Australian Government
The Repatriation Commission

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Mr David Kalisch
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Hospital Performance Study
Productivity Commission
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Dear Mr Kalisch

The Repatriation Commission and the Department of Veterans' Affairs (DVA) has a long history of collaborative arrangements with both the public and private hospital sectors, ensuring the veteran community has access to quality health care. This experience and the uniqueness of the veteran cohort has provided DVA with an unparalleled understanding of the health care needs of the veteran community.

DVA has been providing data to the current study being undertaken by the Productivity Commission on the public and private hospital sectors.

On behalf of the Repatriation Commission, I would like to submit the attached document for your consideration. As detailed in the attachment, it is the Repatriation Commission's experience that the conversation around health care has been focused on cost as inputs. It is our view that the review would also benefit from a focus on the desired outcome for the individual in the hospital system. Having this clarity might provide a frame of reference to address the issue of cost in the hospital system.

Thank you for the opportunity to contribute to this important study.

Shane Carmody
Acting President
11 September 2009

Repatriation Commission submission to the Productivity Commission's Hospital Performance Study

The Repatriation Commission (Commission) has responsibility under the *Veterans' Entitlements Act 1986* for the provision of health services to eligible veterans and their dependants. This responsibility is administered on the Commission's behalf by the Department of Veterans' Affairs (DVA), which provides arrangements for the funding of health care on behalf of the Commission. This responsibility extends the range of available health care from general practitioner and allied health treatment, in-home nursing care and support services, to acute hospital care in the public or private sectors. The objective of the health care and related services provided to veterans is to support them in the home or community.

The current expenditure for health services to the veteran community is in excess of $4 billion per annum, with approximately $1.7 billion being spent on hospital services alone. In terms of DVA health care arrangements, and in particular for hospital services, these are funded on the basis of the DVA fee representing the full cost of treatment. No copayments are levied on DVA patients in relation to the treatment provided under DVA arrangements.

The current DVA treatment population is approximately 272,000, [1] consisting of members of the veteran community with an entitlement to DVA funded health care. The age characteristics of the DVA cohort are:

- 67 percent are aged 75 or more;
- 75 percent are aged 65 or more; and
- 91 percent are aged 55 or more.

Given the age and related characteristics of the DVA cohort, there has been an inevitable focus on the cost of care, in particular the costs associated with hospital admissions. While there is no doubt that there is a clear intention in the health system to place the patient at the centre of the care model, it is acknowledged that this has varying degrees of success based on individual patient profiles.

The age and comorbidities of the DVA cohort are such that there is a high inherent risk of complication over the course of hospitalisation. Whether the conditions that arise are unforseen, indicate a pre-existing chronic status, are complicated due to poly-pharmacy, reflect social isolation within the community, or suggest a greater need for coordination of the different elements of care, they will further compromise patient health. The particular disposition of DVA patients means that the risk of complication associated with hospitalisation is high and this factor represents potentially significant burden in terms of cost to DVA.

As a funder of health care DVA has no direct control of the cost of delivery of the services funded. DVA's focus is not on reducing the direct cost of delivery but on improving measures to support primary care, and to explore opportunities to better manage complex/chronic patients.

Supporting primary care

Under DVA's health care model the Local Medical Officer (LMO) – general practitioner – is central to patient management. The issue confronting DVA is the same as the broader community, the capacity to sustain this traditional model of health care management. With the increasing pressures on LMOs, largely arising from increasing patient demand for services and the workforce shortfall, DVA has to explore opportunities to support the LMO without undermining their role in DVA's health care arrangements.

In the community the role of the LMO is supported by DVA's community nursing program and Veterans' Home Care, providing in-home clinical and domestic support on a casual or longer term

[1] March 2009

basis. The clinical and social success of these activities can be measured in terms of DVA's goal, that veterans are supported in maintaining their independence within the community.

Separate to specific programs and treatment options funded by DVA, there is the ongoing engagement with the medical community through the Divisions of General Practice and the respective medical colleges. This relationship maintains options for DVA to explore emerging models of care that reflects the capacity and concerns of the medical profession.

DVA has been active in exploring different models available for the provision of coordinated care. DVA's experience in this area has shown that based on age and comorbidities it can be difficult to identify positive outcomes due to the complexity of the particular patient cohort. But it is also acknowledged that there are areas of potential where care coordination can deliver benefits, and DVA is keen to explore possible models because such benefits would extend beyond DVA's treatment population.

Medication management

DVA's experience has identified medication management as an opportunity to both support the LMO and also reduce patient opportunity for otherwise preventable hospital admissions. Through the Veterans' Medicines Advice and Therapeutic Education Service (Veterans' MATES) DVA provides information to the LMO on specific medical issues to increase awareness of the doctor's prescribing of those particular patients. This service is provided by DVA through the Quality Use of Medicines and Pharmacy Research Centre at the University of South Australia. An example of the success of Veterans' MATES has been the identification of the underutilisation of care processes, such as lipid tests, for the management of diabetes. The program has also identified the association of certain drugs used in the treatment of heart failure with increased hospitalisations for gastrointestinal ulcers or renal failure.

Another DVA supported medication focused program is the Dose Administration Aids (DAA) project. This project provides a service for managing patient medications for those patients identified at risk of medication misadventure, which would likely result in a hospital admission. Participation in the project is on the basis of patients being identified as at risk after a home medications review. The DAA project will be evaluated with a view to determine whether:

- the cost of providing primary health services to veterans using the DAA Service will be lower than that of the group of veterans not using DAAs; and
- health outcomes will improve for the DAA group compared with veterans in similar age groups and with similar clinical conditions who do use DAAs.

The significance of these two particular projects has yet to be fully realised in terms of impact on patient outcomes and hospital admissions/readmissions. What has been achieved is an improved understanding of the cost of not addressing medication management, together with the compounding effect this has both in and out of hospital, and the impact on individual patients.

Hospital care

Apart from DVA's arrangements for hospital care, DVA is exploring the interface between the hospital and the community to ensure/enhance the continuity of care. The current focus of DVA arrangements with private hospitals is in the area of preventable admissions. Two particular initiatives to address this are Enhanced Discharge Planning (EDP) and the Pay For Performance (P4P) framework. The EDP initiative encourages hospitals to identify patients that are at risk, either for clinical or social reasons. This initiative encourages hospitals to take an active role for up to two weeks after discharge, ensuring that patients have appropriate services in place and have access to these services. The hospital becomes more active in patient education in preparation for discharge as well as managing that immediate post-discharge period that is likely to lead to complications and readmission.

DVA's Pay for Performance (P4P) model was developed between 2004 and 2006. The Department sees this initiative as breaking new ground in the provision of care for the veteran community. This framework was introduced to reward hospitals for providing high quality care to veterans, particularly those suffering from chronic conditions. It complements DVA's broader goals of ensuring comprehensive care arrangements are in place for the older, sicker and more vulnerable of the veteran cohort. This at-risk cohort has traditionally been the most difficult and least cost-effective for the health system, including hospitals, to treat.

The main objective of P4P is to positively impact on patient outcomes through improvements in areas such as:

- better links to primary care to facilitate improved continuity of care
- better understanding of medication regimes and changes
- better education to facilitate veterans' self- management of chronic conditions.

This will lead to a reduction in length of stay and a decreased incidence of readmissions. In addition, P4P is intended to provide hospitals with a financial incentive to strive for higher goals in providing quality care to DVA clients.

Traditionally, hospitals have been paid for the care they provide to patients while in hospital. There has been no incentive for hospitals to help patients avoid hospital stays or to reduce length of stays. What DVA and its contracted hospitals are doing is developing a system whereby hospitals can be encouraged and rewarded for their efforts in this important area.

The P4P concept is relatively new in the Australian health care arena, and the private hospital industry has indicated its support of this model as it encourages hospitals to aspire to higher goals and be rewarded for these additional efforts. While it is expected that the DVA P4P framework will be beneficial to the Department, a successful framework will have to be beneficial and effective for hospitals.

Preventable admissions

The next phase for DVA consideration is how to integrate a range of initiatives focused on minimising the risk of patients entering hospital. DVA is exploring how it can further develop the linkages across its program, working across the health care sector rather than within the existing silos. The opportunity this presents will hopefully contribute to the broader understanding of how such activities may be applied to the challenges facing the nation's health care system. Like the P4P initiative, work on preventable hospital admissions is relatively new to Australia. DVA is keen to explore the opportunities available and quantify the effect in terms of cost and patient outcomes.