[34]

4.4 DVA clients are identified in at least two ways within DVA's systems. The client's UIN is stored on an ObjectStar database, while the client's file numbers are stored on an IMS database.

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[33] The ObjectStar environment resides on DVA's mainframe computer. It provides a more up-to-date and flexible data management environment.

[34] During our data analysis, ANAO noted that on occasions, the client details reported by AIS2000 were inconsistent with those displayed by VIEW. For example, an AIS2000 report showed blank entries for date of birth for some clients while VIEW displayed an entry for date of birth against one or more of the client's file numbers. ANAO raised this matter with DVA and discussed the nature of such discrepancies with relevant DVA IT staff. Our discussions confirmed that some disparate client data was reported across the two databases.

4.5 As the name implies, each client should have only one UIN. However, a client can have multiple file numbers, which are State-based.[35] That is, each file number begins with a letter identifying a State—N for New South Wales, V for Victoria, S for South Australia and so on. Ideally, all of the different file numbers for a given client should be linked or cross-referenced. DVA's IT systems provide the facility to do this.

4.6 ANAO used AIS2000 to generate a number of reports. These reports extracted data from the Compensation and Income Support components of the database, drawing extensively on the *Client Information* and *Treatment Card* elements. We then analysed the data in order to determine whether some clients had two or more UINs.

Methodology

4.7 We commenced our analysis with an extract of almost the entire list of DVA clients, both living and deceased.[36] The AIS2000 report produced 1 635 190 records, each comprising eight data fields.

4.8 In a trial analysis, we sought to identify duplicate records that could reasonably be for the same person. We identified records which matched exactly on the client's surname, given name, initials and date of birth, but which did not match on UIN.

4.9 We then verified that we had identified a client with multiple UINs by checking the records against a more extensive range of information in the VIEW application. We used client address and/or service number and/or HIC personal identification number and/or social security reference number and/or details of the client's spouse (where recorded) to verify that the clients in question, with two UINs, were one and the same.

4.10 Based on a sample of some 130 records, we calculated that about one in 11 pairs of records (or about nine per cent) produced using this method, did not relate to the same person. In particular, relatively common surnames provided a false match. For example, we might have found that two people with the name Walter G Clarke were born on 26 August 1922.[37] On further examination we might have found that they had different service numbers or different addresses or that one had a spouse named Mary while the other's spouse was named Edna.

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[35] While a client may have multiple file numbers, one of these (ideally the one containing the most up-to-date and comprehensive client information) is identified as the Active file number.

[36] The AIS2000 query simply selected all records where the client's sex was identified as male or female. There may be a small number of clients where the sex is recorded as unknown.

[37] The names and date of birth used in this example are fictitious.

4.11 Attempting to exactly match records on surname, given name, initial, date of birth and address details, produced data sets that excluded a significant number of genuine matches. The inclusion of address details—either the first line of an address, or the town—often reduced the output data set by half. We noted that addresses across client files and UINs had been recorded with slight discrepancies. For example, an address on one record might read 'Unit 1, 23 Market Street', while on another record it read 'U1 23 Market St', or '1/23 Market Street'. Such discrepancies resulted in the exclusion of those records from the output data set.

4.12 Attempting to match on surname, given name, initials, date of birth and service number also produced questionable results. Firstly, unless the client was a veteran he or she would not have a service number recorded. Veterans' spouses and children fell into this category.[38] Secondly, service numbers were also observed to be subject to considerable variation. In as many as 10 to 20 per cent of cases, we observed that service numbers recorded across client files varied in some small regard, such as being recorded as 3/45678 on one record and 345678 on another, or 59988 on one and S9988 on another.

4.13 Attempting a broader match on these criteria, using an approach designed to overcome minor discrepancies in address or service number[39], produced unrealistically large output data sets. Similarly, excluding the clients' initials from the matching criteria resulted in unrealistically large output data sets. That is, the proportion of false matches exceeded the estimated nine per cent achieved using the exact match technique.[40]

4.14 Therefore, we are confident that exactly matching surname, given name, initials and date of birth, but mismatching UIN has generated data sets, which provide a reasonable estimation of the number of clients with multiple UINs—by our estimation, to within around 10 per cent accuracy.

Multiple UINs

4.15 Employing this methodology, and commencing with the 1 635 190 records, ANAO identified 36 955 matching records. Of these, 1255 records had

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38 Accounting for at least one third of all records in the data extract.

39 This is often termed a fuzzy logic approach. It provides more latitude than requiring an exact 'character-for-character' match. For example, fuzzy logic might match Smith, Smyth and Smythe.

40 During our sampling, we noticed instances where the same client's initials had been inconsistently recorded across two records—for example T. Smith against one UIN and TM Smith against another UIN. We recognised that an exact match on initials excluded from our analysis these genuine cases of clients with multiple UINs. However, on balance, we considered the number of false matches produced by excluding initials outweighed the number of genuine matches foregone by requiring an exact match on initials.

no date of birth recorded for the client.[41] Excluding those records from our analysis left 35 700 records that could represent records for clients with multiple UINs. Further analysis revealed that up to 17 532 people had been issued with more than one UIN.[42]

4.16 Not all of these clients have eligibility for a health card. ANAO found that 6318 health cards had been issued to 6222 card holders who may have multiple UINs. This represents approximately 1.9 per cent of the treatment population.[43] In addition, our analysis revealed that 94 of these people had been issued with two health cards and one person had been issued with three health cards.[44]

4.17 The function of the UIN is to clearly distinguish each client in DVA's CDB. The business systems that call up client information from the CDB treat each UIN as associated with a single client. Therefore, if a client has two UINs, with their information split or replicated across the two records, the business systems treat the information as though it related to two separate individuals.

4.18 Having clients with multiple UINs presents a number of business risks to DVA. Information split across two or more records clearly subverts the intention of the business systems to maintain one record, containing comprehensive, up-to-date information about an individual client. This situation presents a small risk that when communicating with clients, either by telephone or in person, DVA staff will not readily have access to all of the information relating to that client, with a potential impact on the quality of service able to be offered to that client.

4.19 Clients with multiple UINs may be in receipt of different payments or treatment eligibility assessments under the different records. ANAO discovered a number of such examples and discussed them with DVA staff during the course of the audit. A typical example involved the wife of a veteran who was also a veteran in her own right. As a spouse, she receives a war widow's pension and a Gold Card under one UIN. As a veteran in her own right, she receives a partial disability pension along with a White Card under another UIN. If these two records were held under one UIN, with two

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41 That is, in the output file generated by the AIS2000 query, the date of birth field was blank. Note ANAO's earlier point on discrepancies in information reported by AIS2000 and VIEW. Date of birth is stored on both IMS and ObjectStar databases and the entries may be inconsistently recorded, such as blank on one, non-blank on the other, or two different entries.

42 ANAO's analysis indicated that 1 person may have 9 UINs, 2 people may have 7 UINs, 2 people may have 6 UINs, 10 people may have 5 UINs, 47 people may have 4 UINs, 487 people may have 3 UINs and 16 983 people may have 2 UINs. A total of 17 532 people, accounting for the 35 700 records.

43 An AIS2000 report, produced on 8 November 2003, based on the query used to produce the TPS, returned 330 722 records. This estimate of the treatment population conforms well with contemporary TPS reports published by DVA.

44 All of these health cards were reported with the status 'Card is Current'.

separate file numbers appropriately linked, a comprehensive picture of the client's information would be available to DVA staff. However, with information fragmented across the two UINs, the client's situation is not easily recognised, nor is it always appropriately dealt with.

4.20 In the example above, the Gold Card affords the client access to the full range of medical, hospital and pharmaceutical benefits and the White Card affords the client no additional benefit. In terms of efficiency, the effort associated with administering (reissuing, maintaining and eventually cancelling) the 'unnecessary' White Card is wasted. DVA's TPS would also count both cards. As the records are split across two UINs, the Gold Card would contribute one to the total number of Gold Cards, and the White Card one to the total number of White Cards.

4.21 The potential also exists for duplicate payments to be made across the two UINs. To gain an appreciation of how common duplicate payments might be, ANAO analysed the payment of pharmacy allowances to clients with multiple UINs.

Possible duplicate payment of pharmaceutical allowance

4.22 A pharmaceutical allowance is payable in a number of circumstances, for example, as part of a disability pension, service pension, war widow's pension or single orphan's pension. As noted in the previous example, clients who have multiple UINs could receive a different pension entitlement under each UIN, and inadvertently receive a pharmaceutical allowance under each. ANAO was informed that a client should not receive two pharmaceutical allowances. In the normal course of business, if a client has two active pension payments, such as a disability pension and a war widow's pension, (under one UIN) they would only receive the allowance once.

4.23 Using a report of pharmaceutical allowances paid against each UIN, provided by DVA's Information Management Unit, we analysed the pharmaceutical allowances paid to those clients who may have two UINs and found that 64 clients were being paid a pharmaceutical allowance twice.[45] DVA undertook a detailed investigation of the client and payment records. That investigation revealed that eight of the 64 potential cases of double payment did not relate to clients with multiple UINs. That is, eight pairs of records related to different people who happened to have the same given name, initial, surname and date of birth.

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[45] According to our analysis, 38 clients were receiving two payments of $5.80 per fortnight, two clients were receiving two payments of $2.90 per fortnight and 24 clients were receiving one payment of $5.80 and one of $2.90 per fortnight. Of the 64 clients identified, 44 were current health card holders.

4.24 Of the other 56 cases, 14 were previously known to the department as records requiring corrective action. DVA's investigations revealed that the remaining 42 cases were previously unknown to the department. DVA informed ANAO that appropriate corrective action would be commenced.

4.25 While the costs involved are negligible—we estimated the total to be less than $10 000 per annum—the phenomenon of multiple payments is indicative of some of the difficulties caused by clients having multiple UINs.[46] In this audit, ANAO did not attempt to identify clients with multiple UINs who might be in receipt of two or more pension payments under different UINs. If there are such clients, and if the second pension payment is inappropriate in the circumstances, we would expect the amount to be greater. This matter is addressed in a recommendation at the end of this Chapter.

Orange Cards

4.26 Orange Cards are issued to Commonwealth and Allied veterans, aged 70 years or over, who have qualifying service and meet certain Australian residency criteria. The Orange Card entitles the card holder to receive pharmaceutical products and services, under the RPBS, at the concessional rate.

4.27 ANAO extracted a listing of all Orange Card holders as at 23 August 2003. The extract query generated 20 546 records, which conforms well to the published figure of 20 672 in DVA's annual report for 2002–2003.

4.28 Of the 20 546 Orange Card holders, 3342 also held a current health card—63 had a Gold Card and 3279 had a White Card. A client may validly hold both a White and Orange Card. The White Card provides medical and hospital benefits for accepted conditions only, while the Orange Card provides the full range of pharmaceutical benefits at concessional rates. The overlap of 3279 White and Orange Cards compares well with a figure of 3467, published in DVA's *Fact File* for June 2002.

4.29 However, while a client may qualify for an Orange Card and a Gold Card, in the interests of efficient administration of the card system, ANAO would not normally expect such a client to be issued with the Orange Card. The Gold Card, alone, provides for the full range of medical and pharmaceutical benefits.

4.30 The Orange Card issued to the 63 clients identified above, adds nothing to the benefits afforded them by the Gold Card. A recommendation, at the end

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[46] DVA advised that these cases most likely arose from errors in cross-referencing client files—prior to the introduction of UINs in 1998–99. Whether the errors were caused by poor cross-referencing of file numbers or clients having multiple UINs, it is the fragmentation of client information across records that generates the risk.

of this Chapter, calls on DVA to implement measures designed to prevent the issue of both a Gold and Orange Card to a client. DVA has indicated a willingness to implement these measures.[47]

Mismatch on date of death

4.31 As noted previously, two or more health cards were issued to up to 95 people with multiple UINs. When DVA is notified of the death of a veteran or entitled dependant, a date of death is entered on the client's record. In the case of health card holders, this represents a critical control on the payment of medical claims against the client's health card. Having multiple UINs presents a risk that only one record might be updated with a date of death, leaving the other record active. The following analysis considers anomalies in the date of death recorded on client's files.

4.32 ANAO found that of the 16 983 people who may have two UINs, 4506 had a mismatch on date of death across the two records. We noted 4308 had a date of death recorded against one UIN and no date of death recorded against the other, while 197 had two different dates of death recorded.[48] Of the 4308, twenty clients had a health card issued against the still active UIN, that is, the one without a date of death recorded.

4.33 ANAO also found that of the 549 people who may have more than two UINs, 76 had a mismatch on date of death across the various records. Of these, three clients had been issued with health cards, against a still active UIN.

4.34 On the basis of our analysis, ANAO concluded that health cards could continue to be reissued, in the normal four-year replacement cycle, for up to 23 deceased card holders. While this represents a small exposure for fraudulent use of such cards, the impact on client service standards may be greater. For example, a veteran's widow may receive a replacement card for the veteran anytime up to four years after notifying DVA of the veteran's death. Such an occurrence would have a negative impact on DVA's reputation for high quality service and sensitivity to the veteran community.

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[47] ANAO understands that some controls currently exist to prevent an Orange Card being issued to a Gold Card holder. However, the controls are only effective if the information held on a client's file is complete. Some of the Orange Card holders identified above had information fragmented across two unrelated electronic records with an entitlement to a Gold Card under one record and an Orange Card under the second record.

[48] The figure of 197 represents just over 4 per cent of the 4506 and may relate to the false matches mentioned in the section on ANAO's data matching methodology. That is, many of these 197 pairs of records, although matching exactly on surname, given name, initials and date of birth, may actually relate to different people.

Analysis of dates of birth and death

4.35 The previous section focussed on clients who may have more than one UIN. ANAO also undertook an analysis of the entries for date of birth and date of death for the 1 635 190 records extracted from the CDB. Our analysis concentrated on identifying anomalies in the date of birth and date of death data, in order to gain an appreciation of the integrity of this data stored on the CDB.

4.36 Our analysis revealed that:

- 1 578 559 clients had a date of birth recorded, while 56 631 had no date of birth recorded;
- 8 clients had the same date recorded for both date of birth and date of death;
- 13 282 clients had a date of birth prior to 1 January 1900 yet did not have a date of death recorded—that is, the CDB treats these clients as still alive even though the majority have no payment or treatment eligibility. Of these, 39 were current health card holders; and
- some clients had different dates of birth recorded against different file numbers.[49] At least some of these were obvious data entry errors, such as a client with dates of birth recorded as 1866 and 1966, on two cross-referenced files.

4.37 ANAO identified 88 746 clients with a date of birth prior to 1900 and a date of death recorded. Our analysis of these data revealed the following anomalies:

- according to the recorded date of birth and death, the oldest veteran would have been 177 years old when he died;
- 66 clients would have been over 150 years of age when they died, according to their recorded dates of birth and death;
- the data indicated that 8 veterans were under 15 years of age at the time of their death. Five of them had file numbers indicating service in World War 1, yet they had dates of death between 1900 and 1907; and
- 54 veterans, most with file numbers indicating service in either World War 1 or World War 2, had a date of death recorded prior to 1914.

4.38 The anomalies above are clearly the result of data entry or processing errors. Others entries appear anomalous to varying degrees. For example,

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[49] We were not able to develop a reliable estimate for the number of clients in this situation. However, while conducting detailed checks of selected client records in connection with other analyses during the audit, we identified a number of clients with different dates of birth across linked file numbers.

further analysis indicated that 12 136 current card holders are 90 years of age or older. This compares to DVA's figures of 10 255 (for 2002) and 11 900 (estimated for 2003), published in the March 2003 TPS.

Surviving World War 1 veterans

4.39 DVA's annual report for 2002–03 contains a table of the estimated number of surviving veterans from each conflict, as at 30 June 2003. The listing for surviving World War 1 veterans is seven. ANAO analysed data, based on client file numbers, to compare this number of seven with that generated by our AIS2000 report.[50]

4.40 ANAO's analysis supports DVA's published value of seven as a reasonable estimate of the number of surviving World War 1 veterans (notwithstanding the data we used was extracted from a database current at 6 September 2003). However, in addition to the seven veterans so identified, our analysis revealed another six card holders meeting the same criteria— a World War 1 file number and no date of death recorded—that contain some other anomaly or error.

4.41 Although AIS2000 reports a World War 1 file number for these six additional records, the dates of birth range from 1912 to 1970, whereas the dates of birth for the seven valid records fall between 1898 and 1899. In addition, two of the six spurious records show the veteran has a White Card, whereas all World War 1 survivors are entitled to a Gold Card. These two records show dates of birth of 1960 and 1970 respectively, and also identify the veterans as 'serving members'. Another of the six records contained a reported date of birth of 1925 although the file number indicated service in World War 1.

4.42 While the logically impossible errors are relatively easy to identify and highlight, other less obvious data anomalies exist within DVA's CDB. A recommendation, at the end of this Chapter, encourages DVA to undertake a comprehensive analysis of date of birth and date of death data, and to resolve genuine anomalies.

Inactive records

4.43 The CDB contains a large number of inactive records. These are records relating to clients who are not in payment and do not receive a health card or any other entitlement. Many records relate to veterans who lodged some type of claim with DVA in the past, but whose claim was rejected. Their information

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[50] We selected all file numbers where the second character was a space, indicating service in World War 1, and where the record had no entry in the date of death field. We then ignored records for dependants and concentrated on veterans only.

remains on the CDB despite having had no subsequent dealings with DVA. Other records relate to veterans and dependants who died some time ago.

4.44 DVA maintains over one and a half million records on its database, yet the treatment population is around a third of a million, and the pension population around half a million. ANAO considers that, in the interests of greater efficiency, the production environment databases should primarily contain information relating to DVA's active client populations. Having said that, we recognise that DVA may, for a variety of other reasons, wish to have ready access to inactive records that may need to be reactivated. We are not suggesting that inactive records be archived or deleted. Rather, ANAO suggests that inactive records might usefully be culled and relocated outside the production environment, with the potential to be reintroduced into the production environment if and when required. If this could be achieved with minimal cost and system re-engineering, DVA could expect a positive impact on system performance.

State-based file numbers

4.45 DVA delivers client services to veterans and their eligible dependants across Australia. The department employs staff in six State Offices and some 27 Veterans' Affairs Network offices in larger towns and cities.

4.46 DVA employs a State-based file number system. Each file number is prefixed by one of the letters: N, Q, S, T, V or W, representing a primary State of processing for the client. A client's paper file is usually held at the State Office of primary processing.

4.47 The client file number also includes a code denoting the conflict in which the veteran served. The code for World War 1 is a space between the State identifier and a numeric. So, the file number N 12345 indicates a veteran who served in World War 1 and is now serviced out of the NSW DVA Office. Service in World War 2 is denoted by the letter X. So, the file number SX12345 indicates a veteran who served in World War 2 and is now serviced out of the South Australian DVA Office.

4.48 DVA informed ANAO that the conflict code, included in the file number, is essentially an outmoded concept. From the early 1990s, DVA has relied on other conflict codes and particular dates of war service to determine veteran entitlements, and now treats the conflict code in file numbers as an approximation only. DVA has not removed these conflict codes, because many legacy programs on DVA's IT systems reference the conflict code in file numbers.

4.49 A client may have more than one file, and therefore, more than one file number. A client may have lodged a series of claims for disability pension and/or service pension and/or health card entitlements, over a period of time.

A new file is created on each such occasion. These different file numbers for the one client should be linked within the CDB, and ANAO found that they often were.

4.50 Because of the State-based file number system, whenever clients move interstate, they are issued with new file numbers, bearing the prefix of the receiving State. File numbers are embossed on health cards, so when a client moves interstate their health card, with the file number relating to their previous State, is cancelled and a new health card embossed with the new file number is issued.

4.51 During our visits to the Victorian and Queensland DVA State Offices, we were informed that many clients living near a State border may elect which DVA State Office to deal with. These clients would then have a DVA file number, which did not necessarily reflect their State of residence.

4.52 Figure 4.1 presents the pattern of clients serviced by each State Office, by State of residence of the client.[51] Each of the five larger States service more than 30 000 clients.[52] In the graph, the height of columns for those States has been truncated in order to illustrate the pattern of cross-state processing.

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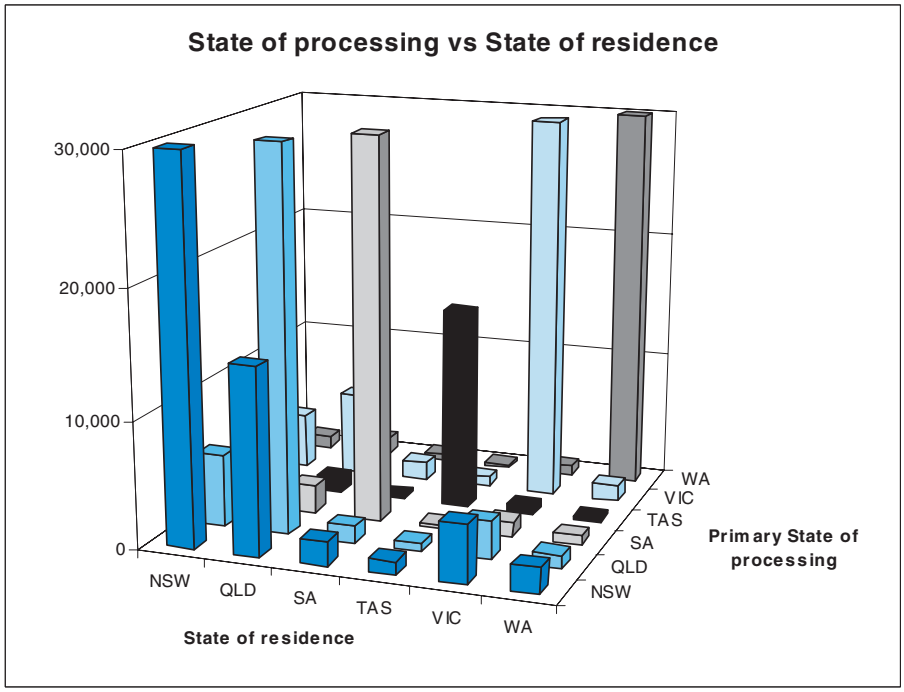
[51] An AIS2000 data extraction, using information current as at 8 November 2003, was used to generate the graph.

[52] For the total number of members of the treatment population, by State, see Table 5.1 later in this report.

Figure 4.1

DVA client distribution by State of processing and residence



Source: ANAO analysis of AIS2000 reports.

4.53 Figure 4.1 reveals that NSW is the primary State of processing for a significant number of Queensland and Victorian residents in addition to those residing in NSW. Queensland is also the primary State of processing for some NSW residents.

4.54 ANAO also identified a significant proportion of clients not resident near a State border with a different primary State of processing. We were informed that, on occasions, a client's file was processed by another State Office. For example, the file for a close relative of a Victorian Office staff member might be processed in another State Office, in order to avoid any perceived conflict of interest.

4.55 In all, ANAO identified some 63 000 clients not resident in their primary State of processing. This represents approximately 12 per cent of the 523 690 record (file number based) data set used.

4.56 ANAO found that DVA's implementation of a system of State-based file numbers is less than ideal and has contributed to many of the data anomalies identified in this audit. While recognising the historical context in which the use of State-based file numbers evolved, and supporting DVA's philosophy of delivering day-to-day administration of client services through

State Offices and the Veterans' Affairs Network, ANAO considers that the State-based file number system introduces a number of risks to the integrity of DVA's data holdings. Through discussion with DVA staff during the audit and based on the results of our data analysis, we concluded that, until recently, a large proportion of data entry errors or inconsistent information, was entered onto client records at the time of changing file numbers for clients who move interstate and when creating a new file for an existing client.

4.57 By comparison, if a veteran moves interstate they would not normally be required to change their Tax File Number, Medicare number, social security reference number, or credit card numbers and may well be able to retain bank account or financial institution numbers, private health insurance membership numbers and the like. Yet DVA establishes a new file number, and associated electronic record, and then if the system operates effectively, links that new file to all previous files for the client. ANAO was informed that, in the past, a client's information was often manually re-entered on the new file number record, thus introducing a further risk of error.[53]

4.58 ANAO concluded that many of the multiple UINs were issued to clients at the time of processing an interstate transfer. During our discussions with staff in DVA's Victorian and Queensland State Offices, we discovered that the two offices employed different methods to determine whether a client already exists on DVA's database. One used VIEW to scan for client records, while the other accessed the IMS database directly to search for client details. As previously noted, different components of client information are stored on the IMS and ObjectStar databases, so the different search methods may produce inconsistent results.

4.59 Sometimes DVA staff were not able to correctly identify an existing client on the CDB and so created a new client record, thereby issuing a second UIN. Until recently the mechanisms for transferring client details from one State to another were too complex or time consuming to facilitate a timely and accurate transfer. ANAO considers that under some circumstances, DVA staff had elected to create a second UIN in order to facilitate timely client service, such as processing a claim, which requires an active record in the State of processing.

4.60 During this audit, DVA advised that the State-based file numbers are recognised and used by other agencies. One example quoted was that some local government councils offered discounts on council rates and other charges. These councils accepted the DVA health cards as proof of residence in a particular State. This could be problematic as ANAO's analysis of State of

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[53] Such as that noted for a serving member with date of birth entries of 1966 and 1866 on two linked files, or the discrepancies in client name and address details or service numbers referred to earlier in this report.

processing versus State of residence revealed that, for around 12 per cent of the veteran population, the file number embossed on their health cards does not reflect their State of residence. For these DVA clients the State-based file number system could be seen to work against their best interests—in this example, at least.

4.61 ANAO concluded that there is no absolute requirement for DVA to maintain a State-based file number system. This is especially so, given that DVA already has a system of UINs for clients. ANAO is sensitive to the matter of costs associated with moving away from a State-based file number system and notes that DVA has considered this matter in the past. A significant number of legacy programs, running on DVA's IT systems, reference the State-based file numbers, and the cost of re-engineering these systems to cope with the removal of the State codes could be significant.

4.62 Nevertheless, ANAO encourages DVA to reconsider the matter, in light of the findings of this audit and a further comprehensive assessment of data integrity. The issue is explored in a recommendation at the end of this Chapter.

COAST

4.63 In 2002 DVA introduced the COAST project—Change of Address and Simplified Transfers. COAST incorporates a number of enhancements for changing a client's address details in VIEW and simplifies interstate transfers. The simplified transfer function facilitates a comprehensive exchange of client information from one State to another and ensures that the client's assessment history is not lost with a change of file number. The process identifies the client's active file and ensures consistent information is transferred. Health cards are automatically recalled in the transfer-out State and reissued in the transfer-in State.

4.64 ANAO found that the introduction of COAST has significantly reduced the opportunity for issuing multiple UINs as a result of clients moving interstate. In December 2003, DVA informed ANAO that a post-implementation review of COAST revealed no cases of clients being issued with two UINs as a result of an interstate transfer.

4.65 The errors and anomalies outlined in this report appear, in the main, to relate to errors introduced prior to the implementation of COAST. While COAST will act to ensure a higher quality of client information transfer in the future, it will not identify or rectify existing errors and data anomalies.

Monitoring data integrity

4.66 Within DVA's Income and Support Branch, the Systems Delivery Section conducts a series of regular checks on data integrity. ANAO was provided with a listing of the data integrity checks performed, along with an

indication of the timing of those checks. Some of the checks are conducted fortnightly, others quarterly or annually. A number of checks are conducted on an ad hoc, or as required basis. In total, 40 separate checks, on different aspects of data integrity, were included on the list.

4.67 The type of checks extend to identifying:

- clients receiving an income support pension who do not show an eligibility for a PCC;
- clients showing a treatment eligibility, but with no record of a card issued;
- deceased clients in receipt of a pension;
- discrepancies between similar fields in IMS and ObjectStar;
- clients with a record of death against one file number but not against all linked numbers; and
- discrepancies in treatment eligibility on ObjectStar and IMS databases.

4.68 ANAO noted that many of these checks were performed on client records that had recently been amended in some way. For example, a check might be performed on an updated data set, resulting from a reassessment of pension entitlements, or records of clients with multiple UINs that had recently been merged.

4.69 While this approach may prove valuable in identifying data anomalies only recently introduced, we understand that DVA has not undertaken a comprehensive analysis of data integrity issues across the entire CDB, particularly involving data related to health cards.

4.70 ANAO is also aware that, in the first quarter of 2002, HIPS commenced an exercise to merge some records for clients with multiple UINs. Employing a series of reports provided by HIC, which list clients with suspected multiple UINs, HIPS compares these records with information available on VIEW to identify and rectify the duplicate records. ANAO was informed that the HIC reports identified some 4000 potential cases of multiple UINs. By October 2003, DVA had examined records for 2400 of these clients and, where appropriate, merged the data.

Conclusion

4.71 DVA operates a large and complex database of client information, maintaining records for over one and a half million individuals. ANAO has concluded that, in general, DVA manages this database well to service clients across Australia with regular payments and the provision of health cards.

4.72 Through our data analyses, ANAO identified a number of anomalies and errors in the information held on veterans and their dependants. In particular, we identified a problem with some clients being issued multiple UINs. We also detected anomalous entries for clients' dates of birth and death, and file numbers indicating service in a particular conflict not in accordance with date of birth or death entries. ANAO also considers the CDB contains a large amount of inactive data, and encourages DVA to relocate these records outside the production environment.

4.73 Recognising that DVA undertakes some data integrity checking and merging of identified cases of clients with multiple UINs, ANAO concluded that the quality and integrity of DVA's data holdings could still be significantly improved.

4.74 If ANAO's analyses are correct, DVA may have up to 17 000 clients with multiple UINs recorded on the CDB, with over 6000 of these being health card holders. This number represents approximately two per cent of the treatment population. Until such records are identified and merged, statistics published by DVA on its Internet site and in its annual report to Parliament may overstate the treatment population by this factor. DVA's internal data analysis activities may also be adversely impacted by the errors and anomalies in the CDB, potentially delivering a less well informed basis for decision-making.

4.75 ANAO found that DVA could improve the efficiency of the health card system by not issuing some Commonwealth and Allied veterans with both Gold and Orange Cards.

4.76 ANAO also concluded that DVA's practice of issuing clients with State-based file numbers presents a risk to the integrity of data in the CDB. We consider a system based on a truly unique client identifier (the UIN theory) would better serve DVA to maintain comprehensive, accurate information regarding its clients.

Recommendation No.2

4.77 The ANAO recommends that DVA conduct a thorough assessment of the integrity and accuracy of data held on the Client Database and Card Database, with a view to:

- identifying and merging records for clients with multiple UINs;
- resolving anomalies in date of birth and date of death data entries; and
- identifying and eliminating inappropriate duplicate payments to clients, whether under multiple UINs or inadequately cross-referenced file numbers.

DVA's response

4.78 Agreed. DVA is of the view that the quality of data held in the Client Database and Card Database is appropriate and will continue to ensure that veterans' entitlements are correctly recorded. The data integrity issues identified by the ANAO that may directly impact on a veteran's entitlements are examined as a priority when identified. Merging of records is undertaken as time and resources permit. The other data issues relate to non-operational data holdings, which do not impact on DVA payments. These data deficiencies are low risk and will be addressed as opportunities arise.

Recommendation No.3

4.79 The ANAO recommends that DVA implement appropriate measures to prevent Commonwealth and Allied veterans being issued with both Orange and Gold Cards.

DVA's response

4.80 DVA agrees with the recommendation. However, an automated preventative control is too costly to install in our legacy system. The 63 orange cards will be recalled and an annual manual procedure will be developed to detect and recall any other Orange cards issued to Gold cardholders.

Recommendation No.4

4.81 The ANAO recommends that DVA re-assess its various methods of client identification, with a view to eliminating the current State-based file number system in favour of a truly unique client identification system, capable of managing comprehensive client information effectively.

DVA's response

4.82 DVA agrees in principle with the recommendation and supports a move in this direction as opportunities arise. As acknowledged by the report,

State-based file numbers are an artefact of the technology available to DVA in the 1970s and the fact that State-based operations were essential at the time. The introduction of the UIN indicates DVA is aware of the importance of a National approach. The continuing need for State-based numbers reflects the ongoing use of legacy systems. The elimination of the State-based system into a truly unique identification system is a strategic aim but is a significant exercise and can best be accommodated as legacy systems are removed/redeveloped.

5. Access to Health Services

This Chapter reports on the number of LMOs participating in the scheme and considers the geographic distribution of LMOs across Australia. It also looks at veterans' access to medical specialist and hospital services. The Chapter concludes by highlighting some difficulties associated with obtaining accurate and reliable information on the number of LMOs registered with DVA at any given time.

Access to Local Medical Officers

LMOs currently registered with DVA

5.1 The Health Information and Payments Section maintains the Provider Database by directly entering or editing providers' details on HIC's IT systems. HIPS draws on information from the signed agreements sent to DVA by individual LMOs. This database contains information relating to all general practitioners registered as LMOs with DVA.[54] HIC uses the information in the Provider Database as an input to its claims processing system, to ensure that LMOs' claims are paid in accordance with the fee schedules in their LMO agreements.

5.2 An LMO may practice at a number of locations, and may have a number of practice addresses recorded. Alternatively a number of LMOs may operate from the one practice address. If they wish, LMOs may request HIC to send all payments for claims to one address. This is referred to as the billing address. Therefore, the number of practice addresses may be greater than the number of billing addresses stored on the Provider Database.

5.3 DVA provided ANAO with information on the number of individual LMOs registered, as at 7 November 2003. This information is mapped against the number of clients in the Treatment Population, in Table 5.1.

[54] The Provider Database also contains details of other medical service providers, such as allied health professionals.

Table 5.1

Number of LMOs registered with DVA at 7 November 2003

State/Territory	Number of LMOs	%	Treatment Population	%
New South Wales & Australian Capital Territory	5130	35.4	117 510	35.1
Victoria	3511	24.2	75 153	22.4
Queensland	2737	18.9	73 985	22.1
South Australia & Northern Territory	1300	9.0	28 422	8.5
Western Australia	1343	9.3	28 995	8.7
Tasmania	460	3.2	11 095	3.3
Total	**14 481**	**100**	**335 160**	**100**

Source: LMO numbers—DVA. Treatment Population numbers—DVA annual report 2002–03, Table 100, p. 236. Percentage figures for the Treatment Population do not total 100 due to rounding.

5.4 These figures relate to the situation as at November 2003. An analysis of trends in LMO participation rates is presented later in this Chapter.

Geographic distribution of LMOs

5.5 Table 5.1 reveals that 79 per cent of LMOs operate within three States—New South Wales, Victoria and Queensland. Similarly, 80 per cent of the DVA treatment population resides in those three States.

5.6 ANAO found that DVA maintained an awareness of the number and geographic distribution of veterans, LMOs and other medical service providers. At 30 June 2003, 33 per cent of veterans and their dependants with a health card entitlement lived in rural and remote areas of Australia.[55] Regular statistical reports such as the TP RARA inform DVA managers of the relative proportion of veterans and the doctors who treat them, in capital cities, metropolitan, rural and remote localities.

5.7 For example, as part of its ongoing monitoring of health service provision to veterans, during the period December 2002 to July 2003 DVA was aware of a small number of towns in New South Wales and South Australia with a lack of LMO coverage. Despite this, ANAO's analysis of DVA files indicated that very few veterans, in the effected regions, complained of difficulties accessing LMO services during that period.

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[55] 111 608 veterans and their dependants live outside the metropolitan areas. (Source: DVA Annual Report 2002–03, p. 67.)

Access to specialists

5.8 Under the terms of their agreements, LMOs are obliged to refer eligible veterans to the closest practicable specialist. The specialist involved should be willing to accept 100 per cent of the Medicare Benefits Schedule (MBS) fee for the medical services provided and not levy any additional fees on the veteran. If the specialist accepts these conditions, claims for services are lodged with HIC against the Gold or White Cards of entitled veterans.

5.9 It is a matter for each specialist to determine whether he or she will treat entitled veterans in line with DVA's treatment arrangements. In contrast to the LMO Scheme, there is no scheme whereby individual specialists enter into agreements with DVA.

5.10 DVA advised the ANAO that, as at 12 December 2003, 323 specialists had informed DVA that they would no longer accept the Repatriation health cards. This corroborates a figure of 319 provided to the Foreign Affairs, Defence and Trade Legislation Committee (Budget Estimates Supplementary Hearings) on 5 November 2003.[56] According to DVA's analysis of specialists' claiming patterns, at any one time there are between 8000 and 9000 specialists treating veterans and entitled dependants in accordance with DVA's treatment arrangements. Therefore, 323 specialists withdrawing services from the veteran community equates to approximately four per cent of the specialist provider population.[57]

5.11 ANAO found that DVA is aware of a shortage of certain specialist services, for veterans, in particular regions of Queensland.[58] DVA identified psychiatric services, neurosurgery, and orthopaedic surgery as areas of acute shortage in some regional areas in that State.

5.12 ANAO also noted a small number of cases in which specialists might be seen to be restricting services to Repatriation health card holders. For example, some specialists had indicated that the veteran would be asked to pay for the initial consultation as a private patient. That is, the specialist would not accept the Repatriation health card for the initial consultation. If subsequent treatment were deemed necessary, the card would be accepted for that treatment.

5.13 A few specialists had informed their veteran patients that they would still accept the Gold Card, but that they would charge the veteran a

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[56] There may be other specialists who have not informed DVA of a change to their veteran treatment policy.

[57] Calculated using 8500 as an estimate of the specialist provider population treating veterans prior to 2002–03.

[58] Specialists in these areas are still providing treatment to the general public, but have advised that they no longer accept the Gold Card. They have advised that they are willing to provide services to veterans as private patients—outside the DVA treatment arrangements.

co-payment. Such practice is not permitted under DVA's treatment arrangements. ANAO noted that, where DVA was advised of such practices, it informed the specialist of DVA's payment arrangements and reminded the specialist of the conditions associated with accepting a Repatriation health card.

5.14 ANAO found that DVA maintains an awareness of the pattern of specialist services provided to veterans. Where veterans had contacted DVA for assistance in accessing specialist services, ANAO found that DVA was responsive to the veterans' needs and supportive in resolving problems.

5.15 For example, if a veteran attended a specialist, only to be informed that the specialist no longer accepted the Repatriation health cards, DVA provided the veteran with information on alternative specialists. The veteran could then discuss options with his or her LMO and obtain a referral to one of the alternative specialists. In circumstances where an alternative specialist was not available in a veteran's local area, DVA arranged to transport the veteran to the nearest available alternative specialist.[59]

5.16 Ex-Service Organisations reported that a small number of their members had experienced problems accessing the services of particular specialists. Some ESOs also claimed that members were made aware of individual specialists planning to charge a co-payment.

Access to hospitals

5.17 The Repatriation Private Patient Scheme was established following the integration or sale of DVA's Repatriation General Hospitals (RGHs). The scheme was introduced progressively between 1992 and 1995, taking effect in each State as the integration or sale of the RGH took place.

5.18 Eligible veterans are entitled to treatment in public hospitals, former RGH and contracted Veteran Partnering private hospitals. These are known as Tier 1 hospitals. Under the RPPS, eligible veterans are entitled to free treatment as a private patient in a shared ward, with the choice of their own doctor.

5.19 The RPPS requires LMOs and specialists to refer veterans to Tier 1 hospitals, whenever this is possible. Prior approval is not required for admission to a Tier 1 hospital. If treatment cannot be provided within an appropriate time, or the service required is not available at a Tier 1 hospital, LMOs and specialists may refer eligible veterans to a contracted private hospital (other than a Veteran Partnering hospital), known as a Tier 2 hospital. DVA requires the doctor to seek approval prior to admitting veterans to Tier 2 hospitals, except in cases of emergency treatment.

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[59] In accordance with the guidelines of the Repatriation Transport Scheme.

5.20 If a service is not available at a Tier 1 or Tier 2 hospital, eligible veterans may be admitted to a non-contracted private hospital—a Tier 3 hospital. All admissions to Tier 3 hospitals require prior financial authorisation (excluding emergencies).

5.21 LMOs are required to check with DVA State Offices to ensure that the department will accept financial responsibility for treatment before hospital admission is arranged for a White Card holder.

5.22 DVA's total administered expenditure for public and private hospitals during 2002–03 was $1.45 billion—some $130 million higher than that of 2001–02. The number of private hospital separations, including day procedure centres, for 2002–03 was 237 090. DVA estimated public hospital separations for the same period at 143 360.[60] DVA estimates that approximately 30 per cent of the treatment population accessed private hospital services during 2002–03.[61]

5.23 DVA engaged a consultant to conduct an independent review of its purchasing of hospital services.[62] The report, produced in April 2003, touched upon the matter of veteran access to hospitals. The information presented in Table 5.2, below, is taken from that report.[63]

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60 DVA usually completes public hospital reconciliation processes six months in arrears and private hospital reconciliations three months in arrears. Therefore, the figures are estimates. (Source; DVA Annual Report 2002–03, pp. 83-84.)

61 ibid., p. 84.

62 TFG International Pty Ltd, *Review of the Purchasing of Hospital Services*, April 2003.

63 ibid., Table 2 - DVA contracted hospitals and total hospitals, p. 13. The figures have not been independently verified by ANAO.

Table 5.2

DVA contracted hospitals (Tier 1 and Tier 2) and total hospitals

	NSW/ ACT	VIC	QLD	SA/NT	WA	TAS	Total
Public	222	145	183	85	90	24	749
Private DVA contracted							
Tier 1	47	36	24	8	3	6	124
Tier 2 Acute	23	26	17	21	0	0	87
Others	15	15	5	6	0	2	43
Contracted Day Procedure Centres	89	36	20	18	0	2	165
Total DVA contracted	**174**	**113**	**66**	**53**	**3**	**10**	**419**

Source: Extracted from TFG International, *Review of the Purchasing of Hospital Services*, April 2003, p. 13.[64]

5.24 The consultant's report noted that, following the divestment of RGHs and the establishment of Veteran Partnering hospitals, card holders had access to a greatly increased number of hospitals, without the requirement of prior approval.

5.25 ESOs surveyed during the audit reported little difficulty associated with access to necessary hospital services. Some ESOs reported difficulties associated with claims for diagnostic services that were not reimbursed by DVA (as the provider was not approved by DVA to perform the service).

Monitoring client satisfaction levels

5.26 DVA monitors client satisfaction levels in relation to access to medical services. DVA conducts regular surveys of veterans and providers. In its annual report for 2002–03 DVA reported achieving a 99 per cent satisfaction level, citing results from its Veterans' Satisfaction Survey. In addition, DVA regularly consults with ESOs on a range of matters, including veterans' health.

5.27 ANAO found that ESOs were generally very supportive of DVA and the Repatriation health card system. Some ESO responses provided examples of a small number of their members experiencing problems with doctors, specialists or allied health providers no longer accepting the Gold Card. Others indicated that some LMOs were attempting to restrict services to health card holders by setting particular times of the day or week when the doctors would treat veterans under DVA arrangements. For example, a doctor might agree to

[64] TFG acknowledges the following sources: Public figures from AIHW's *Australian Hospital Statistics 2000–01*, DVA figures from DVA 2000–01.

accept the Gold Card for treatment on a Tuesday or Wednesday morning, but if the veteran sought treatment outside these times, he or she would be expected to pay a fee in excess of the MBS fee. When DVA was informed of such practices, it contacted the LMOs to remind them of their obligations under the LMO agreement. Following such approaches, some LMOs changed their practices to conform to the conditions of the LMO agreement, others resigned from the scheme.

5.28 Where such difficulties were encountered, ESOs commented that DVA had acted swiftly to solve the problem. DVA either provided the veteran with a list of alternative service providers in nearby locations, or in some cases arranged transport for veterans to attend alternative service providers.

Reliability of LMO numbers

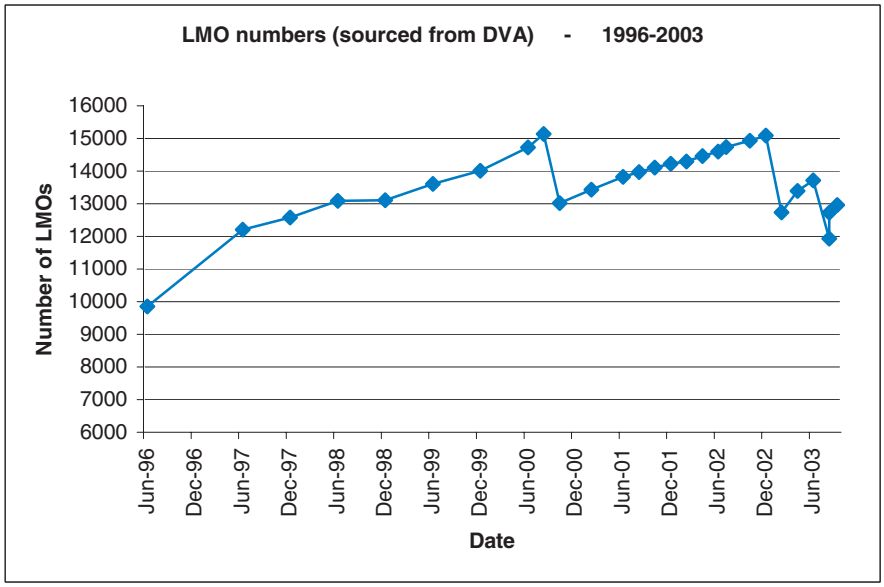
5.29 During this audit, ANAO encountered some difficulty in collecting reliable evidence of the number of LMOs registered with DVA at particular points in time. We firstly examined a series of summary report tables, held on file in HIPS. These summary reports were produced from the Provider Database and covered the period from April 1992 to September 2003.

5.30 After being presented with ANAO's analysis of the data, DVA staff noticed that the figures did not correspond with their understanding of the total number of LMOs. Further analysis by DVA revealed that the summary report tables were flawed. A technical error in the code used to generate the tables resulted in the summary reports understating the number of LMOs by a factor of up to 10 per cent. DVA advised that the error certainly affected the figures for 2002–03, and that the summary reports produced prior to that time might also have been affected by the error.

5.31 Figure 5.1 is based on data extracted from DVA's summary reports. It illustrates LMO participation since the introduction of the RCCS in 1996. The right hand section of the graph—from 2002 onwards—relates to the erroneous data.

Figure 5.1

LMO numbers sourced from DVA's summary reports



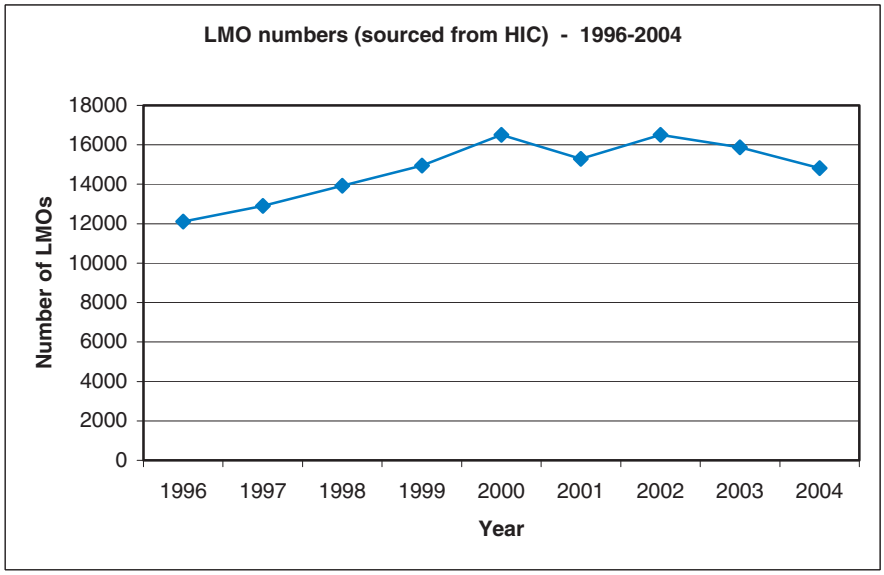
Source: ANAO analysis — summary reports of DVA's Provider Database, covering the period 1996 to 2003.

5.32 In order to obtain a more accurate estimate of LMO participation rates over time, DVA requested HIC to produce a report of the number of registered LMOs for the same period.[65] Figure 5.2 illustrates the trend in LMO numbers from 1996 to 2004, based on the HIC report. Each of the data points represents a count of LMOs that held a valid LMO registration at any time during the year in question. Therefore, they represent the greatest possible number of LMOs available in a year, rather than a snapshot of LMO numbers on a particular date in each year.

[65] The Provider Database resides on HIC's IT system, and is used as the basis for paying claims lodged by LMOs.

Figure 5.2

LMO numbers sourced from HIC



Source: Data sourced from HIC—covering the period 1996 to 2004.[66]

5.33 ANAO concluded that neither set of data provided sufficiently accurate or reliable information upon which to base a rigorous trend analysis. The data in Figure 5.1 reflects the number of LMOs registered on particular dates over the seven year period. The data in Figure 5.2 reflects the number of LMOs holding a valid registration at any time during a particular calendar year from 1996 to 2004. As such, the two graphs are not directly comparable, although we were able to identify some common features in relation to broad trends, over time.

5.34 Both Figure 5.1 and Figure 5.2 show a steady increase in the number of registered LMOs from 1996 to 2000, and then a sharp decrease. Another steady increase ensued over a two to three year period, followed by another sharp drop in numbers. The dates associated with this pattern, in particular the sharp drops, correlate well with the dates of MoU renewal and of LMOs signing new agreements with DVA. The final section of Figure 5.1 relates to the extension of MoU arrangements from December 2002 to June 2003 and, as noted above, is unreliable.

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[66] The first set of this data provided to ANAO was broken down by State. That is, for each State it counted all LMOs registered in that State. Unfortunately, when these figures were totalled, they counted some LMOs twice—as a number of LMOs, particularly those working near a State border, operate practices in more than one State. HIC produced a second report that counted individual LMOs on a national basis.

5.35 Following discussions with DVA, and as a result of our own analysis, ANAO considers that the pattern outlined above is a result of the Provider Database progressively collecting redundant data over the course of an MoU, followed by a cleansing of data associated with the implementation of renewed LMO agreements.

5.36 That is, when the RCCS commenced in 1996, a number of general practitioners registered with DVA as LMOs. Over the course of the subsequent three years, as new general practitioners came into the market, a number registered as LMOs. Some LMOs left the scheme during this time, through resignation, retirement, death, relocation overseas or moving to a specialist field. However, many of those leaving the scheme may not have informed DVA and, therefore, not been removed from the Provider Database. The cumulative effect was to inflate the number of LMOs recorded on the Provider Database.

5.37 At the end of an MoU, when all LMOs were required to enter into new agreements, the number of LMOs who had left the scheme became apparent. The Provider Database was effectively cleansed at this time, as only newly registered LMOs would be eligible for the payment arrangements under the RCCS. ANAO considers that these times of cleansing of the Provider Database result in the most accurate data concerning LMO numbers.

5.38 Given the discussion above, and based solely on the data points coinciding with the commencement of MoUs, our analysis suggests that LMO numbers have remained fairly steady, at around 14 000 to 15 000, for the five years leading up to 2003. The most recent re-contracting exercise, in July 2003, saw a decrease of approximately 1000 to 2000 LMOs. However, the number had recovered to 14 481 by November 2003.

5.39 ANAO was also informed that DVA State Offices maintained their own database of information relating to LMOs within their State. These are typically maintained on a spreadsheet or self-contained database. The State databases often held slightly different information to that held on the Provider Database, such as a doctor's email address or alternative telephone numbers. This information is valuable to the State Office staff in their day-to-day administrative activities and for making direct contact with LMOs when necessary.

5.40 Some DVA staff suggested the State databases are useful for gaining an appreciation of the availability of LMOs in certain geographical areas, as some of these databases contain information on doctors practicing at multiple locations. ANAO found that the Provider Database and the State databases reported different numbers for participating LMOs at any given time. This was attributed to the fact that many State databases were reporting the number of practices rather than the number of individual LMOs.

5.41 Given the difficulties ANAO experienced in obtaining accurate LMO numbers, we were not able to form an opinion as to which data source, the Provider Database or the State databases, provided the most accurate information on registered LMOs at any one time. While figures for the Provider Database were available from 1992 to 2004, DVA was not able to provide historical figures from the State databases for comparison. A recommendation at the end of this Chapter encourages DVA to improve its capacity to report accurate and reliable counts of LMO numbers.

Conclusion

5.42 ANAO concluded that the RCCS operates to provide a good level of access for veterans to health care services. The number of registered LMOs appears to have remained fairly stable for some time, although ANAO notes some variation over the period 2002–03. DVA maintains an awareness of the geographic distribution of LMOs and veterans, and works to ensure veterans in rural and remote areas have appropriate access to primary health care services.

5.43 Overall, entitled veterans and their dependants had a reasonable level of access to specialist medical services, although the proportion of specialists prepared to accept Repatriation health cards had decreased slightly over 2002-03. Furthermore, ANAO observed that DVA was aware of difficulties associated with some specialists no longer accepting the Gold Card. Where veterans or their entitled dependants encountered difficulties in accessing specialist medical services, DVA acted to provide alternative solutions and to ensure the veterans' health needs were met.

5.44 ANAO also concluded that DVA's arrangements with hospitals, in particular Tier 1 and Tier 2 hospitals, afforded a good level of access to entitled veterans and their dependants.

5.45 DVA was not able to demonstrate the capacity to provide accurate and reliable counts for the number of LMOs registered at any given time since the introduction of the RCCS. ANAO noted considerable variation between the number of LMOs reported by the Provider Database, HIC and DVA's State databases.

Recommendation No.5

5.46 The ANAO recommends that DVA improve its capacity to report accurate and reliable information relating to the number of LMOs registered at any given time.

DVA's response

5.47 DVA agrees with the recommendation. DVA proposes to address this issue with the release of the DMIS Medical and Allied Health Data Mart, expected to be available in April/May 2004. This Data Mart has been designed to enable the extraction of specific LMO data without the requirement for a detailed HIC specification. It will be possible for DVA to extract regular reports on LMO availability and services, by State or nationally, uniquely and at all practices.

Canberra ACT
15 April 2004

P. J. Barrett
Auditor-General

Appendices

Appendix 1: Eligibility Criteria for Repatriation Health Cards

Repatriation Health Card—For All Conditions—Gold card—is issued to veterans of Australia's defence force who:

(i) are ex-prisoners of war;

(ii) receive a disability pension at or above 100 per cent of the general rate;

(iii) receive a disability pension at or above 50 per cent of the general rate and also receive any amount of service pension;

(iv) receive a disability pension including an additional amount under section 27 of the *Veterans' Entitlements Act 1986* (VEA) for specific service-related amputations or blindness in one eye;

(v) receive a service pension and satisfy the income/assets reduction limit;

(vi) receive a service pension and are permanently blind in both eyes;

(vii) received a disability pension for pulmonary tuberculosis before 2 November 1978;

(viii) served in World War 1;

(ix) are returned ex-servicewomen of World War 2, that is, who served in Australia's defence force between 3 September 1939 and 29 October 1945 and who have qualifying service from that conflict;

(x) are World War 2 veterans who served in Australia's defence force and mariners who served in Australia's merchant navy, between 3 September 1939 and 29 October 1945, who are aged 70 years or over, and have qualifying service from that conflict;

(xi) are veterans who served in Australia's defence force, who are aged 70 years or over, and have qualifying service.

Some veterans of Commonwealth or Allied forces are eligible for a Gold Card if they are:

(i) a veteran who served with a Commonwealth or Allied Force during World War 2 and who was domiciled in Australia immediately prior to enlistment in the Commonwealth or Allied Force;

(ii) a mariner who served on a Commonwealth or Allied Ship during World War 2, if they or their dependants were residing in Australia for at least 12 months immediately prior to the commencement of their service on that ship;

(iii) a Commonwealth veteran, allied veteran or allied mariner who receives at least 50 per cent Disability Pension under Parts II or IV of the VEA and any amount of Service Pension.

Certain dependants are also eligible for a Gold Card:

(i) a war widow or widower in receipt of the war widow(er)'s pension;

(ii) a dependent child of a deceased veteran whose death has been accepted as war caused, who is under 16 or between the ages of 16 and 25 and undergoing full-time education;

(iii) a child of a deceased veteran whose death was not war-caused and who had operational service, if the child is not being cared for by the remaining parent.

Certain dependants have continuing eligibility from the Repatriation Act 1920:

(Note: no new treatment eligibility grants for these categories have been possible since 18 October 1985.)

(iv) An invalid child of a deceased veteran whose death has been accepted as war-caused, who had treatment entitlement before 18 October 1985;

(v) A widowed mother or widowed step-mother who was dependent on an unmarried deceased veteran whose death has been accepted as war-caused, who had treatment entitlement before 18 October 1985.

Repatriation Health Card—For Specific Conditions—White Card—is issued to:

(i) a veteran with:

a war-caused injury or disease;

malignant neoplasia;

pulmonary tuberculosis;

posttraumatic stress disorder; and/or

anxiety and/or depression (Vietnam veterans only) who is not otherwise entitled under the VEA;

(ii) ex-service personnel who are eligible for treatment under agreements between the Australian Government and New Zealand, Canada, South Africa and the United Kingdom.

Repatriation Pharmaceutical Benefits Card—Orange Card—for pharmaceuticals only is issued to:

(i) British Commonwealth and allied veterans and mariners who have qualifying service from World War 1 or World War 2, are aged 70 years or over and have been resident in Australia for 10 years or more.

Source: Extracted from DVA's Administrative Handbook, Part I, Eligibility and Repatriation health cards. This list is not a substitute for the relevant legislation, which governs veterans' entitlements.

Appendix 2: Statistics Included in DVA's Annual Report for 2002–03

For 2002–03, DVA's annual report included the following statistics for its client and treatment populations.

- Table 1 – Estimated number of surviving veterans as at 30 June 2003 (Table 97 repeats the figures and also provides comparable figures, by conflict, for June 2002);
- Table 4 – VEA treatment population by age as at 30 June 2003;
- Table 31 – Performance information for Output 2.1, including numbers of card holders and price per card holder;
- Table 32 – Veteran treatment population by age and state as at 30 June 2003;
- Table 33 – (a graph) Veteran treatment population by age as at 30 June 2003;
- Table 34 – (a graph) number of public and private hospital separations 1998-03;
- Table 35 – (a graph) Number of pharmaceutical items dispensed 1996-03;
- Table 36 – (a graph) Number of medical services 1997-03;
- Table 37 – (a graph) Number of allied health services 1998-03;
- Table 110 – Treatment population by age group as at 30 June 2003;
- Table 111 – Gold Card and White Card holders at as 30 June 2002 and 30 June 2003;
- Table 112 – Treatment population projections (numbers for 2000 to 2003 are actual); and
- Table 113 – Orange Card holders by age group as at 30 June 2003.

Appendix 3: DVA's Response to the Audit

The following is the full text of DVA's response to the audit report.

24 March 2004

Mr John Meert
Group Executive Director
Performance Audit Services Group
Australian National Audit Office
GPO Box 707
CANBERRA ACT 2601

SUBJECT: DVA's COMMENTS ON ANAO REPORT - MANAGEMENT OF REPATRIATION HEALTH CARDS

Dear Mr Meert

Thank you for your letter dated 24 February 2004, in which you sought management comments relating to the Management of Repatriation Health Cards Report.

DVA agrees with the overall ANAO finding that the administration of the Repatriation health card system is generally sound. DVA believes that this conclusion highlights our ongoing success in one of our key result areas - effective business performance as stated in DVA's Corporate Plan.

As a general comment on the report DVA agrees with the findings and broadly agrees with the recommendations made in the report. Four of the five recommendations focus on data integrity issues at the corporate level. DVA is of the view that the data supporting the payment of veterans' entitlements is complete and ensures accurate service delivery. DVA acknowledges that data cleansing would address the data integrity issues in legacy systems, but given the significance of the work required believes this can best be accommodated, as legacy systems are removed/redeveloped.

Recommendation No. 1 - The ANAO recommends that DVA develop a service level agreement with HIC for the processing of RPBS claims. The service level agreement should facilitate a claim-processing environment that establishes adequate controls over the payment of RPBS benefits to eligible clients. In

particular, the agreement should include reference to appropriate controls over RPBS claims made against White Cards and Pensioner Concession Cards issued by DVA.

DVA Response:

Agreed.

A schedule addressing the processing of RPBS claims has been drafted by the Medication Management Section for inclusion in the next services agreement with HIC. The Schedule incorporates a requirement for HIC to comply with processing rules as defined by DVA. Over the next 12 months the processing rules will include improved checking procedures to determine eligibility of White cardholders for treatment of specific disabilities.

Further opportunities to improve eligibility checking by HIC earlier in the claim process are being investigated for incorporation in the new PBS online claim processing and assessment infrastructure.

It should be noted that improved eligibility checking by HIC relies upon the data recorded at the pharmacy during the dispensing process. It is both likely and possible for a pharmacy to record a White Card number for a DVA client then use that number for all prescriptions, without regard for eligibility for funding related to the specific disabilities. Furthermore, keystroke errors during dispensing at the point of recording the DVA file number will introduce additional errors.

Patients holding White Cards or PCCs are eligible for government funding/subsidisation of RPBS and PBS pharmaceuticals respectively. Therefore, the issue is whether the RPBS or PBS programs incur the expense.

Recommendation No. 2 - The ANAO recommends that DVA conduct a thorough assessment of the integrity and accuracy of data held on the Client Database and Card Database, with a view to:

- Identifying and merging records for clients with multiple UINs;
- Resolving anomalies in date of birth and date of death data entries; and
- Identifying and eliminating inappropriate duplicate payments to clients, whether under multiple UINs or inadequately cross-referenced file numbers.

DVA Response:

Agreed

DVA is of the view that the quality of data held in the Client Database and Card Database is appropriate and will continue to ensure that veterans' entitlements are correctly recorded. The data integrity issues identified by the ANAO that may directly impact on a veteran's entitlements are examined as a priority when identified. Merging of records is undertaken as time and resources permit. The other data issues relate to non-operational data holdings, which do not impact on DVA payments. These data deficiencies are low risk and will be addressed as opportunities arise.

Income Support Branch undertakes regular data integrity checks, with a focus on payment data discrepancies.

The identification of multiple UINs is ongoing and where these are identified, are included in work schedules where time permits. Clean-up work where eligibility is recorded on more than one record is time-consuming and therefore an ongoing and lengthy process.

Where systemic improvements to systems are identified, these are progressed. Again this occurs as time and resources permit.

COAST is a new computer system developed to automate the interstate transfer process, which has significantly reduced the instance of creation of duplicate UINs. Also an edit was put into the Death Recording system to validate the input file number so that the date of death could only be updated on the active file number. From the active file update all other file numbers are updated automatically.

Recommendation No. 3 - The ANAO recommends that DVA implement appropriate measures to prevent Commonwealth and Allied veterans being issued with both Orange and Gold Cards.

DVA Response:

Agreed.

An automated preventative control is too costly to install in our legacy system and would be a low priority as the Gold card entitlements do supersede the Orange card and therefore no extra benefits can be obtained. DVA will recall the 63 Orange cards identified by the ANAO and develop a suitable report and manual procedure to detect and annually recall any other Orange cards issued to Gold cardholders.

Having these two cards does not represent a significant risk to DVA or any advantage to the dual card holders - the Orange card covers pharmaceuticals only whilst the Gold card covers all health treatment and pharmaceuticals.

Recommendation No. 4 - The ANAO recommends that DVA re-assess its various methods of client identification, with a view to eliminating the current State-based file number system in favour of a truly unique client identification system, capable of managing comprehensive client information effectively.

DVA Response:

Agreed in Principle.

DVA agrees in principle to the recommendation and supports a move in this direction as opportunities arise. As acknowledged by the report, State-based file numbers are an artefact of the technology available to DVA in the 1970s and the fact that State-based operations were essential at the time. The introduction of the UIN indicates DVA is aware of the importance of a national approach. The continuing need for State based numbers reflects the ongoing use of legacy systems. The elimination of the State-based system into a truly unique client identification system is a strategic aim but is a significant exercise and can best be accommodated as legacy systems are removed/redeveloped.

Recommendation 5 - The ANAO recommends that DVA improve its capacity to report accurate and reliable information relating to the number of LMOs registered at any given time.

DVA Response:

Agreed.

DVA proposes to address this issue with the release of the DMIS Medical and Allied Health Data Mart, expected to be available in April/May 2004. This Data Mart has been designed to enable the extraction of specific LMO data without the requirement for a detailed HIC specification. It will be possible for DVA to extract regular reports on LMO availability and services, by State or nationally, uniquely and at all practices.

Extraction of LMO data is heavily reliant upon the interpretation of HIC specifications, as well as the timeliness of GPs updating their practice information. Data extractions are reliant upon a sound knowledge of the business, and possible variations include:

- Number of LMOs at only one practice;
- Number of LMOs at all practices;
- Number of LMOs at only one practice, by state.

Where data is extracted for LMOs at only one practice, but the data is requested at a state level, each LMO practice in each state is counted once. However, this means that if the total of each state is added, it will be overstated, as LMOs practicing in more than one state are counted more than once. Understanding the complexities of the data is essential to ensure data accuracy. DVA will engage with the HIC to discuss how better accuracy can be achieved.

Yours sincerely

Neil Johnston
SECRETARY

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