1 Executive summary

1.1 Introduction

In managing the health care of veterans and those entitled to support under the *Veterans' Entitlement Act 1986* (VEA), it is important to understand how these health services are delivered, to whom, and at what cost. This understanding is improved if the level of services can be compared with services used by other population groups in the community.

This report brings together information on health care utilisation and costs for those entitled to a Gold Card under the VEA, and the rest of the community (RoC) in relation to three major health expenditure areas—hospital admitted patient treatment and associated medical services (estimated at $1,200m in 1999–00), pharmaceuticals ($280m), and local medical officers (LMOs)/general practitioners (GPs) ($120m).

While it is recognised that the VEA also entitles some veterans and their dependants to health care under other schemes (e.g. the White and Orange Cards), for comparative purposes the Gold Card holders (of which there were 290,000 in 1999–00) were chosen due to the quality and range of data regarding their service use and cost.

It should be remembered that the delivery and costs of health services is clearly changing in the type of services, method of delivery, the level and type of entitlements, and the population age and health status distribution. While it is known that some of these elements have changed recently, this report provides a snapshot using the latest available data for the period 1997–2000.

Comparing populations

In comparing the use of, and expenditure on health services of Gold Card holder veterans, war widows and widowers and the rest of the community, the important differences between these populations must be understood.

First, there are differences in the following characteristics of the individuals concerned:

- age
- service-related disability
- selection effects
- marital status
- other socioeconomic and cultural factors.

Second, there are differences in the health system each group has to negotiate and use, in particular the level of co-payments (or the lack of them) required for each

service. Similarly, whether the service is delivered in a public or a private setting (e.g. hospital) can impact on the nature and quantity of services provided.

Many of these factors have been allowed for in these comparisons using statistical techniques such as age-standardisation. However data on these issues are not perfect and no statistical technique can fully adjust for differences between populations. This must be kept in mind in the interpretation of these results.

1.2 Differences in age structure, service-related disability and marital status between Gold Card holders and the rest of the community

The most obvious difference between the Gold Card holder population and the rest of the community is age structure. In 1999, 78% of the Gold Card population were aged 70 to 84 years compared to 6% of the rest of the Australian population.

Veterans and war widows and widowers comprise a significant proportion of the older Australian population:

- 34% of males aged 75 years or over are Department of Veterans' Affairs (DVA) Gold Card holders—these are mostly veterans but some are widowers.
- 11% of females aged 75 years and over are DVA Gold Card holders. Almost all are war widows, but some are veterans.

While DVA manages the health care of veterans across the age spectrum, it is important to note that due to the concentration of Gold Card holders in the 70 years and over age group, small changes in usage here have much greater significance than larger changes for those below 70 years of age.

It is also important to note that the significant differences in the level of disability within the DVA client population have a profound effect on this analysis. Of the total Gold Card holder population of 290,020 (December 1999), the four major groupings are:

- males with a service-related disability pension (113,874—39%)
- males without a service-related disability pension (66,702—23%)
- females with a service-related disability pension (2,998—1%)
- females without a service-related disability pension (106,446—37%)—mostly war widows.

The utilisation and expenditure on health services for each of these four groups is significantly different, and it is expected their future use and expenditure will also be different.

Males with service-related disability use more services than males without service-related disability and exhibit a lower life expectancy. This presumably is a reflection of poorer health status.

1.3 Summary of results

Men and women have served Australia in a number of wars and peace keeping missions over the last century. This service has placed them at greater risk of particular diseases, has exacerbated certain conditions or has resulted in newly acquired physical or mental disabilities.

The Department of Veterans' Affairs assists veterans in managing their health care through the provision of funding for services and the allocation of pensions. While some veterans enjoy good health, others have significant health problems, resulting in various forms of disability and therefore require the use of health services on a regular basis. This level of health care is provided through access to a Gold Card. It is on these Gold Card holders that this study focuses. The results of this study have shown that the patterns of health care use vary according to age, disability level, as reflected by the type of veteran disability pension, and sex. This pattern also varies according to the type of services accessed.

For example, veterans entitled to an Extreme Disablement Adjustment in their pension have a usage of local medical officers (LMO) over twice the usage of General Practitioners (GPs) by the rest of the community of similar age. In contrast, those male veterans without service-related disability have a usage of LMOs which is 9% lower than the GP usage of the rest of the community. Thus the higher use of LMO services by male veterans overall, as compared to the rest of the community of similar age, is due to the higher use by veterans with service-related disability.

Female Gold Card holders without service-related disability have somewhat higher health service usage than the rest of the community. The likely reason for this difference is that they are mostly widows. Widows are known to have poorer health status than married women, and therefore require health services more than the rest of the female population. This result is mirrored in national studies of women by marital status (AIHW: Mathers 1994).

Overall, the results of this analysis show that the patterns of health service use largely reflect the needs of the veteran community in relation to disability. After adjusting for disability and other key factors the use of health services by veterans and war widow(er)s shows similarity with the rest of the community.

Local medical officer (LMO) and general practitioner (GP) (out-of-hospital) medical services

Utilisation of LMO/GP (out-of-hospital) medical services 1999–00

- Overall, utilisation per person of LMO services by Gold Card holders aged 40 and over in 1999–00 was 17% higher than utilisation by the rest of the community (Tables 1 and 2).
- However those Gold Card holders without service-related disabilities visited their LMO at a rate on average 1% lower than that of the rest of the community—9% lower for males and 10% higher for females (Table 2).

- In this study, pension level is used as a proxy for disability status (conditions caused or aggravated by war service) as generally speaking, the more incapacitated the veteran is, the higher the amount of pension received (DVA 2002). However it should be noted that the mix of disabilities and the services required to ameliorate them would be variable within disability levels (see Section 2.2 and Appendix A for details on disability levels).
- As service-related disability pension levels increase, usage of LMO services per person increases. In comparison with the rest of the community, Gold Card holders:
  - with a low level of disability used 15% more LMO services;
  - with a medium level of disability used 42% more LMO services;
  - with special disability pensions used 59% more LMO services; and
  - in the small group receiving an Extreme Disablement Adjustment (EDA) used 111% more services (Table 2).

LMO/GP costs per attendance 1999–00

- For those aged 40 years and over, the cost per attendance was 12% higher for Gold Card holders ($30.41) than their community cohort ($27.13) in 1999–00 (Table 10). This difference is exactly what was expected given that the contracts between DVA and LMOs specify payment of 100% of the Medicare Schedule Fee, and the rest of the community is mostly bulk-billed—overall the average cost for a GP service for the rest of the community aged 70 and over is 88% of the Schedule Fee for the period examined.
- Whether there is a difference in the quality or type of services, e.g. average length of consultation, is a matter that requires further investigation.

LMO/GP expenditure per person 1999–00

- Gold Card holders (both male and female) aged 40 years and over have expenditure on LMO services 31% higher than expenditure by the rest of the community—17% of this difference was due to higher utilisation and 12% was due to higher cost per attendance (Table 13).
- For male Gold Card holders aged 40 years and over without service-related disability, expenditure on LMO services per person was 1% higher than expenditure by the rest of the male population—a combination of 9% lower utilisation and 11% higher cost per attendance.
- For females without service-related disability—mostly war widows—expenditure on LMO services per person was 23% higher than expenditure by the rest of the female population—a combination of 10% higher utilisation and 12% higher cost per attendance.

Growth in LMO/GP expenditure per person 1997–98 to 1999–00

- The growth in expenditure on LMOs per Gold Card holder between 1997–98 and 1999–00 was 7.7%, compared to an increase of 10.1% for the rest of the community (Table 16).
- The growth in expenditure per person can be split into utilisation and price components. For Gold Card holders, utilisation per person fell by 0.4% between 1997–98 and 1999–00, compared to an increase of 2.8% for the rest of the community. The growth in cost per attendance for Gold Card holders was 8.1% compared to a 7.1% increase for the rest of the community.

Table 1: Age-standardised LMO and GP attendances per person for Gold Card holders and the rest of the community, by age, Australia, 1999–00

	Gold Card holders						
Age	Nil or no disability[a]	Low disability[b]	Medium disability[c]	Special disability[d]	Extreme disability[e]	Total	Rest of community[f]
Males							
40–59	7.1 *	5.9 *	6.8 *	11.1 *	..	9.9 *	4.9
60–69	7.1 *	9.2 *	13.0 *	15.2 *	22.8 *	11.5 *	7.6
70–84	10.0 *	12.2 *	16.8 *	18.7 *	27.7 *	13.2 *	11.4
85+	13.4	15.4 *	19.2 *	21.0 *	28.9 *	15.8 *	13.2
40+	*9.9 *	*11.9 *	*16.0 *	*18.1 *	*25.5 *	*13.1 *	*10.9*
Females							
40–59	7.8 *	3.4 *	4.1 *	9.9 *	..	8.0 *	6.7
60–69	10.5 *	9.9 *	11.8 *	7.3 *	..	10.5 *	9.1
70–84	12.8 *	14.5 *	16.3 *	18.5 *	23.5 *	12.9 *	11.6
85+	15.9 *	18.8 *	15.2 *	17.3 *	19.0 *	15.9 *	14.0
40+	12.5 *	13.8 *	15.5 *	17.1 *	20.0 *	12.6 *	11.3
Persons							
40–59	7.2 *	5.5 *	6.4 *	10.9 *	..	9.6 *	5.2
60–69	9.0 *	9.6 *	12.4 *	10.8 *	10.1 *	11.0 *	8.4
70–84	11.0 *	13.1 *	16.6 *	18.6 *	26.2 *	13.1 *	11.5
85+	14.6 *	17.1 *	17.2 *	19.2 *	24.1 *	15.9 *	13.6
40+	11.0	12.8 *	15.8 *	17.8 *	23.5 *	13.1 *	11.1

(a) Includes war widow(er)s, non-pensionable incapacity veterans and other Gold Card holders without service-related disability.

(b) Low disability are 5–95% disability pensioners.

(c) Medium disability are 100% disability pensioners.

(d) Special disability include special and intermediate rate disability pensioners—TTI, TPI, BLI and INT.

(e) Extreme disability are pensioners receiving extreme disablement adjustment (EDA).

(f) Rest of community includes White Card holders.

Notes

1. .. Denotes not applicable, as there are no veterans or war widow(er)s with these disability allowances in these age groups.
2. * Denotes significantly different at the 5% level from the rest of community.

Table 2: Ratio of LMO and GP attendances per person for Gold Card holders and the rest of the community, by age, Australia, 1999–00

	Gold Card holders						
Age	Nil or no disability[a]	Low disability[b]	Medium disability[c]	Special disability[d]	Extreme disability[e]	Total	Rest of community[f]
Males							
40–59	1.46 *	1.21 *	1.40 *	2.27 *	..	2.03 *	1.00
60–69	0.93 *	1.20 *	1.71 *	1.99 *	2.98 *	1.50 *	1.00
70–84	0.87 *	1.07 *	1.47 *	1.64 *	2.43 *	1.16 *	1.00
85+	1.01	1.17 *	1.46 *	1.59 *	2.19 *	1.20 *	1.00
40+	*0.91 **	*1.09 **	*1.47 **	*1.67 **	*2.34 **	*1.21 **	*1.00*
Females							
40–59	1.17 *	0.51 *	0.62 *	1.48 *	..	1.20 *	1.00
60–69	1.16 *	1.09 *	1.31 *	0.81 *	..	1.16 *	1.00
70–84	1.10 *	1.25 *	1.40 *	1.60 *	2.03 *	1.11 *	1.00
85+	1.13 *	1.34 *	1.08 *	1.24 *	1.36 *	1.14 *	1.00
40+	*1.10 **	*1.22 **	*1.37 **	*1.52 **	*1.77 **	*1.11 **	*1.00*
Persons							
40–59	1.40 *	1.06 *	1.23 *	2.10 *	..	1.85 *	1.00
60–69	1.07 *	1.14 *	1.47 *	1.28 *	1.19 *	1.30 *	1.00
70–84	0.96 *	1.14 *	1.45 *	1.62 *	2.28 *	1.14 *	1.00
85+	1.08 *	1.26 *	1.27 *	1.41 *	1.77 *	1.17 *	1.00
40+	*0.99*	*1.15 **	*1.42 **	*1.59 **	*2.11 **	*1.17 **	*1.00*

(a) Includes war widow(er)s, non-pensionable incapacity veterans and other Gold Card holders without service-related disability.

(b) Low disability are 5–95% disability pensioners.

(c) Medium disability are 100% disability pensioners.

(d) Special disability include special and intermediate rate disability pensioners—TTI, TPI, BLI and INT.

(e) Extreme disability are pensioners receiving extreme disablement adjustment (EDA).

(f) Rest of community includes White Card holders.

Notes

1. .. Denotes not applicable, as there are no veterans or war widow(er)s with these disability allowances in these age groups.
2. * Denotes significantly different at the 5% level from the rest of community.

Pharmaceuticals

- Male Gold Card holders have a higher usage rate of pharmaceuticals than the rest of the community, for all age groups (Table 17). These differences seem to be related to the higher number of LMO/GP consultations for Gold Card holders, whereas the propensity to prescribe pharmaceuticals in each consultation seems to be similar to the rest of the community.
- Estimates of script usage for Gold Card holders by disability group are not available at present, although may be the subject of further work. Despite this, it is expected that Gold Card holders without service-related disabilities will show lower script usage per person than the rest of the community, as a result of their lower LMO/GP consultation rates.

- In contrast to males, female Gold Card holders show lower utilisation rates of pharmaceuticals compared with their rest of community counterparts, with fewer scripts filled per LMO/GP consultation. However, this difference is not supported by the Bettering the Evaluation and Care of Health (BEACH) GP survey data (see Methodology section), which indicates no difference in scripts written per LMO/GP visit between the two groups. A possible explanation is that some female Gold Card holders may be processing their scripts through the Pharmaceutical Benefits Scheme (PBS) (with or without using a seniors concession card), rather than using the Gold Card, resulting in only a proportion of their script purchases being recorded on the DVA Repatriation Pharmaceutical Benefits Scheme (RPBS) database.

Table 3: Age-standardised PBS script utilisation per person for Gold Card holders and the rest of the community, by age, Australia, 1999–00

	PBS scripts per person per year		
Age	Gold Card holders	Rest of community[a]	Ratio of Gold Card holders to rest of community
Males			
40–69	36.4 *	17.2	2.11
70–79	45.7 *	37.0	1.24
80–89	45.4 *	38.9	1.17
90+	41.1 *	32.5	1.26
40+	*44.5 **	*35.1*	*1.27*
Females			
40–69	27.2 *	22.6	1.20
70–79	36.5 *	39.8	0.92
80–89	38.6 *	40.1	0.96
90+	35.6 *	36.9	0.96
40+	*36.0 **	*37.8*	*0.95*
Persons			
40–69	33.1 *	19.9	1.66
70–79	42.3 *	38.6	1.10
80–89	42.8 *	39.7	1.08
90+	37.7 *	35.8	1.05
40+	*41.3 **	*36.7*	*1.13*

(a) Rest of community includes White Card holders.

Note: * Denotes significantly different at the 5% level from the rest of community.

Hospital services

- Utilisation of acute hospital services by Gold Card holders was higher than for the rest of the community. Hospital separations per person for 1999–00 showed a 21% higher use for all Gold Card holders (Table 4).
- As with LMO/GP services, the utilisation of acute hospital services by Gold Card holders is strongly related to their level of service-related disability. In 1999–00, the hospital separation rate for Gold Card holders aged 40 years and over increased from 0.8 separations per person for those with nil or no disability to 2.4 separations per person for those with an Extreme Disablement Adjustment. The hospital separation rate for those with nil or no service-related disability was similar to the rate for the rest of the community in 1999–00, while those with low disability (5–95% disability pension) had a rate 14% higher than the rest of the community.
- There is little difference in the average length of stay spent in hospital per episode between Gold Card holders and the rest of the community for the 70 and over age group. However, in the 40–69 age group, the average length of stay for Gold Card holders is about 15% higher than for the rest of the community.
- Hospital separations can be cost weighted to reflect the relative cost of different hospital procedures undertaken for each separation. A comparison of the Diagnosis Related Group (DRG) cost weights for separations of Gold Card holders and the rest of the community indicates there is little difference in the costliness of hospital procedures undertaken for each group.

Table 4: Ratio of hospital separations per person for Gold Card holders and the rest of the community, by age, Australia, 1999–00

	Gold Card holders						
Age	Nil or no disability[a]	Low disability[b]	Medium disability[c]	Special disability[d]	Extreme disability[e]	Total	Rest of community[f]
Males							
40–59	1.21	1.22 *	1.71 *	2.70 *	..	2.37 *	1.00
60–69	0.98	1.27 *	1.74 *	2.20 *	4.65 *	1.64 *	1.00
70–84	0.88 *	1.08 *	1.55 *	1.56 *	3.02 *	1.20 *	1.00
85+	0.90 *	1.09 *	1.44 *	1.41 *	2.49 *	1.12 *	1.00
40+	*0.90 **	*1.09 **	*1.55 **	*1.59 **	*2.93 **	*1.24 **	*1.00*
Females							
40–59	1.19 *	0.74 *	1.16	1.68 *	..	1.24 *	1.00
60–69	1.22 *	0.45 *	1.31	0.91	..	1.22 *	1.00
70–84	1.14 *	1.27 *	1.47 *	1.90 *	2.81 *	1.16 *	1.00
85+	1.04	1.49 *	0.89	0.90	1.81	1.04	1.00
40+	*1.11 **	*1.17 **	*1.39 **	*1.74 **	*2.45 **	*1.13 **	*1.00*
Persons							
40–59	1.20 *	1.14 *	1.61 *	2.52 *	..	2.17 *	1.00
60–69	1.11	0.84 *	1.51 *	1.52 *	2.20 *	1.42 *	1.00
70–84	0.96 *	1.13	1.52 *	1.66 *	2.96 *	1.19 *	1.00
85+	0.95 *	1.25 *	1.21 *	1.20 *	2.21 *	1.09 *	1.00
40+	*0.97 **	*1.14*	*1.49 **	*1.62 **	*2.77 **	*1.21 **	*1.00*

(a) Includes war widow(er)s, non-pensionable incapacity veterans and other Gold Card holders without service-related disability.

(b) Low disability are 5–95% disability pensioners.

(c) Medium disability are 100% disability pensioners.

(d) Special disability include special and intermediate rate disability pensioners—TTI, TPI, BLI and INT.

(e) Extreme disability are pensioners receiving extreme disablement adjustment (EDA).

(f) Rest of community includes White Card holders.

Notes

1. .. Denotes not applicable, as there are no veterans or war widow(er)s with these disability allowances in these age groups.
2. * Denotes significantly different at the 5% level from the rest of community.

Conclusion

The tale of health services usage and expenditure by veterans and war widow(er)s is a tale of difference and similarity.

For LMO/GP services, pharmaceuticals and hospital services there is substantial similarity of usage between Gold Card holders and the rest of the community once differences in age, service-related disability and marital status are accounted for.

With regard to cost per service, there are differences between Gold Card holders and the rest of the community due to policy decisions. The national health insurance scheme—Medicare—has encouraged bulk-billing of accounts at a discounted price of 85% of the Schedule Fee. In 1999–00 many GP consultations were bulk-billed, especially for the older population, but some were charged at a higher rate. The

average cost per GP consultation was 88% of the Schedule Fee for those aged 70 and over. DVA have agreed higher prices with LMOs than the bulk-billing rate, and it is probable that this policy has positive consequences with regard to patient care. Similar circumstances have applied for medical specialists but the introduction of gap insurance and reduced utilisation of bulk-billing will have diminished, and in some cases increased, differences in incentives for treatment of veterans compared to the rest of the community.

The payment regime for pharmaceuticals is similar for Gold Card holders and the rest of the community of a similar age, so this is not expected to be a factor in any differences in utilisation.

Further work

In undertaking the analyses discussed in this report, it has become clear that further work is required to more fully understand the patterns of health care utilisation amongst Gold Card holders. Some of the key questions that have been raised during this analysis are:

- What are the health care utilisation patterns and costs for Gold Card holders for specialists?
- How does pharmaceutical use relate to disability status?
- Are war widows putting all of their prescriptions through the Gold Card system?
- Is DVA being inappropriately charged for safety net scripts that are for the spouses of veterans?
- How does hospital utilisation vary over time by DRG, hospital-associated medical services, public/private hospital and State?

Further work also needs to be done to address:

- effects of transition from White Card holder status to Gold Card holder status
- effects of transition to and across disability categories
- projections of utilisation and expenditure
- expenditure on health care services in the last years of life
- incorporating later years of data to address new policy circumstances
- analysing other areas of health care (e.g. allied health, aged care homes, Veterans' Home Care and Health and Community Care services, dental).