

The Auditor-General
Audit Report No.35 2011–12
Performance Audit

Indigenous Early Childhood Development. New Directions: Mothers and Babies Services

Department of Health and Ageing

Australian National Audit Office

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ISSN 1036-7632

ISBN 0 654 81242 X

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Canberra ACT
29 May 2012

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Department of Health and Ageing in accordance with the authority contained in the Auditor-General Act 1997. I present the report of this audit, and the accompanying brochure, to the Parliament. The report is titled *Indigenous Early Childhood Development. New Directions: Mothers and Babies Services*.

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



Ian McPhee
Auditor-General

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

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACHS	Australian Council on Healthcare Standards
AH&MRC	Aboriginal Health and Medical Research Council
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
ANAO	Australian National Audit Office
ANFPP	Australian Nurse Family Partnership Program
COAG	Council of Australian Governments
DEEWR	Department of Education, Employment and Workplace Relations
DoHA	Department of Health and Ageing
EQulP	Evaluation and Quality Improvement Council
HFL	Health for Life program
IECD NP	National Partnership Agreement on Indigenous Early Childhood Development
IGA	Intergovernmental Agreement on Federal Financial Relations
ISO	International Organization for Standardization
New Directions	New Directions: Mothers and Babies Services
NIRA	National Indigenous Reform Agreement

nKPI	National Key Performance Indicator
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OECD	Organisation for Economic Cooperation and Development
PBS	Portfolio Budget Statement
QIC	Quality Improvement Council
RAM	Resource Allocation Model
RAPT	Risk Assessment Profile Tool
RSD	Remote Service Delivery
SDRF	Service Delivery Report Framework
STOs	State and Territory Offices
WGIR	Working Group on Indigenous Reform

Glossary

Aboriginal Community Controlled Health Service	An Aboriginal Community Controlled Health Service (ACCHS) is a primary health care service initiated and operated by the local Aboriginal community to deliver health care to the community which controls it (through a locally elected Board of Management). An ACCHS may range from a large multi-functional service employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, which rely on Aboriginal health workers and/or nurses to provide the bulk of primary care services, often with a preventive, health education focus.
Aboriginal Medical Service	An Aboriginal Medical (AMS) is a health service funded principally to provide services to Aboriginal and Torres Strait Islander people, however an AMS is not necessarily community controlled.
Closing the Gap	Closing the Gap is a commitment by all Australian governments to improve the lives of Indigenous Australians, and in particular provide a better future for Indigenous children. The commitment is supported by six targets that measure improvements in life expectancy, employment and education.
Council of Australian Governments (COAG)	Peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association. The role of COAG is to initiate, develop and monitor the implementation of policy reforms that are of national significance and which require cooperative action by Australian governments.
Infant mortality	Deaths of children under one year of age.

Children 0–4 years mortality rate	The number of deaths of children 0 to 4 years of age in a given period, expressed per 1000 live births in the same period.
National Indigenous Reform Agreement	Overarching agreement between the Australian and state/territory governments to give effect to the Closing the Gap policy commitment. Supported by a series of bilateral agreements with each state and territory government, and a range of national partnership agreements.
National Partnership Agreement	An agreement between the Australian Government and state and territory governments related to the delivery of specified projects that deliver on nationally-significant reforms.
Service Delivery Principles for Programs and Services for Indigenous Australians	Principles articulated in the National Indigenous Reform Agreement to guide the Council of Australian Governments in the design and delivery of programs and services provided to Indigenous people and the development and negotiation of National Partnership Agreements, National Agreements and reform proposals.
Service providers	Service providers are organisations that receive funding from the Australian Government for the delivery of programs and services.

Summary and Recommendations

Summary

Introduction

1. In December 2007, the Council of Australian Governments (COAG) committed to a national effort to close the gap in life expectancy and opportunity between Indigenous and non-Indigenous Australians. COAG identified six targets that, if achieved over the long term, would increase the life expectancy, health, education and employment opportunities of Indigenous Australians. While all Australian Governments had previously committed to raising the standard of Indigenous Australians' health to that of other Australians, COAG's commitment was the first time Australian governments had agreed to be accountable for reaching this goal by placing its targets within a timeframe.¹ One of the targets agreed by COAG is to halve the mortality rate of Indigenous children within 10 years (by 2018).
2. Currently, Indigenous children do not enjoy an equal start in life. Indigenous children are more likely to be born with certain congenital anomalies, and to live with some chronic health conditions, than non-Indigenous children.² Many Indigenous families are also not using the maternal and early childhood services that would help give their children a healthy start in life.
3. Poor maternal health, growing up in households with multiple disadvantages, or having poor access to effective services can affect children's development, health, social and cultural participation, educational attainment and employment prospects.³ Evidence for investing in the early years in all aspects of a child's development, health, education, family and community support is strong, and is particularly compelling for children from disadvantaged backgrounds.⁴ Research shows that a greater focus on

¹ Australian Human Rights Commission, *Closing the Gap: National Indigenous Health Equality Targets (2008)*, viewed online <www.hreoc.gov.au/social_justice/health/targets/index.html> [accessed 2 September 2011].

² K Rudd, N Roxon, J Macklin & S Smith, *New directions: An equal start in life for Indigenous children*, May 2007, Canberra, Australian Labour Party, May 2007, p. 6.

³ Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra.

⁴ Australian Medical Association, *Lifting the Weight - Low Weight Babies: An Indigenous health burden that must be lifted*, AMA, 2005. [Internet] available from <<http://ama.com.au/node/3185>> [accessed 9 June 2011].

interventions in the critical years from conception to age eight, can accrue substantial benefits for Indigenous children and can also contribute significantly to the achievement of the COAG targets relating to later life outcomes.⁵

Infant and child mortality

4. Infant mortality, defined by the Australian Bureau of Statistics as deaths of children aged under one year⁶, has been traditionally viewed as an indicator of the general level of mortality, health and wellbeing of a population and as such has received special attention in public health policy. Most childhood deaths occur in the first year of life and the mortality rate of infants is generally different to that of children aged one year and over.

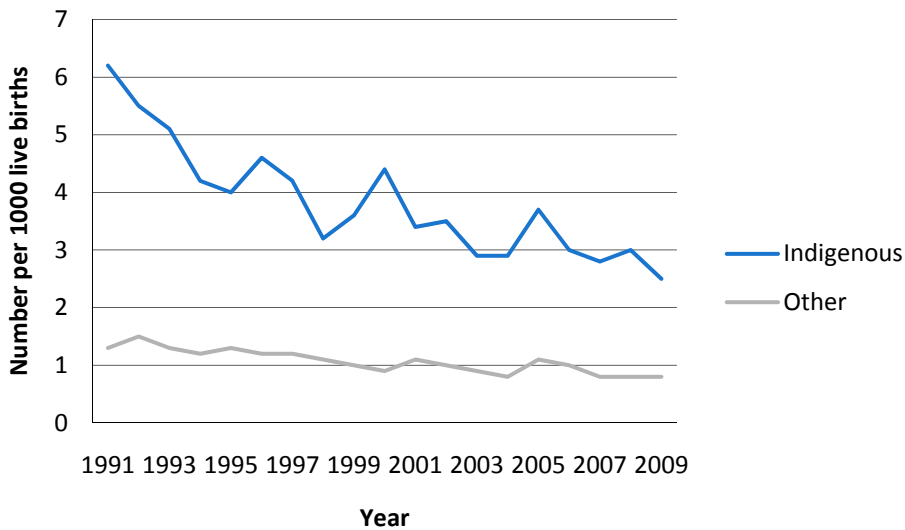
5. Long-term mortality data over the period 1991 to 2009 shows that the Indigenous child mortality rate is declining and the gap between the Indigenous and non-Indigenous rate is also narrowing. However, the mortality rate is still considerably higher for Indigenous children and Indigenous children still experience significantly worse health outcomes compared to non-Indigenous children.⁷ Figure 1 shows that the gap between mortality rates for Indigenous and non-Indigenous children aged 0 to 4 years narrowed from a rate of 4.9 to 1.7 per 1000 between 1991 and 2009.⁸ Figure 1 also shows, that despite the narrowing gap, mortality rates for Indigenous children remain higher than those of non-Indigenous children.

⁵ Council of Australian Governments, *National Partnership Agreement on Indigenous Early Childhood Development*, 2009, p.3. [Internet] available from <http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NP_indigenous_early_childhood_development.pdf> [accessed 6 June 2011].

⁶ Australian Bureau of Statistics, *Deaths, Australia*, cat. no. 3302.0, Canberra, ABS, 2009, p. 13.

⁷ Australian Institute of Health and Welfare, *A Picture of Australia's Children*, cat. no. PHE112, Canberra, AIHW, 2009.

⁸ Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra, p. 4.24.

Figure 1**Child (0 to 4 years) mortality rates 1991–2009**

Source: ABS, *Deaths, Australia, 2010*, cat no. 3302.0

6. International and Australian research shows that improving access to quality antenatal healthcare and maternal health services combined with other factors, such as better nutrition, the reduction in risk behaviours during pregnancy (such as alcohol and tobacco use), and annual health checks for children, can reduce the risk of poor health outcomes among Indigenous children.⁹ While 97 per cent of Aboriginal and Torres Strait Islander mothers access antenatal services at least once during their pregnancy,¹⁰ the challenge has been to facilitate more frequent and earlier access as Indigenous mothers are accessing these services later in their pregnancy and less frequently than other mothers.¹¹

7. There are a range of factors and policy interventions that influence child mortality rates. The Australian Government has also invested in

⁹ Australian Institute of Health and Welfare, *A Picture of Australia's Children*, cat. no. PHE112, Canberra, AIHW, 2009.

Australian Health Ministers Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2010*, AHMAC, Canberra, p. 8.

¹⁰ *ibid.*, p. 130.

¹¹ Australian Health Ministers Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2010*, AHMAC, Canberra, p. iv.

measures aimed at directly addressing Indigenous maternal and child health as part of the *National Indigenous Reform Agreement* (NIRA) in support of COAG targets. Under the *Indigenous Early Childhood Development National Partnership*, specific attention is being given to improving access to, and use of, maternal and child health services. Governments in all Australian jurisdictions have jointly committed to expenditure of \$165.3 million over the 5 year period 2007–08 to 2011–12.¹² The Australian Government's contribution of \$90.3 million¹³ is provided through the *New Directions: Mothers and Babies Services* (New Directions) program administered by the Department of Health and Ageing (DoHA).

New Directions: Mothers and Babies Services

8. The New Directions program was established by the Australian Government as a separate program on 1 January 2008. It was subsequently subsumed into the *Indigenous Early Childhood Development National Partnership*, (IECD NP) from 1 July 2009 following the development of the *National Indigenous Reform Agreement* (NIRA) in November 2008. A range of national partnerships were developed to give effect to the NIRA. Among these, the IECD NP commits to improving child health and education through integrated service provision, linking and building on existing services and helping to ensure that services are tailored to specific needs of rural, regional and urban communities. The IECD NP has three elements:

- Element One: integration of early childhood services through Children and Family Centres;
- Element Two: increased access to antenatal care, pre-pregnancy and teenage sexual and reproductive health; and
- Element Three: increased access to, and use of, maternal and child health services by Indigenous families (*New Directions: Mothers and Babies Services*).

¹² Council of Australian Governments, *National Partnership Agreement on Indigenous Early Childhood Development*, July 2009, paragraph 34. [Internet]. COAG, available from <http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NP_indigenous_early_childhood_development.pdf> [accessed 12 October 2011].

¹³ This funding includes both administered and departmental funds and a small amount for scholarships. The Puggy Hunter Memorial Scholarship Scheme aims to help address the under-representation of Aboriginal and Torres Strait Islander people in health professions. The scholarship provides financial assistance to Aboriginal and Torres Strait Islander people who are undertaking study or are intending to undertake study in a health related discipline. The scholarships are outside the scope of this audit.

9. Elements One and Two are implemented by state and territory governments using Australian Government funding. Parallel arrangements have been put in place for the delivery of Element Three by the Australian Government through DoHA.

10. The Australian Government's commitment to Element Three of \$90.3 million over five years represents the Australian Government's own purpose contribution. Of this amount, \$86.1 million has been allocated for provision to service providers. As maternal and child health is seen to be a shared responsibility between the Australian and state and territory governments, under Element Three the states and territories have also made direct investments of \$75 million to deliver antenatal, postnatal and maternal and child health services to Indigenous families¹⁴ alongside the services funded by the Australian Government.

11. Australian Government funds are apportioned across jurisdictions taking into account the Indigenous population in each state and territory and applying a loading for remote service delivery. Unlike other National Partnership Agreements, where Australian Government funds are provided to state and territory governments for implementation, these funds are paid by DoHA directly to the selected service providers in each state and territory under grant agreements. Table 1 shows the indicative proportion of New Directions Australian Government funds across the jurisdictions to 2011–12 and the separate funding contributions of each state and territory.

Table 1

New Directions, indicative proportion of Australian Government and state and territory funding 2007–08 to 2011–12

Jurisdiction	Australian Government own purpose expenditure* (\$m)	State and territory own purpose expenditure (\$m)
NSW	20.0	21.50
QLD	25.5	21.50
SA	4.0	3.75
WA	15.0	11.25

¹⁴ Council of Australian Governments, *National Partnership Agreement on Indigenous Early Childhood Development*, July 2009, paragraph 35. [Internet]. COAG, available from <http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NP_indigenous_early_childhood_development.pdf> [accessed 12 October 2011].

Jurisdiction	Australian Government own purpose expenditure* (\$m)	State and territory own purpose expenditure (\$m)
VIC	4.0	4.50
Tas	3.0	2.50
ACT	0.5	0.50
NT	18.0	9.75
TOTAL	90.0	75.00

Source: Closing the Gap: National Partnership Agreement of Indigenous Early Childhood Development. The IECD identified total funding of \$90.3m. The sum of the components does not add to the total because of rounding.

* Australian Government funds are paid directly to service providers in each state and territory.

12. The Australian Government announced in the 2011–12 Budget that the program would receive additional funding of \$133.8 million over the four year period from 2011–12.

13. The IECD NP identifies that the New Directions program is designed to provide increased access to, and use of, Indigenous maternal and child health care in regions of high need with an emphasis on early presentation and regular visits throughout pregnancy. This is to be facilitated through the Australian Government funding the expansion of child and maternal health services and by increasing the number of health professionals working in the identified priority regions so that more Indigenous children can be seen and treated—directly resulting in better health.

14. The objective of the program is to deliver services in five priority areas:

- antenatal and postnatal care;
- standard information about baby care;
- practical advice and assistance with breastfeeding, nutrition and parenting;
- monitoring of developmental milestones, immunisation status and infections; and
- health checks and referrals to treatment for Indigenous children before starting school.

Audit objectives and criteria

15. The objective of the audit was to examine the effectiveness of the Department of Health and Ageing's administration of New Directions. In this respect the ANAO considered whether:

- planning processes were developed to support the program's objectives and rationale;
- implementation arrangements were clearly defined and aligned to the objectives of the program; and
- robust performance management arrangements had been established and were in use by the department.

16. Fieldwork was conducted in DoHA's National Office and in its New South Wales, Queensland and Victorian state offices. The ANAO visited 12 health service providers funded under the program located in the same states.

Overall conclusion

17. Good maternal health is an important factor in achieving good health outcomes for children, and a low infant mortality rate is a major contributor to improving overall life expectancy. Through the *National Indigenous Reform Agreement*, Australian governments have committed to a set of development targets, including halving the gap in mortality rates between Indigenous and non-Indigenous children under the age of five years by 2018. Improving access to, and use of, maternal health care services is a key objective of the *Indigenous Early Childhood Development National Partnership* (IECD NP). To this end the Australian Government committed an initial \$90.3 million between 2007–08 to 2011–12 to expand access for Indigenous women to maternal and child health services. A further \$133.8 million has been committed to maintain these services over a further four years from 2011–12.

18. Overall, the Department of Health and Ageing (DoHA) has been effective in establishing and implementing the *New Directions: Mothers and Babies Services* (New Directions) program, consistent with the objectives set by government. To meet the Government's required implementation timeline within the first six months of the program, the department undertook a truncated process to identify priority sites and engage the initial five service providers. In subsequent annual funding rounds, however, DoHA made effective use of its existing local level coordination and consultative

mechanisms to support the planning and implementation of the program by inviting applications from providers which were then assessed against agreed criteria. Against an original target of engaging 50 service providers by 2011–12, as at November 2011 DoHA was funding 80 providers to deliver a combination of agreed services in all states and territories. Total program expenditure had reached \$65 million of the \$86.1 million allocated for provision to service providers. By the end of 2011–12 the department anticipates that it will be funding 82 service providers with no further providers to be funded.

19. The responsibilities for local program implementation have been devolved to DoHA's state and territory offices and the department has put in place approaches to promote a general level of consistency across the states and territories in the selection of sites, providers and the services to be offered. Risk management approaches have been less well developed and the department would benefit from an improved ability to aggregate information at the national level about the delivery of the program in each state and territory.

20. Between 1991 and 2009 the gap between the mortality rates for Indigenous and non-Indigenous children has narrowed. The Australian Health Ministers' Advisory Council considered that if current trends continue, it is likely that Indigenous child mortality rates will fall within the COAG target by 2018.¹⁵ A range of factors influence mortality rates and improving access to, and use of, maternal and child health services is likely to be an important contributor to this trend, although its actual contribution will vary depending upon the relative importance of other influencing factors such as housing, education, employment and other social determinants.

21. A consequence of there being a range of influencing factors is that identifying the specific contribution of any one factor is challenging. Nonetheless, in terms of the specific objectives contained in the IECD NP of increasing the access to, and use of, maternal and child health services, DoHA's performance management approach could be improved as it currently only captures the numbers of service providers being funded as a proxy indicator for improved access. Collecting and reporting data that provides an indication on whether New Directions has been effective in improving the use

¹⁵ Australian Health Ministers Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2010*, AHMAC, Canberra, p. i.

of these services would significantly strengthen the understanding of the specific changes resulting from the program's funding in this respect.

22. The ANAO has made one recommendation to support the effective administration on New Directions. The recommendation relates to DoHA's approach to service provider and program performance management and the need for improved access to, and capture of, performance data to more effectively manage and support the program.

Key findings

Program development and planning for effective service delivery

23. The New Directions program went through two separate implementation periods; the first from January 2008 as a Labor Government election commitment, and the second from July 2009 following its integration into the IECD NP. In the initial stages of implementation, DoHA gave appropriate consideration to most of the key aspects of program development, including how the program would be governed, as well as providing clarity about the policy objectives and rationale, program components, delivery model, and implementation strategy. However, the audit found that less attention was given in the planning stage to the program performance and monitoring arrangements and to risk identification.

24. In adapting the program to become part of the IECD NP, DoHA engaged with relevant government stakeholders at both the federal and state/territory levels through the COAG supported Working Group on Indigenous Reform. In the process of incorporating the program into the IECD NP, the program's objective was refined by adding a focus on the use of maternal and child services to the original access objective. However, this change has not been reflected in the Australian Government's IECD NP Implementation Plan, annual report and associated documents.

Program implementation

25. The first round of funding was implemented in a tight timeframe because of the Government's desire to quickly implement election commitments, and funding was provided to a small number of providers through a select tender process. Subsequent funding rounds have been more tightly managed through DoHA's annual coordination and planning processes. Coordination of program effort has taken into account other Australian and state/territory government initiatives directed at child and

maternal health. DoHA recognised that the continued successful delivery of services through New Directions required a significant level of planning and coordination across DoHA's state and territory offices (STOs).

26. Implementation responsibilities have been devolved to DoHA's STOs. DoHA has put in place mechanisms to promote coordination and procedural consistency in regards to regional planning and site selection, service provider selection and management. DoHA has also used the pre-existing Aboriginal and Torres Strait Islander Health Forums to develop relationships with state and territory stakeholders, such as health departments and Indigenous medical services. The forums have proven to be an effective way for the department to consult jurisdictions on priority regions, on the identification of service gaps and to coordinate delivery of maternal and child health services.

27. The implementation of the program is dependent on the effective operation of service provider organisations and DoHA has developed regular processes for assessing risk at this level. Until December 2011, DoHA STOs undertook risk assessments using a standard Risk Assessment Profile Tool (RAPT) to assess corporate governance and financial management. Since December 2011 risk assessments have been outsourced but continue to use the standard RAPT. Program implementation would be strengthened by a stronger approach to risk management at the program level to complement the operational risk assessments of providers. The 2009 Implementation Plan, covering the Australian Government's contribution, indicated that a risk management plan was to be completed and reviewed each year. However, this has not occurred. DoHA is aware of this issue and has indicated that efforts are underway to complete the plan.

Performance monitoring and reporting

28. There is presently little performance data available to support an assessment of the extent to which New Directions has contributed to improvements in maternal and child health and the quality and effectiveness of the services provided. The performance indicators in use relate to the number of service providers and the timeliness of enlisting new service providers. The indicators, while helpful to measure activity under the program, do not provide sufficient insight into the program's achievements with regard to improving access to, and use of, maternal and child health services as intended by the IECD NP.

29. In the initial development phase of the program, DoHA deliberately sought to limit the amount of information it would require from service providers. This decision was influenced by concerns at the time from the sector about administrative burden and a desire to streamline data collection. While it is important to ensure the costs involved in collecting data for performance indicators are appropriate to the benefits gained from the resulting information in this case the emphasis on minimising performance reporting requirements has had a significant impact on the quality of performance data available to assist managers and external stakeholders. As a consequence, very few performance indicators and targets were developed and there was no agreement to any baseline information against which to measure change. This has limited DoHA's ability to understand the program's effectiveness and, in particular, the impact and contribution it is making to the outcomes of the IECD NP. This will also constrain the ability of the department to conduct an evaluation of the program, the results of which are planned for release in 2014, some seven years after the commencement of New Directions.

30. Proportionality is a key consideration in determining the comprehensiveness of a performance measurement framework. As the Government has committed a further \$133.8 million to continue the program, it would be timely for DoHA to develop a stronger approach to collecting performance information so as to better assess whether the specific objectives of the program are being achieved.

Summary of agency response

31. A summary of the Department of Health and Ageing's (DoHA) response to the report, dated 9 May 2012, is as follows.

The Department of Health and Ageing welcomes the ANAO report and notes that work is underway to enhance the performance monitoring of the New Directions: Mothers and Babies Services program. The Department is also implementing strategies to apply a stronger approach to risk management of the program.

The Department agrees with the report's recommendation.

Recommendations

Recommendation No.1

Paragraph 4.33

To support better management of the *New Directions: Mothers and Babies Services* program, ANAO recommends that the Department of Health and Ageing review its performance framework and strengthen measures to monitor service delivery and determine whether use of services is improving in line with the program's objectives.

DoHA's response: Agreed

Audit Findings

1. Introduction

Background

Indigenous maternal and child health

1.1 In December 2007, the Council of Australian Governments (COAG) committed to a national effort to close the gap in life expectancy and opportunity between Indigenous and non-Indigenous Australians. COAG identified six targets that, if achieved over the long term, would increase the life expectancy, health, education and employment opportunities of Indigenous Australians. Appendix 1 sets out the six COAG targets. While all Australian Governments had previously committed to raising the standard of Indigenous Australians' health to that of other Australians, COAG's commitment was the first time Australian governments had agreed to be accountable for reaching this goal by placing its targets within a timeframe.¹⁶ One of the targets agreed by COAG is to halve the mortality rate of Indigenous children within 10 years (by 2018).

1.1 Currently, Indigenous children do not enjoy an equal start in life. Indigenous children are more likely to be born with certain congenital anomalies, and to live with some chronic health conditions, than non-Indigenous children.¹⁷ Many Indigenous families are also not using the maternal and early childhood services that would help give their children a healthy start in life.

1.2 Poor maternal health, growing up in households with multiple disadvantages, or having poor access to effective services can affect children's development, health, social and cultural participation, educational attainment and employment prospects.¹⁸ Evidence for investing in the early years in all aspects of a child's development, health, education, family and community support is strong, and is particularly compelling for children from

¹⁶ Australian Human Rights Commission, *Closing the Gap: National Indigenous Health Equality Targets (2008)*, viewed online <www.hreoc.gov.au/social_justice/health/targets/index.html> [accessed 2 September 2011].

¹⁷ K Rudd, N Roxon, J Macklin & S Smith, *New directions: An equal start in life for Indigenous children*, May 2007, Canberra, Australian Labour Party, May 2007, p. 6.

¹⁸ Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra.

disadvantaged backgrounds.¹⁹ Research shows that a greater focus on interventions in the critical years from conception to age eight, can accrue substantial benefits for Indigenous children and can also contribute significantly to the achievement of the COAG targets relating to later life outcomes.²⁰

Trends in Indigenous infant and child mortality rates

1.3 Australia's overall (Indigenous and non-Indigenous) death rate²¹ compares well to other Organisation for Economic Cooperation and Development (OECD) countries.²² However, in 2010 Australian children ranked in the bottom third of OECD countries for infant and child mortality, and Indigenous children are known to experience significantly worse health outcomes compared to non-Indigenous children.²³

1.4 Mortality rates have halved for Australian infants and children over the 20 years between 1986 and 2006, however, rates among Indigenous children remain much higher than the national rate. Infants and children living in remote and very remote areas also have higher death rates than their peers in major cities.²⁴ In 2010, the infant mortality rate was lowest in Major Cities (3.9 deaths per 1000 live births) and highest in Very Remote areas (8.8 deaths per 1000 live births).²⁵

1.5 Data limitations are a characteristic of infant and child mortality statistics. According to the Australian Bureau of Statistics (ABS):

¹⁹ Australian Medical Association, *Lifting the Weight - Low Weight Babies: An Indigenous health burden that must be lifted*, AMA, 2005. [Internet] available from <<http://ama.com.au/node/3185>> [accessed 9 June 2011].

²⁰ Council of Australian Governments, *National Partnership Agreement on Indigenous Early Childhood Development*, 2009, p.3. [Internet] available from <http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NP_indigenous_early_childhood_development.pdf> [accessed 6 June 2011].

²¹ The death rate is a ratio between the total number of deaths and the total population over a specified period of time.

²² Australian Institute of Health and Welfare, *Australia's Health 2008*, cat. no. AUS 99, Canberra, AIHW, 2008.

²³ Australian Institute of Health and Welfare, *A Picture of Australia's Children*, cat. no. PHE112, Canberra, AIHW, 2009.

²⁴ *ibid.*

²⁵ Australian Bureau of Statistics, *Deaths, Australia*, cat. no. 3302.0, Canberra, ABS, 2010, p. 11.

The exact scale of differences between the mortality of Aboriginal and Torres Strait Islander Australians and the total population is difficult to establish conclusively, due to quality issues with Aboriginal and Torres Strait Islander Australian death data and the uncertainties inherent with estimating and projecting the size and structure of the Aboriginal and Torres Strait Islander population over time.²⁶

1.6 Policy makers and analysts must contend with these issues when making decisions and judgements about the impact that child and maternal health policies are having on mortality rates.

Infant mortality

1.7 Infant mortality, defined by the ABS as deaths of children aged under one year²⁷, has been traditionally viewed as an indicator of the general level of mortality, health and wellbeing of a population and, as such, has received special attention in public health policy. Infant mortality has a strong association with both fertility (births) and life expectancy (at birth) as the increased survival of infants and young children is generally accompanied by a decline in fertility. It is generally accepted that the survival of infants and young children is strongly influenced by preventive health measures and public health programs which aim to improve life expectancy.²⁸

1.8 For Western Australia, South Australia, and the Northern Territory (jurisdictions with long-term data and similar levels of coverage of Indigenous deaths), the Indigenous infant mortality rate²⁹ for 2007–09³⁰ was 7.8 deaths per 1000 live births compared with 4.0 for the non-Indigenous population. This indicates that in these states and territory the mortality rate for Indigenous infants is almost double that for non-Indigenous infants.³¹

²⁶ Australian Bureau of Statistics, *Deaths, Australia*, cat. no. 3302.0, Canberra, ABS, 2010, p. 11.

²⁷ *ibid*, p. 13.

²⁸ Australian Bureau of Statistics, *Causes of Infant and Child Deaths 1982–96*, cat.no. 4398.0, Canberra, ABS, 1998, p. 3.

United Nations, *Mortality of Children Under 5: World Estimates and Projections, 1950-2025*, Population Studies Series, no. 105, 1988.

²⁹ The number of deaths of infants less than 1 year of age in a given period, expressed per 1000 live births in the same period.

³⁰ This was the latest available data at the time of the audit.

³¹ Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra, p. 4.24.

Child (aged 0 to 4 years) mortality

1.9 Most childhood deaths occur in the first year of life and the mortality rate of infants is different to that of children aged one year and over. Infant deaths comprise 1 per cent of all deaths, but 82 per cent of deaths for children under five years of age.³²

1.10 In Western Australia, South Australia and the Northern Territory the mortality rate of Indigenous children³³ aged 0–4 years for 2007–09 was 2.8 deaths per 1000 live births compared with 0.8 for non-Indigenous Australians in the same states and territory. The difference equates to the Indigenous child mortality rate being 3.8 times higher than for non-Indigenous children.³⁴

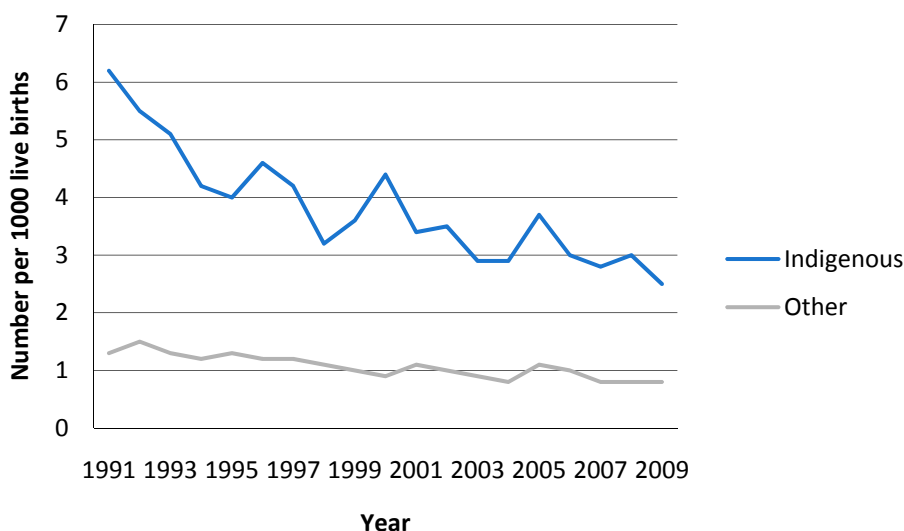
1.11 Figure 1.1 shows that over the period 1991 to 2009 the gap between Indigenous and non-Indigenous long-term child mortality rates has narrowed.³⁵

³² Australian Health Ministers Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2010*, AHMAC, Canberra, p. 54.

³³ The number of deaths of infants and children aged 0 to 4 years of age in a given period, expressed per 1000 live births in the same period.

³⁴ Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra, p. 4.24.

³⁵ Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra, p. 4.24.

Figure 1.1**Child (0 to 4 years) mortality rates 1991–2009**

Source: ABS, *Deaths, Australia, 2010*, cat no. 3302.0

1.12 While there are a range of factors and policy interventions that influence child mortality rates, the Australian Government has also invested in measures aimed at directly addressing Indigenous maternal and child health as part of the *National Indigenous Reform Agreement* (NIRA) in support of COAG targets. Under the *Indigenous Early Childhood Development National Partnership*, specific attention is being given to improving access to, and use of, maternal and child health services. Governments in all Australian jurisdictions have jointly committed to expenditure of \$165.3 million over the 5 years³⁶ 2007–08 to 2011–12. The Australian Government’s contribution of \$90.3 million³⁷ is provided through the *New Directions: Mothers and Babies*

³⁶ Council of Australian Governments, *National Partnership Agreement on Indigenous Early Childhood Development*, July 2009, paragraph 34. [Internet]. COAG, available from <http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NP_indigenous_early_childhood_development.pdf> [accessed 12 October 2011].

³⁷ This funding includes both administered and departmental funds and a small amount for scholarships. The Puggy Hunter Memorial Scholarship Scheme aims to help address the under-representation of Aboriginal and Torres Strait Islander people in health professions. The scholarship provides financial assistance to Aboriginal and Torres Strait Islander people who are undertaking study or are intending to undertake study in a health related discipline. The administration of these scholarships is outside the scope of this audit.

Services (New Directions) program administered by the Department of Health and Ageing (DoHA).

Closing the gap in Indigenous disadvantage and targets for child and maternal health

1.13 The major causes of infant mortality as reported by the Australian Institute of Health and Welfare, are low birth weight, congenital anomalies and sudden infant death syndrome. The major causes of death for children 1 to 4 years are injuries, cancer and diseases of the nervous system.³⁸ Factors that can exacerbate child mortality rates include poor antenatal care, smoking during pregnancy, alcohol consumption, teenage pregnancy, and poor nutrition. Socio-economic disadvantage also increases the risk of child mortality.³⁹ International and Australian research shows that improvements in both access to quality antenatal healthcare and maternal health—through improved nutrition and reduction in risk behaviours during pregnancy (such as alcohol and tobacco use), and annual health checks for children—may serve to reduce the risk of poor health outcomes among Indigenous children.⁴⁰

1.14 As set out in the *Overcoming Indigenous Disadvantage Report, Key Indicators, 2011*⁴¹, many of the results for early childhood development have not been improving over recent years.

- Low birth weight rates for Indigenous mothers were constant at around two and a half times the rates for other mothers between 1998–2000 and 2006–08.
- Approximately half of Indigenous mothers smoked during pregnancy in 2001 and 2008, around three times the non-Indigenous rate.

³⁸ Australian Institute of Health and Welfare, *A Picture of Australia's Children*, cat. no. PHE112, Canberra, AIHW, 2009.

³⁹ Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health equity through action on the social determinants of health*, World Health Organisation, Geneva, 2008, p. 1.

Australian Human Rights Commission, *Social Justice Report 2005*, Human Rights and Equal Opportunity Commission, Sydney, 2005, pp. 17–18.

⁴⁰ Australian Institute of Health and Welfare, *A Picture of Australia's Children*, cat. no. PHE112, Canberra, AIHW, 2009.

Australian Health Ministers Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2010*, AHMAC, Canberra, p. 8.

⁴¹ Steering Committee for the Review of Government Service Provision (SCRGSP) 2011, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra, p. 6.

- Already high hospitalisation rates for Indigenous children aged 0 to 4 years increased between 2004–05 and 2008–09, widening the gap between Indigenous and non-Indigenous children. This was most evident for children in regional and remote areas.
- Indigenous children had consistently higher rates of hearing problems than other children in 2001, 2004–05 and 2008.
- Around 97 per cent of Aboriginal and Torres Strait Islander mothers access antenatal services at least once during their pregnancy. However, these mothers are accessing these services later in their pregnancy and less frequently than other mothers.⁴²

New Directions: Mothers and Babies Services

1.15 *New Directions: Mothers and Babies Services* (New Directions) was one of the Australian Labor Party's 2007 election commitments. Funding was proposed over five years (2007–08 to 2011–12) to give Indigenous children a better start in life and to reduce Indigenous infant and child mortality rates.

1.16 The design of the New Directions policy accepted international evidence pointing to the importance of investing in all aspects of a child's development, including health, education, family and community support.⁴³ An integrated approach to service delivery was favoured by adopting the principle that the services would, where possible, be delivered within a single centre or networked to maximise access and participation. DoHA was to work collaboratively and to consult all key partners and stakeholders, including Indigenous communities, health peak bodies, Indigenous medical services and state and territory governments to identify need and capacity; and the program was to be delivered through additional New Direction services being established each year according to available funding levels.

1.17 New Directions was established by the Australian Government as a separate program on 1 January 2008. It was subsequently subsumed into the *Indigenous Early Childhood Development National Partnership*, (IECD NP) from 1 July 2009, following the development of the *National Indigenous Reform Agreement* (NIRA) in November 2008. A range of national partnerships were

⁴² Australian Health Ministers Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2010*, AHMAC, Canberra, p. 130.

⁴³ *ibid.*

developed to give effect to the NIRA. Among these, the IECD NP commits to improving child health and education through integrated service provision, linking and building on existing services and helping to ensure that services are tailored to the specific needs of rural, regional and urban communities.

1.18 The IECD NP has three elements:

- Element One: integration of early childhood services through Children and Family Centres;
- Element Two: increased access to antenatal care, pre-pregnancy and teenage sexual and reproductive health; and
- Element Three: increased access to, and use of, maternal and child health services by Indigenous families (*New Directions: Mothers and Babies Services*).

1.19 Elements One and Two are delivered through the partnership between the Australian, state and territory governments while Element Three, although part of the IECD NP, is primarily delivered by the Australian Government through the Department of Health and Ageing (DoHA).

1.20 The focus of this audit was Element Three, New Directions. The IECD NP identifies that the New Directions program is designed to provide increased access to, and use of, Indigenous maternal and child health care in regions of high need with an emphasis on early presentation and regular visits throughout pregnancy. This is to be facilitated by the Australian Government funding the expansion of child and maternal health services and by increasing the number of health professionals working in the identified priority regions so that more Indigenous children can be seen and treated—directly resulting in better health.

1.21 The objective of the program is to allocate grants to primary health care providers to enable them to deliver five priority areas of activity:

- antenatal and postnatal care;
- standard information about baby care;
- practical advice and assistance with breastfeeding, nutrition and parenting;
- monitoring of developmental milestones, immunisation status and infections; and

- health checks and referrals to treatment for Indigenous children before starting school.

1.22 The Australian Government's commitment to Element Three of \$90.3 million over five years represents the Australian Government's own purpose contribution. Of this amount, \$86.1 million has been allocated for provision to service providers. As maternal and child health is seen to be a shared responsibility between the Australian and state and territory governments, under Element Three the states and territories have also made direct investments of \$75 million to deliver antenatal, postnatal and maternal and child health services to Indigenous families⁴⁴ alongside the services funded by the Australian Government.

1.23 Australian Government funds are apportioned across jurisdictions taking into account the Indigenous population in each state and territory and applying a loading for remote service delivery. Unlike other National Partnership Agreements, where Australian Government funds are provided to state and territory governments for implementation, these funds are paid by DoHA directly to the selected service providers in each state and territory under grant agreements.

1.24 Table 1.1 shows the indicative proportion of Australian Government funding across the jurisdictions to 2011–12 and the separate funding contributions of each state and territory. The Australian Government announced in the 2011–12 Budget that the program would receive additional funding of \$133.8 million over the four year period from 2011–12.

⁴⁴ Council of Australian Governments, *National Partnership Agreement on Indigenous Early Childhood Development*, July 2009, paragraph 35. [Internet]. COAG, available from <http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NP_indigenous_early_childhood_development.pdf> [accessed 12 October 2011].

Table 1.1**New Directions, indicative proportion of Australian Government and separate state and territory funding 2007–08 to 2011–12**

Jurisdiction	Australian Government own purpose expenditure* (\$m)	State and territory own purpose expenditure (\$m)
NSW	20.0	21.50
QLD	25.5	21.50
SA	4.0	3.75
WA	15.0	11.25
VIC	4.0	4.50
Tas	3.0	2.50
ACT	0.5	0.50
NT	18.0	9.75
TOTAL	90.0	75.00

Source: Closing the Gap: National Partnership Agreement of Indigenous Early Childhood Development. The IECD identified total funding of \$90.3m. The sum of the components does not add to the total because of rounding.

* Australian Government funds are paid directly to service providers in each state and territory.

1.25 As at November 2011, the total program expenditure was \$65 million of the allocated \$86.1 million program administered funds and a total of 80 organisations across Australia were funded through New Directions. (Refer to Appendix 3 for a list of funded service providers). This number is expected to increase to 82 by the end of 2011–12.

1.26 Table 1.2 shows the distribution of service providers by remoteness categories based on the physical remoteness of a population from goods and services.

Table 1.2

New Directions, services providers by remoteness categories⁴⁵ by state and territory, 2007–08 to 2011–12

	Urban	Regional	Remote	Total
NSW	6	15		21
QLD	3	6	7	16
SA		1	3	4
WA		5	8	13
VIC	1	3		4
TAS	1	4	1	6
ACT	1			1
NT	2		13	15
TOTAL	14	34	32	80

Source: ANAO analysis

* Funding round for 2011–12 has not yet been finalised. As a result the total number of service providers may increase.

1.27 The management of the overall IECD NP is shared between the Department of Education, Employment and Workplace Relations (DEEWR), and DoHA. DEEWR is responsible for Element One while DoHA is responsible for the progress of Elements Two and Three. New Directions is administered by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) within DoHA.

Audit objectives, criteria and methodology

1.28 The objective of the audit was to examine the effectiveness of the Department of Health and Ageing's administration of New Directions. In this respect the ANAO considered whether:

- planning processes were developed to support the program's objectives and rationale;

⁴⁵ Defined by an index developed to categorise population differences based on their physical remoteness from goods and services.

- implementation arrangements were clearly defined and aligned to the objectives of the program; and
- robust performance management arrangements had been established and were in use by the department.

Audit methodology

1.29 The audit methodology included:

- interviews with DoHA officials in the department's National Office and the New South Wales, Queensland and Victorian state offices;
- visits to 12 health service providers funded under the program located in the same states and in urban, regional and remote areas; and
- an examination of DoHA's program documentation, files and management systems.

1.30 The audit was conducted in accordance with the ANAO auditing standards at a cost of \$385 148.

Acknowledgements

1.31 The ANAO wishes to express its appreciation to the management and staff of DoHA and the representatives of service providers and peak bodies for their assistance during this audit.

Report structure

1.32 The report is structured as follows:

- Chapter 2 examines the planning and development processes followed by the Department of Health and Ageing to implement the program in line with the Government's broader maternal and child health objectives, and with the service delivery principles set out in the National Indigenous Reform Agreement;
- Chapter 3 examines the role of DoHA in the ongoing implementation of New Directions, and the procedures developed to support implementation; and
- Chapter 4 examines DoHA's performance monitoring and reporting of New Directions under Element Three of the IECD NP.

2. Program Development and Planning for Effective Service Delivery

This chapter examines the planning and development processes followed by the Department of Health and Ageing to implement the program in line with the Government's broader maternal and child health objectives, and with the service delivery principles set out in the National Indigenous Reform Agreement.

Introduction

2.1 Program planning provides a map of how an initiative will be implemented, addressing such matters as timeframes, phases of program activity, roles and responsibilities, and resourcing. Effective implementation planning contributes to an agency's ability to successfully prepare for intended policy outcomes. Successful planning involves getting the program strategy and design right before beginning time-critical and expensive implementation activities, particularly where an activity has multi-agency and cross-jurisdictional dimensions, as was the case for the *New Directions: Mothers and Babies Services* (New Directions) program.

2.2 DoHA's planning also had to consider an additional set of service delivery requirements specifically designed for Indigenous programs. The *National Indigenous Reform Agreement* (NIRA) provides the overarching framework for the delivery of programs aimed at contributing to the six targets across the Indigenous-specific National Partnership Agreements. To promote consistency across the development of National Partnership Agreements, the Council of Australian Governments (COAG) agreed to a set of service delivery principles for Indigenous Australians (refer to Appendix 2). These principles are a guide for all COAG reforms, and all governments are expected to take these principles into account in designing policies and providing services.⁴⁶

⁴⁶ Council of Australian Governments, *National Indigenous Reform Agreement (Closing the Gap)*, Schedule D, p. D-67 [Internet] available from <http://www.federalfinancialrelations.gov.au/content/national_agreements/indigenous_reform/National_Indigenous_Reform_Agreement_from_13_Feb_11.pdf> [Accessed November 2011].

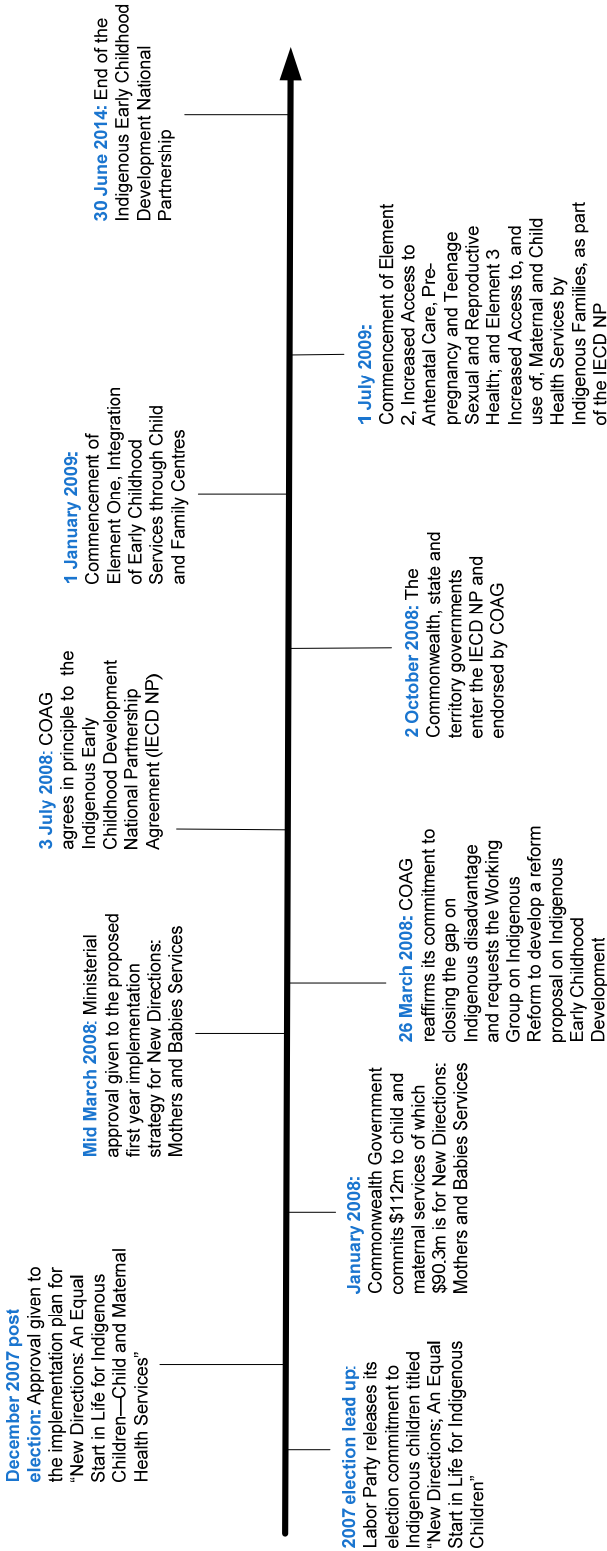
Development timeline of New Directions: Mothers and Babies Services

2.3 The development of the New Directions was part of a broader Indigenous early childhood development policy covering maternal and child health, early years services for families and their children, and literacy and numeracy.⁴⁷ The New Directions program was established in January 2008 as a stand-alone program. In July 2009 it was integrated into the IECD NP. Figure 2.1 provides a timeline of developments in the *New Direction: Mothers and Babies Services* (New Directions) program.

⁴⁷ K Rudd, N Roxon, J Macklin & S Smith, *New directions: An equal start in life for Indigenous children*, Canberra, Australian Labour Party, May 2007.

Figure 2.1

Timeline of developments relating to New Directions: Mothers and Babies Services



Source: ANAO analysis

2.4 As discussed in Chapter 1, in the lead-up to the 2007 Federal Election, the Australian Labor Party outlined its plan for improving Indigenous early childhood health.⁴⁸ It was recognised in the Labor Party's policy statement that:

...the significant health gap between Indigenous and non-Indigenous Australians is unlikely to be closed while Indigenous people fail to have equal access to primary health care services.⁴⁹

2.5 Following its election in December 2007, the Labor Government set about implementing the policy titled *New Directions: An Equal Start in Life For Indigenous Children*, focusing on the critical years from birth to eight years. The key elements of the policy were:

- child and maternal health services;
- early development and parenting support; and
- literacy and numeracy in the early years.

2.6 In January 2008 the Labor Government committed funds over five years to 2011–12 for child and maternal health services. This included \$112 million for the following initiatives:

- \$90.3 million for comprehensive mothers and babies services (*New Directions: Mother and Babies Services*);
- \$10 million for an Indigenous Mothers Accommodation Fund managed by the Department of Families, Housing Community Services and Indigenous Affairs; and
- \$11.2 million for a Rheumatic Fever Strategy.

2.7 Integral to the Labor Party's early childhood policy was the desire to integrate and network the services;

Where practical Federal Labor will seek to combine Mother and Babies services with Parent-Child services and other existing infrastructure to create Indigenous Child and Family hubs.⁵⁰

⁴⁸ K Rudd, N Roxon, J Macklin & S Smith, *New directions: An equal start in life for Indigenous children*, Canberra, Australian Labour Party, May 2007, p. 12.

⁴⁹ Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2005*, ABS and AIHW, Canberra 2005, p. 6.

2.8 In the initial phase of planning, DoHA quickly identified nine regions to be the focus of the first funding round and also agreed on procedures for selecting and funding health service providers. This initial phase of planning enabled the Minister for Health and Ageing to approve implementation of the first round in mid March 2008.

2.9 During the same period the Australian Government was pursuing a range of reforms to federal financial relations to develop the *Intergovernmental Agreement on Federal Financial Relations* (IGA). This resulted in the identification of, and agreement to, by the Council of Australian Governments (COAG) of significant reforms which would be supported by national partnership agreements. On 26 March 2008, COAG affirmed its commitment to Closing the Gap on Indigenous disadvantage and asked the Working Group on Indigenous Reform (WGIR) to bring forward a reform proposal on Indigenous Early Childhood Development. The WGIR's reform proposal was developed by a cross-agency team comprising the Department of Health and Ageing, Department of Families, Housing, Community Services and Indigenous Affairs, Department of Education, Employment and Workplace Relations, Department of the Prime Minister and Cabinet and representatives from each state and territory government.

2.10 The resulting proposal concentrated on key priority areas where the evidence indicated a high impact could be made on outcomes for Indigenous children. The WGIR proposed that the existing New Directions program be integrated in with the *Indigenous Early Childhood Development National Partnership* (IECD NP). The WGIR reform proposal obtained in-principle agreement from COAG in April 2008 and became the IECD NP. The IECD NP was entered into by the Australian, state and territory governments in October 2008.

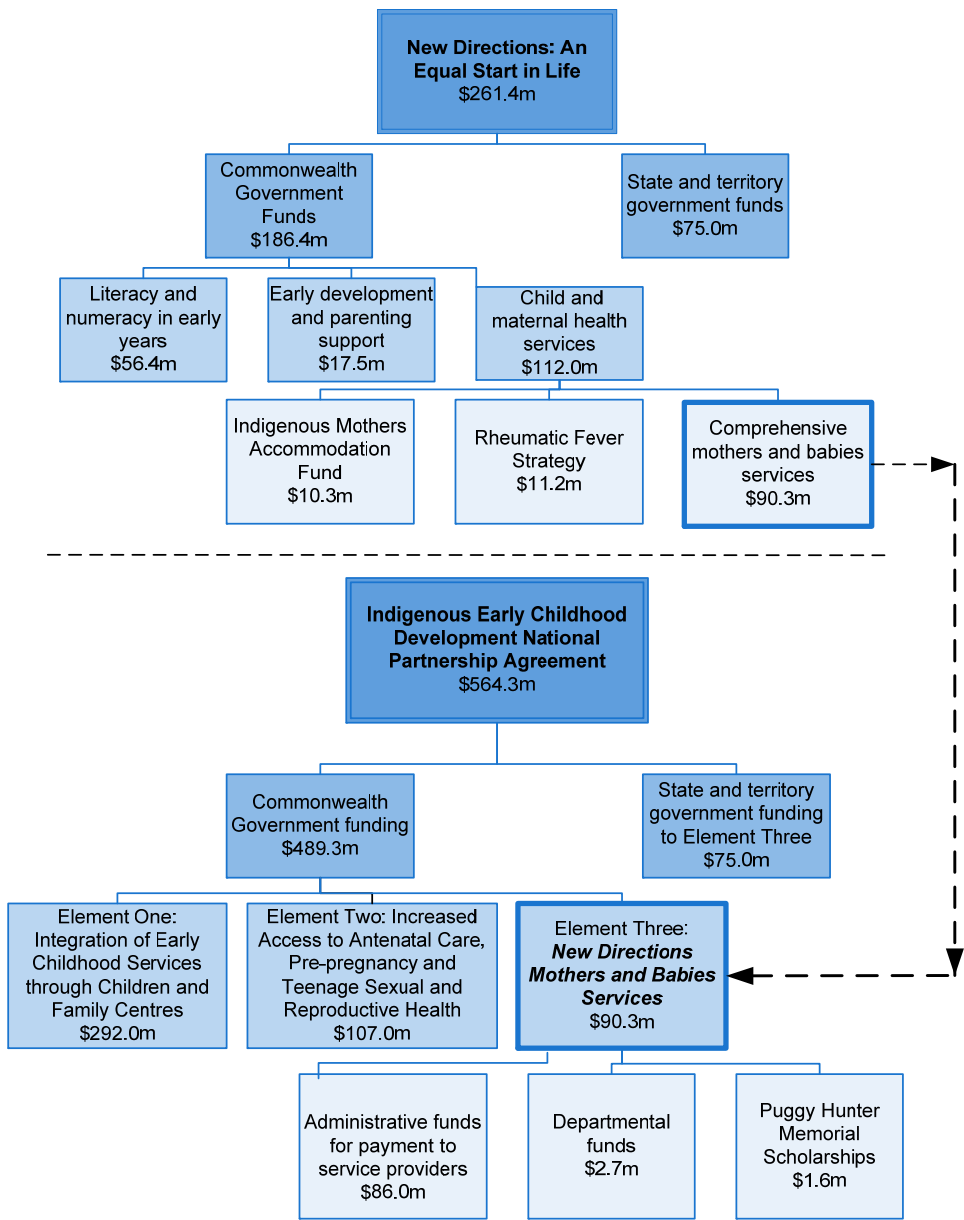
2.11 The IECD NP comprises \$564 million of joint funding over six years to deliver three elements as noted in paragraph 1.19. The implementation of the three elements is outlined in a series of bilateral Implementation Plans between the Australian, state and territory governments. On 1 July 2009 the Labor Government's election commitment, New Directions, commenced operations

⁵⁰ K Rudd, N Roxon, J Macklin & S Smith, *New directions: An equal start in life for Indigenous children*, Canberra, Australian Labour Party, May 2007 p. 16.

under the IECD NP. The location of the New Direction program under its initial framework and the subsequent IECD NP is shown in Figure 2.2.

Figure 2.2

The transition of New Directions: Mothers and Babies Services from part of the Equal Start in Life initiative to Element Three of the IECD NP



Source: ANAO analysis.
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Development and planning of New Directions: Mothers and Babies

2.12 As part of the initial program development, DoHA identified five priority activities that each grant funded service provider would deliver under the program. These activities aligned with the government's policy direction and are:

- antenatal and postnatal care;
- standard information about baby care;
- practical advice and assistance with breastfeeding, nutrition and parenting;
- monitoring of developmental milestones, immunisation status and infections; and
- health checks and referrals to treatment for Indigenous children before starting school.

2.13 In an effort to develop a level of national consistency, these five areas were incorporated into the selection process for health service providers and embedded into the Action Plans developed by each provider.

Development and planning for New Directions: An Equal Start in Life for Indigenous Children—Mothers and Babies Services

2.14 Considerable planning was undertaken shortly after the 2007 Federal Election in order to have the first funding round allocated before the end of the 2007–08 financial year. This was a period of tight timelines with the new Labor Government focused on implementing election commitments. DoHA's planning and program design culminated in the approval of a formal 'Implementation plan for New Directions: An Equal Start in Life for Indigenous Children—Child and Maternal Health Services' in December 2007.

2.15 Implementation plans should reflect adequate consideration of the key risks to implementation and provide a map of how an initiative will be implemented.⁵¹ Table 2.1 shows an analysis of the program's implementation

⁵¹ ANAO Better Practice Guide, *Implementation of Programme and Policy Initiatives*, October 2006, Canberra, p. 26.

plan against the criteria outlined in the ANAO Better Practice Guide, *Implementation of Programme and Policy Initiatives*.

Table 2.1

Analysis of New Directions planning against better practice

Criteria	Evident in DoHA's planning	ANAO comment on New Directions implementation plan against better practice
Governance and decision-making arrangements	✓	Sets out the internal governance arrangements and a diagram showing the proposed broader governance arrangements.
Key deliverables and milestones	✓	Specifies key deliverables and milestones up to October 2008. The implementation plan noted that milestones for subsequent years would be completed following Ministerial agreement to the proposed policy implementation directions.
Resources	✓	Presents resource allocations by financial year over the intended five year period 2007–08 to 2011–2012. The plan also flagged the need to purchase additional services to assist with the implementation of the program.
Risk management strategies	Partial	Identifies a number of low to high risks, their origin or cause and proposed mitigation. The set of risks is not comprehensive, focusing on post implementation and not identifying risks before and during implementation.
Stakeholder management	✓	Sets out a list of the key stakeholders and DoHA's weaknesses and strengths in terms of particular stakeholder views.
Communication	✓	Includes proposals for communicating with stakeholder and promoting the program.
Contracting with service providers.	✓	Sets out the delivery model, including an estimate of the number of health services to be contracted to provide the necessary services in the identified priority regions.
Monitor and Review	X	Contains no information on implementation monitoring, performance management and implementation and program review.

Source: ANAO analysis.

2.16 Overall, DoHA undertook a structured approach to the development of the overarching program plan. Its development planning was generally

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appropriate for setting out the policy objectives, proposed delivery model, consultation plans, and establishing a timeline with milestones identified. The planning and program design also recognised the government's policy directions of closing the gap in Indigenous life expectancy with a focus on early childhood interventions. However, the initial approach to risk management could have been strengthened by better identifying risks that could occur during planning and implementation in addition to the focus that was given to the post implementation ongoing operations of the program.

2.17 In relation to the performance monitoring and review arrangements, DoHA made the decision to minimise the reporting burden on service providers because of the relatively small amount of funding allocated to the program and given the program's intention to target regions of high need where services may have limited capacity and resources. As a consequence, the service monitoring arrangements were limited to the indicators contained in providers' Action Plans. At the program level, the objective of improved access was measured by the number of health service providers being funded. Based on these arrangements, it would not have been possible to identify the contribution made by New Directions to improve maternal and child health, its value for money and effectiveness. Additionally, no baseline information was collected at the outset for each selected region to be able to measure the level of change in maternal and child health attributed to New Directions. These issues are discussed in Chapter 4.

Program operational plans

2.18 Program operational plans were developed to provide direction and guidance on the:

- establishment of DoHA's National Office and State and Territory Offices (STO) roles and responsibilities;
- procedures and criteria to be used for the selection of priority regions;
- scope of activities to be funded;
- grant selection process;
- reporting responsibilities of service providers; and
- size and type of service provider eligible to apply for funding.

2.19 DoHA went through a process of program mapping, involving both National Office and STOs, to develop the plans and associated guidelines. A working group of STO and National Office representatives was formed and there were regular meetings and teleconferences to gather input to and feedback from the group. As implementation was to occur under DoHA's existing model of devolved management to its STOs, an additional intention of this work was to position the STOs to implement the operational aspects of the program. All of the operational plans existed for the first round of funding (2007–08) but in different formats, making them difficult to access and consolidate.

Incorporation of New Directions: Mothers and Babies Services into the Indigenous Early Childhood Development National Partnership

2.20 Following the development of the IECD NP, the New Directions program needed to be integrated into the National Partnership. This integration did not change the program's delivery model and the strategies adopted by DoHA. However, the program's objectives were expanded to include both 'increased access to, and use of, maternal and child health services'. As the lead agency for Element Three, DoHA was now required to develop a specific implementation plan to be approved by the then Minister for Health and Ageing.⁵² However, the changed objective of the program was not reflected in the Australian Government's Implementation Plan, annual reports and associated documents.

2.21 Bilateral implementation plans were required between DoHA and each jurisdiction because of state and territory commitments to contribute \$75 million to Element Three. Although there is no linkage between these funds and the funds allocated by the Australian Government, the implementation plans served to identify the areas that each jurisdiction intended to focus on, and provided for a level of communication of these intentions.

⁵² The implementation plan developed under the IECD NP is separate to the implementation plan developed at the establishment of the program in 2007–08. The IECD NP Implementation Plan shows how the program will deliver the specified outputs in the Agreement and contribute to delivering the Agreement's objectives and outcomes. The original implementation plan developed in 2007–08 provides more detailed information about program administration and delivery.

2.22 DoHA held a series of conferences with each state and territory throughout July and August 2009 to discuss and negotiate the content of their implementation plans. DoHA advised the ANAO that it was satisfied with the initiatives proposed by states and territories under Element Three of the IECD NP, which comprised extensions of existing services and the development of new programs. In addition, most jurisdictions included a strong focus on increasing their workforce capacity to enhance service delivery. Once finalised, the jurisdictional implementation plans were approved by the then Minister for Health and Ageing.

2.23 DoHA's own implementation plan outlines the objectives, deliverables, milestones and success criteria to support the implementation of New Directions. Jurisdictional implementation plans contain similar information directed at their commitment to spend \$75 million on Element Three of the IECD NP. The Australian Government's and jurisdictional Implementation Plans are made publicly available on the Ministerial Council for Federal Financial Relations website to enable visibility over the proposed activities and approaches.

2.24 As mentioned in paragraph 2.2, to ensure consistency across the development of National Partnership Agreements, COAG agreed to a set of service delivery principles for Indigenous Australians (refer to Appendix 3) to be used as a guide for all COAG reforms. All governments were expected to take these principles into account in designing policies and providing services. At an overall level, DoHA's program planning for health services delivery reflect the service delivery principles for Indigenous Australians as set out in the National Indigenous Reform Agreement.⁵³ Table 2.2 shows an analysis of the New Directions service delivery planning against these principles.

⁵³ Council of Australian Governments. *National Indigenous Reform Agreement (Closing the Gap)*, Schedule D, Page D-67.

Table 2.2

National Indigenous Reform Agreement's service delivery principles

Principle	Evident in DoHA's planning	ANAO comment on New Directions service delivery implementation planning against service deliver principles
Priority: Programs and services should contribute to Closing the Gap by meeting the targets endorsed by COAG while being appropriate to local community needs.	✓	The IECD NP aims to support programs and strategies to Close the Gap in Indigenous health outcomes through improved child and maternal health, although the particular contribution of New Directions in Closing the Gap is not separately identifiable (see Chapter 4). Priority areas are identified and services are selected and delivered, factoring in local community needs.
Indigenous engagement: Engagement with Indigenous men, women and children and communities should be central to the design and delivery of programs and services.	✓	Indigenous medical organisations are involved in the planning, coordination and delivery of health services. Service provider Action Plans are tailored to the particular services required in the selected sites.
Sustainability: Programs and services should be directed and resourced over an adequate period of time to meet the COAG targets.	✓	Service providers are resourced out of recurrent program funding up until 2014–15 and integrate increasing the workforce capacity in their planning and service delivery.
Access: Programs and services should be physically and culturally accessible to Indigenous people recognising the diversity of urban, regional and remote needs.	✓	DoHA has chosen a strategy of using predominantly Indigenous organisations with the ability to deliver services in a culturally appropriate way. As at December 2011, there were 14 service providers operating in urban areas, 34 in regional areas and 32 in remote areas.
Integration: There should be collaboration between and within Governments at all levels and their agencies to effectively coordinate programs and services.	✓	Coordination and planning incorporates collaboration between and within governments at all levels.
Accountability: Programs and services should have regular and transparent performance monitoring, review and evaluation.	Partial	Program performance monitoring, review and evaluation is limited, as discussed in Chapter 4.

Source: ANAO analysis.

ANAO Audit Report No.35 2011–12
Indigenous Early Childhood Development.
New Directions: Mothers and Babies Services

Integrated delivery of early childhood services

2.25 Early childhood experts advocate integrated delivery of services, including antenatal services, maternal and child health services, parenting and family support services, and early learning and child care as the best delivery platform to ensure families actually receive the support needed. Evidence shows that early childhood programs are most effective when they support parents' active participation in their children's development.⁵⁴ This approach has been evident in the planning for the delivery of New Directions in both its initial phase and as part of the IECD NP.

2.26 Under the initial development phase, *An Equal Start in Life for Indigenous Children* program linked early childhood education and care and family support services through Child and Family Hubs, creating an integrated whole-of-government approach. The original proposal for New Directions was to provide the services within a single centre or networked service, and where practical, combined with parent-child services and other existing infrastructure to maximise mothers' access and participation. The implementation plan proposed the need for consultation with other Australian Government agencies regarding site selection for Indigenous Child and Family Hubs and to fund maternal and child services to link with other early childhood providers in identified regions.

2.27 These links were transferred to and reinforced in the structure of the three elements making up the IECD NP. COAG further agreed to an integrated policy framework⁵⁵ for inclusion in the IECD NP and to be used as a basis for future investment and reform by all governments in Indigenous early childhood development. The framework was developed under the auspices of the COAG Working Group on Indigenous Reform.

⁵⁴ Secretariat of National Aboriginal and Islander Child Care, *Indigenous Parenting Project*, 2004, p. 13. Available online <<http://www.snaicc.asn.au/tools-resources/dsp-default-e.cfm?loadref=167&txnid=856&txnctype=resource&txncstype=document>> [accessed 11 November 2011].

⁵⁵ Council of Australian Governments, *National Partnership Agreement on Indigenous Early Childhood Development*, July 2009, Attachment A. [Internet]. COAG, available from <http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NP_indigenous_early_childhood_development.pdf> [accessed 12 October 2011].

2.28 The policy framework directly relates to the three COAG targets that are most relevant to Indigenous early childhood development:

- halve the gap in mortality rates for Indigenous children under five within a decade;
- halve the gap for Indigenous students in reading, writing and numeracy within a decade; and
- ensure all Indigenous four-year-olds have access to quality early childhood education within five years, including Indigenous children living in remote areas.

2.29 The six priority reform areas of the policy framework are:

- pre-pregnancy and teenage sexual health;
- antenatal, child and maternal health;
- quality early learning and child care;
- parent and family engagement and support;
- better integration and coordination for all services; and
- development of a sustainable Indigenous and non-Indigenous workforce that is culturally competent.

2.30 The policy does not give explicit direction about how best to achieve an integrated approach that connects these elements. Intergovernment consultation on this policy has, however, led to the position that co-location of services is just one way of integrating child services. Integration of service delivery can be achieved outside of co-location through effective partnerships and practices between various groups and organisations, and it is important that the service delivery models are tailored to respond to meet community needs. Alternative models to co-location may need to be developed, particularly where there are already well established and high performing services in an area.

2.31 At a delivery level, DoHA has pursued integration by ensuring that service providers include a strategy on local linkages in their annual Action Plans. Funded organisations are required to develop and maintain linkages with other organisations in the service region to improve maternal and child health and related services, and must demonstrate capacity and commitment

to initiate and maintain linkages with other early childhood services (for example, early learning and family support) in the local area. STOs have the responsibility for assessing a service provider's capacity and commitment to the networking of services, and this is reviewed in their biannual reports.

Conclusion

2.32 The New Directions program went through two separate implementation periods; the first from January 2008 as a Labor Government election commitment, and the second from July 2009 following its integration into the IECD NP. In the initial stages of implementation, DoHA gave appropriate consideration to most key program development aspects, including how the program would be governed, as well as providing clarity about the policy objectives and rationale, program components, delivery model, and implementation strategy. However, the audit found that less attention was given in the planning stage to the program performance and monitoring arrangements and to risk identification and management.

In adapting the program to become part of the IECD NP, DoHA engaged with relevant government stakeholders at both the federal and state/territory levels through the COAG supported Working Group on Indigenous Reform. In the process of incorporating the program into the IECD NP, the program's objective was refined by adding a focus on the use of maternal and child services to the original access objective. However, this change has not been reflected in the Australian Government's IECD NP Implementation Plan, annual reports and associated documents.

3. Ongoing Program Implementation

This chapter discusses the role of the Department of Health and Ageing in the ongoing implementation of New Directions: Mothers and Babies Services, and the procedures developed to support implementation.

Introduction

3.1 The implementation arrangements of the *New Directions: Mothers and Babies Services* (New Directions) program are based on the use of third-party service providers who receive grant funding from the Department of Health and Ageing (DoHA). The program is delivered in all Australian states and territories, with providers in each jurisdiction being managed by DoHA's respective state and territory offices.

3.2 There are five broad priority areas which the program aims to target. These areas are:

- antenatal and postnatal care;
- standard information about baby care;
- practical advice and assistance with breastfeeding, nutrition and parenting;
- monitoring of developmental milestones, immunisation status and infections; and
- health checks and referrals to treatment for Indigenous children before starting school.

3.3 Service providers have been undertaking these services in a variety of service delivery models including: home-visiting; outreach, such as mobile clinics; clinic-based activities, such as provision of antenatal classes and group gatherings; cooking classes to teach nutrition; education about babies' development and child hearing checks.⁵⁶

⁵⁶ Department of Health and Ageing, *Element Three 2010/11 Annual Report, Indigenous Early Childhood Development National Partnership* [Internet] available from <<http://www.health.gov.au/internet/main/publishing.nsf/Content/1D00A20690DD46EFCA2579860081EE4?OpenDocument>> [accessed 25 January 2012].

3.4 This chapter considers DoHA's management of the following elements central to the delivery of the program: roles and responsibilities, the allocation of funding, site selection, and contract management.

Roles and responsibilities within DoHA

3.5 Within DoHA the *New Directions: Mothers and Babies Services* (New Directions) program is administered by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) involving both the National Office and state and territory offices (STOs). The roles and responsibilities of National Office and STO staff are generally understood by both parties. The structure of each STO differs according to the needs of their regions; however, the management of New Directions aligns with the broader OATSIH structure. Typically, a staff member takes portfolio responsibility for the program within the state or territory, acting as the primary liaison person between National Office and their STO. Supporting this role are contract managers with responsibility for the management of the program at the service level.

3.6 National Office staff are reliant on STO input to appropriately target the program by identifying appropriate health service provider organisations and high priority regions, as well as monitoring the progress and expenditure of the providers. The specific and detailed roles and responsibilities on site selection and the funding process were documented for the second funding round, which was the largest of the rounds. This clearly sets out the funding processes and the necessary tasks and timeframes.

3.7 To facilitate the implementation of the program, a working group was established comprising STO and National Office representatives. Teleconferences are scheduled approximately every six weeks to facilitate information sharing across states and territories, identify better practices in service delivery and raise issues or questions about the implementation of the program. The ANAO observed that communication between National Office and the STOs was not dependent on the working group as there is generally a free flow of information between OATSIH staff as needed.

3.8 Program operational plans and the associated guidelines have continued to evolve and are updated each funding round. The three states visited as part of the audit have documentation spread across electronic and hard copy files, potentially making it difficult for new staff members to obtain a complete understanding of the program's procedures and their

responsibilities. While this has not necessarily hindered program implementation to date, this potentially has a greater impact on the program when experienced personnel leave the program and cannot be called upon to provide guidance and advice to the new staff. The development of consistent program management documentation would be an advantage as staff turnover in some states is perceived to be high by the staff interviewed by ANAO in the National Office, STOs and the service providers.

Allocation of program funding

3.9 Under the *Indigenous Early Childhood Development National Partnership* (IECD NP), the Australian Government is responsible for funding the implementation of New Directions, investing \$90.3 million over five years⁵⁷, which includes \$2.6 million on departmental expenditure and \$1.6 million contribution to the Puggy Hunter Memorial Scholarship Scheme.⁵⁸ The remaining \$86.1 million is used to fund service providers. Table 3.1 shows the breakdown of the New Directions funding by year, as originally budgeted.

⁵⁷ Council of Australian Governments, *National Partnership Agreement on Indigenous Early Childhood Development*, July 2009, paragraph 34. [Internet]. COAG, available from <http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NP_indigenous_early_childhood_development.pdf> [accessed 12 October 2011].

⁵⁸ The Puggy Hunter Memorial Scholarship Scheme aims to help address the under-representation of Aboriginal and Torres Strait Islander people in health professions. The scholarship provides financial assistance to Aboriginal and Torres Strait Islander people who are undertaking study or are intending to undertake study in a health related discipline. The administration of these scholarships is outside the scope of this audit.

Table 3.1**New Directions, original budgeted funds by year**

	Funding round 1 2007–08 (\$m)	Funding round 2 2008–09 (\$m)	Funding round 3 2009–10 (\$m)	Funding round 4 2010–11 (\$m)	Funding round 5 2011–12 (\$m)	Total (\$m)
Departmental	0.108	0.743	0.688	0.645	0.480	2.664
Administered – New Directions	0.653	8.959	19.308	25.881	31.239	86.040
Administered – Puggy Hunter Scholarship	0	0.168	0.344	0.526	0.537	1.575
Total	0.761	9.870	20.340	27.052	32.256	90.279

Source: ANAO analysis of OATSIH information.

3.10 The Australian Government announced in the 2011–12 Budget that the program would receive additional funding of \$133.8 million over the four-year period from 2011–12 to continue the funding of the service providers that had been engaged by the end of 2011–2012. No new providers are expected to be funded after 2011–2012. The continuation of funding through to June 2015 means that, on current arrangements, the last year of funding will be implemented outside the framework of the IECD NP which expires in June 2014. As at March 2012 no decision on continuing the IECD NP had been made.

Distribution of funding across states and territories

3.11 The New Directions funding represents the Australian Government's own purpose contribution to the IECD NP. Funding is provided directly to service providers and does not go through state and territory governments, as is the case with other elements of the IECD NP and other national partnerships. During the early period of program implementation and design, DoHA considered that the allocation of funding by the Australian Government directly to primary health care organisations would support a more efficient and effective approach to service delivery, and ensure that funding could be accessed by a broad range of maternal and child health service providers

including general practitioners, community controlled health organisations, and state and territory government child and maternal health services.

3.12 The distribution of Australian Government funding across states and territories is undertaken by DoHA's National Office and takes into consideration the Aboriginal and Torres Strait Islander population as well as a loading for remote locations. Table 3.2 shows the distribution of administered funding across the states and territories for the period 2007–08 to 2011–12.

Table 3.2

New Directions, distribution of administered funding across states and territories by year

	Funding round 1 2007–08 (\$m)	Funding round 2 2008–09 (\$m)	Funding round 3 2009–10 (\$m)	Funding round 4 2010–11 (\$m)	Funding round 5 2011–12 (\$m)	Portion of 5 year total (%)	Total over 5 years (\$m)
NSW	0.266	1.987	4.291	5.751	6.955	22.22	19.250
QLD	0.127	2.533	5.470	7.332	8.867	28.33	24.329
SA	0	0.422	0.911	1.222	1.477	4.72	4.032
WA	0.132	1.514	3.271	4.384	5.302	16.94	14.603
VIC	0	0.373	0.805	1.079	1.305	4.17	3.562
TAS	0	0.249	0.537	0.719	0.870	2.78	2.375
ACT	0	0.050	0.108	0.145	0.176	0.56	0.479
NT	0.116	1.831	3.916	5.249	6.348	20.28	17.442
Total	0.641	8.959	19.309	25.881	31.300	100.00	86.131

Source: OATSIH.

3.13 DoHA's STOs are responsible for monitoring funding within the respective jurisdictions and this is done through the production of quarterly financial statements, which are triggers for the release of funds. This expenditure information is provided to National Office where jurisdictional allocations and one-off payments are approved. DoHA advised that some service providers have difficulty spending their allocated funds in a timely manner. Some service providers have experienced staff shortages and recruitment difficulties, while others have been faced with the release of funds late in the financial year and delays in the completion of minor capital works projects. The STOs generally try to carry the funds over to the following

quarter where possible, or to find high priority one-off opportunities within their respective state/territory to reinvest unspent funds. Where this has not been possible, the transfer of funds between jurisdictions can be approved by National Office.

3.14 Table 3.3 shows the comparison between budgeted funds and actual expenditure by year.

Table 3.3

New Directions, budgeted and actual administered funding expenditure over the life of the program 2007–08 to 2014–15.

Funding year	Budgeted funding (\$m)	Actual Expenditure (\$m)
2007–08	0.641	0.641
2008–09	8.942	9.121
2009–10	19.309	19.258
2010–11	25.881	25.049
2011–12*	31.300	31.300
2012–13	32.757	Not available
2013–14	34.250	Not available
2014–15	35.846	Not available
Total	188.926	85.370

Source: ANAO analysis.

* Funding round yet to be finalised.

3.15 The table highlights that actual expenditure has generally tracked closely to budgeted expenditure. To date, the 2010–11 funding round is the only year where New Directions has incurred a noticeable underspend totalling \$841 000 (3 per cent of the budgeted total). This occurred as a result of the contracts with new service providers not being signed in time to expend the money in the financial year. Because the funding was not able to be committed in time, the funds were returned to consolidated revenue.

3.16 Table 3.4 shows the number of service providers contracted in each year and by jurisdiction.

Table 3.4

New Directions, number of service providers in each state and territory by year.

	Funding round 1 2007–08	Funding round 2 2008–09	Funding round 3 2009–10	Funding round 4 2010–11	Funding round 5 2011–12*	Total
NSW	2	9		10		21
QLD	1	10	1	5		17
SA		2	2			4
WA	1	5	4		3	13
VIC		4				4
TAS		1	2	3		6
ACT		1				1
NT	1	6	4	2	1	14
Total	5	38	13	20	4	80
Cumulative annual total	5	43	56	76	80	

Source: OATSIH.

* Funding round yet to be finalised.

3.17 Initially DoHA planned to provide funding for a total of 50 service providers. Funding to service providers covers wages for qualified medical staff, including Aboriginal Health Workers, staff training, administration and IT or other equipment. Over the period in which New Directions has been operating, DoHA has found that the actual cost per service provider has been less than the \$400 000 originally estimated, allowing DoHA to fund a larger number of service providers to ensure that the allocated program budget is used. As of November 2011, the program has been able to provide funding to 80 services providers with an average allocation in 2010–11 of \$338 622 per provider per year. The department anticipates funding another two service providers during 2011–12.

Site selection

3.18 Identifying and selecting appropriate sites and regions in which to invest program funding is central to the overall success of the program. In line

with the overall objectives, services should be targeted to areas where there is an identified need for greater Indigenous maternal and child health services.

3.19 DoHA's National Office is designated with responsibility for developing and implementing the funding processes, supported by the STO network. To ensure a level of consistency in a devolved management environment, DoHA has established a number of procedures to guide STOs in site selection. With particular emphasis on the 29 priority communities identified in COAG's *National Partnership Agreement on Remote Service Delivery* (RSD), STOs are responsible for identifying priority regions by undertaking an analysis of Indigenous population data, current service delivery and access to maternal and child health services, assessment of need and consultations with state-based stakeholders. Priority regions are regions where Indigenous maternal and child services are lacking compared to non-Indigenous services.

3.20 OATSIH Regional Planning occurs in the context of the OATSIH National Planning Framework, which incorporates:

- the Aboriginal and Torres Strait Islander health priorities under the National Strategic Framework for Aboriginal and Torres Strait Islander Health and the Aboriginal and Torres Strait Islander Health Performance Framework as the focus for service planning and priority setting;
- a national OATSIH planning geography; and
- the national OATSIH Resource Allocation Model incorporating the Indigenous Primary Health Care Benchmark.⁵⁹

⁵⁹ OATSIH uses the Resource Allocation Model (RAM) to assist in determining the relative need for any new available funding at a state/territory or OATSIH Planning Region level. The OATSIH RAM is based on the Indigenous Primary Health Care Benchmark (the Benchmark). This Benchmark takes into consideration:

- the higher levels of illness in the Aboriginal and Torres Strait Islander population;
- the low levels of Indigenous access to mainstream primary health care; and
- the additional costs of providing services in remote areas.

In recognition of these factors, the Benchmark formula is based on '3 times' the national average MBS expenditure per capita. When adjusted for cost differentials across Australia, the Benchmark translates into a factor of '2 times' the national average MBS for Indigenous health care in urban areas and a factor of '4 times' the national average MBS in very remote areas.

3.21 DoHA maintains strong links with its state and territory government equivalents to ensure that coordinated and complementary services are funded with the separate Australian Government's and jurisdictional funds. The Aboriginal and Torres Strait Islander Health Forums that pre-existed in each state and territory were chosen as the appropriate meetings at which to hold discussions between major stakeholders such as OATSIH, state and territory health departments and Indigenous medical services. The forums are used to:

- determine priorities for child and maternal health services;
- implement agreed priority child and maternal health actions;
- identify gaps in service provision and information exchange; and
- work collaboratively to achieve agreed targets.

3.22 The forums operate effectively and support the coordination of Australian, state and territory governments' health services. In some states, feeding into the Aboriginal and Torres Strait Islander Health Forums are sub-committees and working groups tasked with developing priorities. Using existing and planned jurisdictional activities, identifying linkages and gaps in service provision and ensuring that health services are delivered in a coordinated way, the sub-committees pass up recommendations to the Health Forums for consideration. For example, in New South Wales, a maternal and child health sub-committee has been formed under the Aboriginal Health Partnership Forums to deal specifically with maternal and child health issues. It is made up of representatives from DoHA, NSW Health, Aboriginal Health and Medical Research Council (AH&MRC), the Department of Families, Housing, Community Services and Indigenous Affairs and General Practice NSW. In Queensland, the Aboriginal and Torres Strait Islander Health Partnership is supported by a regional network rather than sub-committees. Through these arrangements, DoHA is able to consult with a variety of stakeholders, including representatives from the Indigenous health sector.

3.23 The selection process for New Directions sites and priority areas has varied slightly over each of the funding rounds. In the first round of funding in 2007–08, nine possible priority regions were identified by OATSIH (National Office and STO) through the internal analysis of where child and maternal health needs were unmet. These regions were also prioritised on the basis that they had primary health care organisations with the capacity to readily implement the Government's expanded Indigenous child and maternal health

objectives. The implementation plan for the first funding round required DoHA to shorten the consultation processes in order to select the regions of highest need, select and assess suitable service providers and allocate funding to the successful providers before the end of the 2007–08 financial year. As a result of this process, and the direct approach to known service providers located in the identified priority areas, five Aboriginal community controlled health organisations (ACCHO) received funding in May 2008.

3.24 The approach to site selection used in the first funding round was tailored due to the fact that the program was implemented quickly following the election of the Labor Government in November 2007. DoHA recognised that the continued successful delivery of services through New Directions required a significant level of planning and coordination across DoHA's state and territory offices, Aboriginal and Torres Strait Islander Health Forums, state and territory health departments and peak Aboriginal and Torres Strait Islander health organisations. Subsequent funding rounds have adopted this approach, ensuring an appropriate level of consultation on priority regions and investment.

Health service providers

3.25 The delivery of the New Directions program is dependent on third party providers funded through Australian Government grants. Service providers play a crucial role in achieving the objectives of the program and therefore need to be carefully selected, with consideration of their capacity to contribute to the objectives of the program. DoHA has targeted New Directions funding at organisations that may not necessarily be the most high performing, high capacity organisations, but those that nevertheless have the capacity to provide services in areas that would otherwise miss out.

3.26 Improved access is a key service delivery principle agreed by COAG for programs and services for Indigenous Australians.⁶⁰ To achieve the overall program objectives, the barriers that limit access need to be addressed at the program planning and implementation stages. These barriers typically include

⁶⁰ Ministerial Council for Federal Financial Relations, *National Indigenous Reform Agenda*, Schedule D, 'Service delivery principles for programs and services for Indigenous Australians', 'Integration principle', paragraph D12. [Internet]. MCFRR, available from <http://www.federalfinancialrelations.gov.au/content/national_agreements.aspx> [accessed June 2011].

language and cultural differences, geographical distance and the availability of economically feasible transport and the cost of health care.⁶¹ Engaging primary health care organisations with the capacity to overcome these barriers in their community is critical to meeting these challenges to service delivery. One of the strengths of New Directions is that it allows organisations to tailor the service to the particular needs of the community, while ensuring that the five key areas (refer to paragraph 3.2) of activity that are critical to maternal and child health are covered.

Profile of service providers

3.27 Both government and non-government organisations are eligible to receive New Directions funding, if they have the capacity to provide maternal and child health services to Indigenous populations in a priority region. New Directions providers are primary health care organisations, with the majority (about 70 per cent) being either Aboriginal Community Controlled Health Organisations (ACCHOs) or Aboriginal Medical Services (AMS) while the remaining 30 per cent are state health services (20 per cent) and other organisation types (10 per cent). Most providers interviewed as part of this audit receive funding from DoHA for other health initiatives, such as primary health care services, chronic disease or social and emotional wellbeing services. Approximately 26 per cent (21 of the 80 services) of New Directions service providers also receive funding to deliver the *Healthy for Life* program.

3.28 To be suitable for funding, applicants have had to demonstrate:

- their potential capacity and commitment to delivering maternal and child health services and the ability to develop linkages with other early childhood services (e.g. early learning and family support) in the local area;
- a capacity and commitment to identify innovative approaches and solutions to addressing gaps in service delivery; and
- a capacity and commitment to focus on the five priority areas of the program (refer to paragraph 3.2).

⁶¹ Australian Bureau of Statistics, *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, no. 4704.0, ABS, Canberra, 2008, pp. 189–190.

Organisations must also be financially viable and if they already receive DoHA funding for other services, not be rated as an Extreme Risk under the department's risk assessment process.

3.29 For each funding round assessment, DoHA undertakes a merit-based-selection process to select and fund health care organisations to deliver services that meet the aims of the program. Interested service providers must initially provide a comprehensive application covering the organisation's details and information about current activities, the funding requested, proposed mothers and babies services, and any needs for minor capital works. The service delivery model is determined by the service provider to ensure that services will be provided in the most appropriate way for their clients and communities. As part of the assessment process DoHA reviews budgets against proposed Action Plans to ensure that the service provider will provide services that address the program's objectives and that the proposed costs are comparable with similar projects across the country. In the three states visited by ANAO, DoHA's STOs maintained adequate records on the assessment process and associated correspondence.

3.30 New Directions funding can be used for the following:

- salaries and on-costs for new or additional staff;
- travel and accommodation associated with the initiative, including rental or leasing costs;
- related management and administration costs;
- minor capital expenses, including plant and equipment;
- dissemination of information materials; and
- minor capital projects under \$150 000.

Service providers interviewed for this audit indicated that funding was generally used to support staff salaries.

3.31 One of the key challenges experienced by service providers relates to workforce issues and the ability to attract and retain suitably qualified staff. This issue was reported by DoHA in the department's 2009–10 annual report as a key program constraint and was raised by service providers in urban, regional and remote areas, citing an inability to compete with salaries and conditions offered by larger state government health providers. Staff positions

commonly used across the New Directions program include: registered nurses; midwives; Aboriginal health workers; paediatricians; and specialists/allied health professionals such as speech therapists and dieticians. Some providers are able to use self-generated income to pay staff over the award rate to remain competitive; however, where providers are dependent on New Directions funding alone to continue operating, recruitment remains an ongoing issue and a main cause of underspends for the program. DoHA has recognised these workforce issues as a risk to the program in early implementation plans. However, the link between the identification of the risk and its management by DoHA has not been strongly formed.

3.32 Employment and training of local Indigenous people is considered by both the Australian Government and COAG to be a key principle in promoting better participation in the economy. Several service providers interviewed for this audit indicated that they aim to employ local Indigenous people where possible and help them gain qualifications that contribute to the objectives of the organisation.

Service provider management

3.33 Building and maintaining cooperative relationships with service providers is an important part of good program and service provider management. Contract management responsibility for the New Directions program lies with the STO staff as the first point of contact for organisations. Contract managers are responsible for monitoring the performance and compliance of the service providers in accordance with the terms and conditions of their agreements. Information on the expenditure of funds is collected through service providers' Action Plan reports, however, this information is not aggregated to give an overall picture of the type of expenditure across the program.

3.34 In 2011–12, DoHA introduced a new multi-year head funding agreement to reduce the number of funding agreements service providers have with the department. To support contract managers in its STOs, DoHA has developed guidelines which set out the risk assessment framework, communication strategy between DoHA and the providers, and contract management responsibilities.

3.35 National Office staff do not undertake site visits and as a consequence, are removed from the service providers' issues and the day-to-day operation of

the program. Periodic field visits by program staff can assist to develop a practical understanding of the issues faced in program implementation, help to gauge community and stakeholder support for the program, and provide information that can assist the department to assess overall provider performance. More generally, periodic field visits assist the department by improving understanding of such areas as the various operating environments, community involvement and interaction, and performance reporting processes.

Risk management and accreditation

3.36 Early identification of risks can mitigate their impact⁶² on programs, and there are several levels at which risks to the program can be assessed and managed. At the program level, a review of risks that have the potential to affect the overall program or the department would normally be completed early in the program and updated throughout the life of the program. At the operational level, an assessment of the risks of the service provider organisation is consistent with good grant management better practice.⁶³

3.37 DoHA's National Office staff are responsible for developing and updating the program risk assessment plan as an element of the IECD NP. In the 2009 Element Three Implementation Plan, DoHA indicated that a risk management plan was to be completed and reviewed each year. At the time of this audit, this had not occurred. DoHA is aware of this issue and indicated that efforts are underway to rectify this issue.

3.38 The implementation of the program is dependent on the effective operation of service provider organisations, and an assessment of the risks of the contract for service approach is an important element of overall program management. A risk assessment of a service provider organisation is undertaken by DoHA where the organisation has a Board of Directors and is in receipt of more than \$300 000 per annum. DoHA uses a Risk Assessment Profile Tool (RAPT) developed for OATSIH to manage risk. It is used to assess all OATSIH funded organisations that meet the criteria for assessment every

⁶² ANAO Better Practice Guide, *Implementation of Programme and Policy Initiatives*, October 2006, Canberra, p. 19.

⁶³ ANAO Better Practice Guide, *Implementing Better Practice Grants Administration*, June 2010, Canberra, p. 87.

two years, or annually where there is an indication that the organisation might be a significant risk.

3.39 As a result of a recommendation from the Major Review of OATSIH's Risk Assessment Framework in December 2010, DoHA outsourced the risk assessment of service providers. Up until then, as part of their contract management responsibilities, STO staff undertook service provider risk assessments. During this process, corporate governance and financial management were assessed to determine the viability of the organisations and to ensure that processes were in place to appropriately manage risk.

3.40 In addition to the risk assessments of service providers, many of the New Directions providers have been supported by DoHA to undergo a process of accreditation to bring them in line with the mainstream health care sector. Accreditation can be either for clinical services or organisational structures. Primary health care organisations providing general practice services are encouraged, in the first instance, to pursue accreditation under the Royal Australian College of General Practitioners (RACGP) Standards for General Practice. Organisational accreditation can be achieved through a number of eligible accreditation institutions serving the health and community services sectors, including: Quality Improvement Council (QIC); Health and Community Services Standards; International Organization for Standardization (ISO); Quality Management Systems; the Evaluation and Quality Improvement Council (EQuIP); and Australian Council on Healthcare Standards (ACHS).⁶⁴ Through *A Better Future for Indigenous Australians—Establishing Quality Health Standards*, DoHA offers financial assistance to Aboriginal community controlled organisations to achieve accreditation through support grants.

3.41 Service providers interviewed for this audit, who had completed the organisational accreditation process, reported that it was a complex and thorough process. However, some also reported that it was a beneficial process that had strengthened their organisational processes and procedures. During DoHA's review of the RAPT, service providers raised concerns that there was

⁶⁴ Department of Health and Ageing, *Health Service Accreditation*, 4 October 2011. [Internet] <<http://www.health.gov.au/internet/main/publishing.nsf/Content/healthservicesaccreditation>> [accessed 19 October 2011].

duplication between the risk assessment and the accreditation because of the rigour of the organisational accreditation process. The RAPT review concluded that where a funded service provider had achieved organisational accreditation, the rigour of the risk assessment process would be reduced, but not removed.

Conclusion

3.42 New Directions funding has encouraged primary health care providers to focus more effort on delivering child and maternal health to more hard-to-reach clients. Many of the services are building on existing clinic-based services by developing home visiting, mobile or outreach models and thereby aiming to increase access to clients in more remote regions.

3.43 DoHA has routine processes for the identification and selection of high priority sites and the targeted selection of new service providers. Mechanisms have been put in place to facilitate coordination and procedural consistency in regards to regional planning and site selection, service provider selection and management. DoHA has also used the pre-existing Aboriginal and Torres Strait Islander Health Forums to develop strong relationships with state and territory stakeholders, such as health departments and Indigenous health and medical services. The forums have proven to be effective mechanisms to consult jurisdictions on priority regions, on the identification of service gaps and to plan and coordinate maternal and child health services expenditure.

3.44 The first round of funding was implemented in a tight timeframe because of the Government's desire to quickly implement election commitments and funding was provided to a small number of providers through a select tender process. Subsequent funding rounds have been more tightly managed through DoHA's annual coordination and planning processes. Coordination of the program effort has taken into account other Australian and state/territory government initiatives directed at child and maternal health. DoHA recognised that the continued successful delivery of services through New Directions required a significant level of planning and coordination across DoHA's state and territory offices.

3.45 The implementation of the program is dependent on the effective operation of service provider organisations and DoHA has developed regular processes for assessing risk at this level. Until December 2011, DoHA STOs undertook risk assessments using the OATSIH Risk Assessment Profile Tool

(RAPT) to assess corporate governance and financial management. Since December 2011 risk assessments have been outsourced but continue to use the standard RAPT. Program implementation would be strengthened by a stronger approach to risk management at the program level to complement the operational risk assessments of providers. The 2009 Implementation Plan covering the Australian Government's contribution indicated that a risk management plan was to be completed and reviewed each year. However, this has not occurred. DoHA is aware of this issue and has indicated that efforts are underway to complete the plan.

4. Performance Monitoring and Reporting

This chapter examines the Department of Health and Ageing's performance monitoring and reporting of New Directions: Mothers and Babies Services under Element Three of the Indigenous Early Childhood Development National Partnership (IECD NP).

Introduction

4.1 Understanding performance is a key aspect of sound program management. Performance monitoring and reporting is important throughout the life of a program as it enables stakeholders to assess progress against the program objectives, identify and address emerging issues, make management improvements and review the program's ongoing relevance and priority.⁶⁵ Reporting on program performance provides stakeholders, including Parliament, with an indication of the relative success of a particular program in achieving its outcomes.⁶⁶

4.2 A key objective of the *Intergovernmental Agreement on Federal Financial Relations* (IGA), under which National Partnerships operate, is enhanced public accountability through simpler, standardised and more transparent performance reporting.⁶⁷ To improve accountability of the Australian, state and territory governments to the community, the performance reporting framework for the IGA requires a focus on the achievement of outcomes, the quality and efficiency of service delivery and timely provision of publicly available performance information. This includes reporting the achievement of objectives, outcomes, outputs and performance benchmarks in National Partnerships. The performance management framework for the New

⁶⁵ ANAO Better Practice Guide, *Implementation of Programme and Policy Initiatives*, October 2006, Canberra, p. 51.

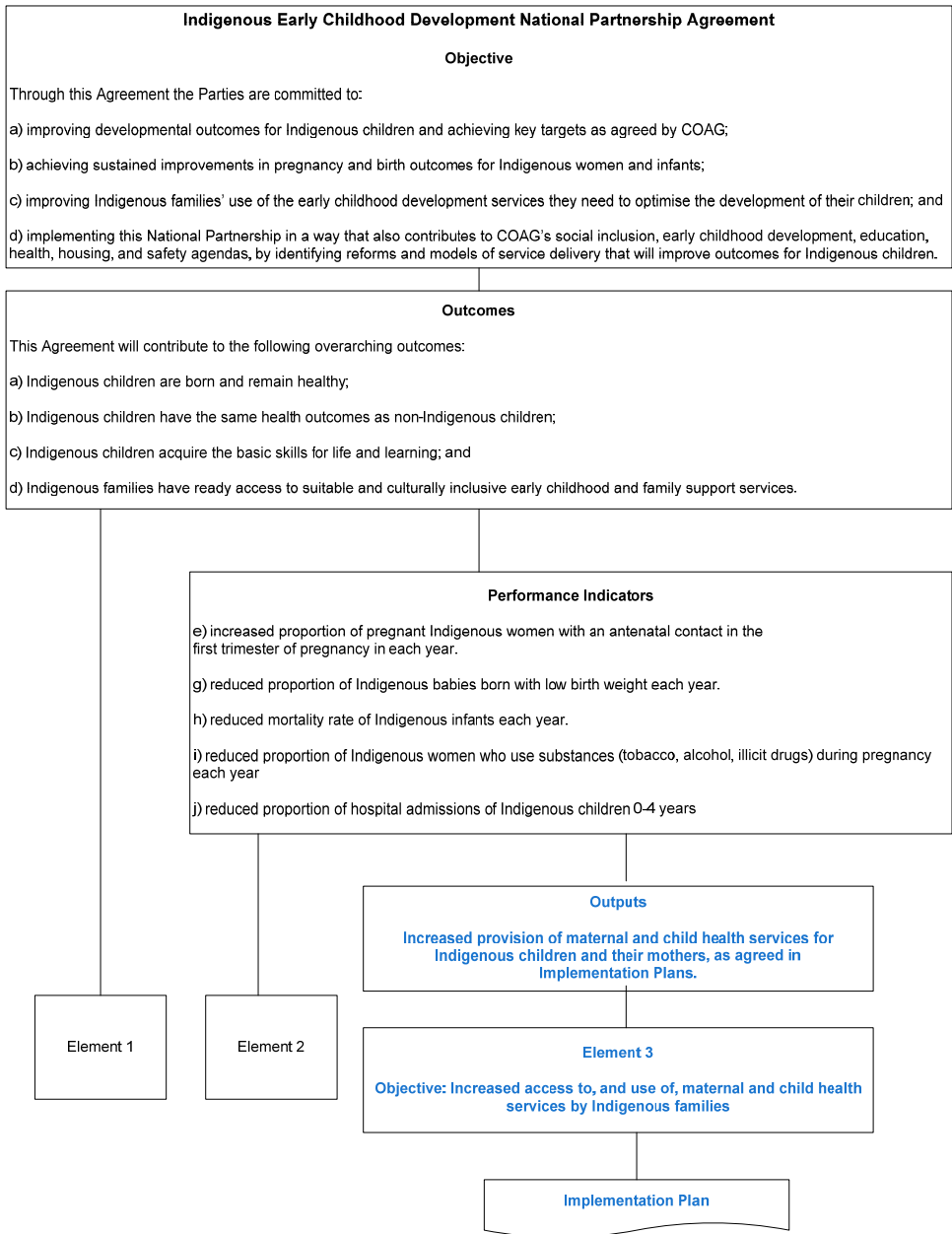
⁶⁶ *Department of Finance and Deregulation, Portfolio Budget Statements Constructors Kit*, 2011–12 Canberra, p. 37. [Internet] available from <http://www.finance.gov.au/budget/budget-process/docs/Guidance_for_the_Preparations_of_the_2011-2_Portfolio_Budget_Statements.pdf>, [accessed 16 June 2011].

⁶⁷ *Intergovernmental Agreement on Federal Financial Relations*, pp. 5–6.

Directions program is encompassed in the broader performance management framework of the IECD NP as detailed in Figure 4.1.

Figure 4.1

Performance management framework for Element Three of the IECD NP



Source: IECD NP.
ANAO Audit Report No.35 2011–12
Indigenous Early Childhood Development.
New Directions: Mothers and Babies Services

4.3 The performance management framework is designed to report on progress towards the key outcomes of the IECD NP. In particular that Indigenous children are: born and remain healthy; have the same health outcomes as other children; acquire the basic skills for life and learning; and have ready access to suitable and culturally inclusive early childhood and family support services. All three elements of the IECD NP aim to contribute to these outcomes. These outcomes will also be influenced by a range of other programs outside the IECD NP and indicators such as infant mortality and birth weights are relevant to other existing child and maternal health initiatives.⁶⁸ These high-level indicators are widely used measures of infant health and are related to many factors—including the overall social and economic conditions for Indigenous Australian women and their families—and not just primary health care.⁶⁹ Therefore, movements in the IECD NP performance indicators will not be solely attributable to activities funded through the national partnership, as a range of other programs and factors impact on the achievement of the outcomes and objectives, blurring the Agreement's specific contribution to overall maternal and child health outcomes.

Monitoring the performance of New Directions

4.4 In such circumstances, where determining the contribution a program makes to a particular outcome is challenging, it remains important to focus on measuring more specific elements of program performance. In the case of New Directions, this would include measuring the program against its specific objectives of increasing access to, and use of, maternal and child health services, the effectiveness of its service delivery model, performance of service providers, and program management. With this information DoHA would be able to identify what is working and what is not, ascertain if the same result

⁶⁸ For example, the *Healthy for Life* program seeks to improve health outcomes in the areas of child and maternal health, chronic disease management and detection and men's health, while the *Australian Nurse Family Partnership Program* aims to improve pregnancy and childhood outcomes, and empower parents to make good decisions about their life and their child's life.

⁶⁹ Australian Health Ministers Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2010*, AHMAC, Canberra, p. 14 and 54.

could have been achieved with less cost, determine if the program is achieving value for money and verify if other alternatives are missed opportunities.

New Directions Implementation Plan

4.5 The strategies and measures for delivering and assessing the outputs and objectives of New Directions are outlined in the program’s Implementation Plan. The Implementation Plan is a requirement of the IECD NP and includes milestones, performance indicators, timelines and financial resources for program delivery. Table 4.1 is an extract from the New Directions Implementation Plan and sets out the performance framework developed to measure progress towards increasing access to, and use of, maternal and child health services by Indigenous families. This extract is mirrored in the Implementation Plan for each financial year over the life of the National Partnership. The objective in the Implementation Plan, as shown in Table 4.1, does not reflect the ‘use of’ aspect of the program’s objective under the IECD NP.

Table 4.1

Performance framework for New Directions

Objective	Strategies	Performance Indicators
Increase access to child and maternal health services in priority regions across Australia	Select, approve and fund sites	Suitable proposals are received from eligible primary health care providers. New services are funded in priority regions.
	Manage funding agreements with existing sites.	Waves 1 & 2 sites are operational.
	Consult with stakeholders to review earlier wave investment and identify priority regions for future wave.	Outcomes of consultations are recorded. Minister approves priority regions.

Source: IECD NP Implementation Plan – Element Three.

4.6 Guidance for developing national partnerships highlights that when developing program key performance indicators (KPIs), there should be a

focus on demonstrating whether the program is effective in achieving the intended result, the result is attributable to the program, and the program exerts an influence over the result.⁷⁰

4.7 The performance indicators identified in the Implementation Plan do not provide a clear insight into the program's achievements with regard to improving access to, and the use of, maternal and child health. For example, some performance indicators are more like input indicators and therefore do not measure progress towards achieving a program's objectives. An illustration of this in the table above, is the concept that the provision of funding will result in better access to services.

4.8 The ANAO Better Practice Guide, *Implementing Better Practice Grants Administration*⁷¹ lists a number of commonly occurring issues in performance management design including:

- assuming that the awarding of a grant automatically secures the desired outcome;
- assuming that the consumption of inputs results in the delivery of desired outputs and outcomes;
- using the number of grants awarded under a program as a measure of program output and achievement against the desired government outcomes (this is simply a measure of administrative activity); and
- not relating performance measures to operational and strategic objectives or outcomes. It is more important to achieve the desired strategic outcomes from the program than to maximise, for example, the number or value of grants approved.

4.9 Analysis of the performance framework for New Directions suggests that these issues are present in the design of the program's performance framework. Further, the program's objectives, as reflected in the Implementation Plan, refer only to increasing 'access' to child and maternal

⁷⁰ Department of Finance and Deregulation, *Performance Information and Indicators*, October 2010, p. 2.

⁷¹ Australian National Audit Office, Better Practice Guide, *Implementing Better Practice Grants Administration*. June 2010, p. 99.

health services and do not address the objective of increasing the 'use' of these services, which was introduced as part of the program's objectives in the IECD NP. The number of services provided under the program (also the program's outputs) is seen to be the key measure of access and, in turn, program success.

4.10 The current focus of DoHA's performance indicators can, in part, be attributed to a decision by the department at the establishment of the program to minimise the reporting and data collection requirements on service providers, particularly given the program intended to target regions of high need where services providers may have limited capacity and resources. (Refer to paragraphs 4.27 to 4.30 for details on Action Plan reporting.) While it is important to ensure the costs involved in collecting data for performance indicators are proportionate to the benefits gained from the resulting information, the emphasis on minimising performance reporting requirements has had a significant impact on the quality of performance data available to assist managers and external stakeholders. This has limited DoHA's ability to understand the program's effectiveness and, in particular, the impact and contribution it is making to the outcomes of the IECD NP.

4.11 Proportionality is a key consideration in determining the comprehensiveness of a performance measurement framework and the COAG's emphasis on the importance of agencies applying judgement in this respect. The Commonwealth Grant Guidelines also emphasise the importance of periodically reviewing decisions based on proportionality so the changes in circumstances can be taken into consideration.⁷² The department took a staged approach to implementing the program, which in the first year involved only five providers and expenditure of \$640 000. Subsequent funding rounds have increased the number of providers involved and lifted annual expenditure to \$31 million. This level of expenditure will be maintained into the future with recurrent funds paid as grants to over 80 services providers. These changes make it timely for DoHA to review its performance information requirements.

⁷² Department of Finance and Deregulation, *Commonwealth Grant Guidelines, Policies and Principles of Grants Administration*, July 2009, Canberra, p. 29.

Development of additional performance indicators

4.12 There is scope for improving the performance framework for New Directions by developing KPIs that support an assessment of the program's achievements. Indicators developed for the program would ideally be comprised of an appropriate mix of quantitative and qualitative indicators, including targets against which progress towards the program objectives can be assessed.

4.13 Some service providers interviewed by the ANAO have incorporated the use of surveys as a tool for measuring client satisfaction. As there are different and tailored approaches to service delivery across services (in order to meet local need), qualitative indicators would facilitate the identification of innovative and successful approaches to service delivery and assist with continuous improvement strategies. This approach is consistent with the IGA's strategy for enhancing public accountability, which encourages performance reporting frameworks to focus on quality and efficiency of service delivery, among other things.

4.14 In 2009, the Australian, state and territory governments undertook to develop a set of national Key Performance Indicators (nKPIs) under the auspices of the *National Indigenous Reform Agreement*. The objective of the reporting reform was to reduce the reporting burden on funded health services and improve current health outcomes and performance data by streamlining and simplifying the reporting requirements and data collection systems.

4.15 Australian, state and territory government funded Indigenous primary health care services will be required to report against these indicators. The 24 recommended nKPIs will be introduced in stages over an 18 month period (refer to Appendix 4 for details). The nKPIs relevant to maternal and child health outcomes are outlined in Table 4.2.

Table 4.2**National key performance indicators relevant to maternal and child health outcomes**

Indicator	Description	Status	Original implementation date	Revised implementation date
Birth weight recorded	Number and proportion of Indigenous babies born within the previous 12 months whose birth weights were recorded	Agreed (Stage 1)	July 2012	January 2013
Birth weight result	Number and proportion of Indigenous babies born within the previous 12 months with a recorded birth weight of either low, normal, or high	Agreed (Stage 2)	January 2013	July 2013
First antenatal visit	Number and proportion of regular clients who are Indigenous and who had their first antenatal visit within specified periods	Agreed (Stage 2)	January 2012	July 2013
Smoking during pregnancy	Number and proportion of regular clients who are Indigenous, gave birth to a baby in the previous 12 months AND who had an antenatal visit during that pregnancy AND who smoked at that time	Proposed (Stage 3)	July 2013	July 2014

Source: DoHA Fact Sheet OATSIH Reporting Reforms: Reporting of National Key Performance Indicators, 29 July 2011 and advice from DoHA.

Note: The original implementation date refers to the date all OATSIH funded health services, including services funding under the New Directions program, were to have commenced reporting the nKPIs.

Note: The implementation date refers to the month in which service providers report the nKPIs. The reported activity is for the previous six, twelve or twenty-four months depending on each indicators specification.

4.16 In 2010, efforts by DoHA to introduce additional KPIs for New Directions were deferred as there were several other initiatives underway relating to the reporting frameworks for Indigenous primary health care services. These included work on the data requirements for the proposed IECD NP evaluation and the development of nKPIs. In view of the potential for duplication in the frameworks, the department did not proceed with the development of indicators for the New Directions program. The indicators that were proposed to be developed would, however, have provided a relevant measure of the program's objectives linking results to the program's activities. Examples of proposed KPIs that would enable measurement of the level of access and usage of services provided under New Directions include:

- number of organisations (operational and establishing);
- number of clients who use New Directions;
- number of episodes of care funded under New Directions;
- number of pregnant women who gave birth to an Indigenous baby during the period 1 July 2010 to June 2011 and who attended an antenatal care session funded under New Directions:
 - Number of mothers who attended at least one antenatal care session
 - Number of mothers who first antenatal care session occurred in the first trimester (<13 weeks)
 - Number of mothers who attended five or more antenatal care sessions.

4.17 These indicators are well aligned with the program objectives, so performance data collected to support the indicators would provide program managers with meaningful and comparable information to assess progress towards achieving program objectives and would also help to assess the performance of service providers. There is also limited duplication of information designed to be collected under the nKPIs. As discussed in paragraph 4.10, DoHA's performance reporting could be strengthened to improve its understanding of the program's effectiveness and the impact and contribution the program is making to the outcomes of the IECD NP. There would be opportunities to draw on the earlier work undertaken for the New Directions program to improve the current KPIs.

Program implementation reporting

Annual reporting by DoHA against Element Three: New Directions

4.18 Under the IECD NP, clause 47 requires states and territories to provide a detailed annual report to the Australian Government for the preceding financial year by 31 August of each year. The reports describe the progress in achieving the performance indicators, outputs, outcomes and objectives and report achievements against the milestones, financials, and timelines detailed in the implementation plans. The Australian Government is also required to report annually by 31 August to COAG on the Implementation Plan for the program. Following ministerial approval the Australian Government's annual report is publicly accessible on the DoHA website. State and territory progress reporting on Element Three is not linked to payments by the Australian Government as is the case for Elements One and Two and many other National Partnership Agreements. As a result, state and territory annual reports have not been publicly released by DoHA and their requirement is under review.

4.19 Timely reporting of performance is a key aspect of enhancing public accountability. Annual reports outlining achievements for the previous financial year have not been released by the department in a timely manner as required by the IECD NP. DoHA's 2009–10 annual report was released in May 2011, nine months after the August deadline and the 2010–11 annual report was released in January 2012.

4.20 The strategies outlined in the Australian Government's Implementation Plan are focused on increasing access to maternal and child health services through the increased provision of services. DoHA's annual reports are focused on implementation and as a result, the performance information provided is of limited use for the purposes of understanding whether the program is effective in increasing access to, and use of, services and providing quality services.

Program Evaluation

4.21 Program evaluation is an integral part of an effective performance management framework and is complementary to monitoring systems. Good evaluative information provides managers with useful and timely information to assist with resource allocation, assess the appropriateness of government policy and programs, and identify emerging issues and unintended outcomes.

4.22 Under the IECD NP, a comprehensive national evaluation is required to be undertaken throughout the life of the Agreement to determine the effectiveness in achieving the outcomes of the Agreement. In November 2010, an evaluation strategy was developed. The strategy describes the key evaluation questions (refer to Appendix 5), indicators and data sources to assess the efficiency and effectiveness of the overall National Agreement, as well as the individual elements, in delivering the identified outputs, objectives and outcomes.

4.23 Data sources include quantitative administrative data from the Australian, state and territory governments, as well as survey data and qualitative information from interviews and consultations. The evaluation strategy highlights that there is no expectation for states and territories to implement new data collections.

4.24 Although the IECD NP has been in operation since January 2009, data definitions and specifications for performance indicators were only finalised in April 2011, and the collection of some baseline data is currently being pilot-tested as part of the evaluation. Ideally, the development of data definitions and the collection of baseline data would be undertaken during the early stages of, or prior to, a program's implementation to allow sufficient time for changes to occur and to measure the associated improvements, identify trends in data, and establish interim performance targets that challenge the program to maximise its outputs and outcomes.

4.25 While the evaluation might provide useful information regarding the effectiveness and appropriateness of the overall Agreement, the extent to which it will be able to assess the effectiveness and contribution of New Directions may be limited, as adequate, and in particular quantitative, performance data on the program is not currently being collected. Qualitative data will be helpful to understand how services are delivered and to identify what works, however the value of any comparative analysis may be limited.

4.26 The results of the evaluation of the IECD NP are due in 2014. By that time New Directions will have been operating for seven years. Given the limitation of the program's existing performance and monitoring framework, as discussed earlier in this chapter, this is a lengthy period to wait to understand whether the program has been working effectively and providing value for money. The evaluation, while important, is not sufficient to enable

regular monitoring and reporting of the New Directions program and to support timely and evidence-based decision making by program managers.

Monitoring the effectiveness of service providers

4.27 In a service delivery model based on the use of contracted service providers, it is critical that, as part of the overall performance framework, funding departments develop and implement appropriate ways of monitoring the effectiveness of service providers. This should cover the program cycle, from the implementation stage through on going management to post-implementation evaluation. In the implementation phase of New Directions emphasis was placed on not burdening the service delivery organisations with additional reporting and data collection requirements, particularly given the program's intention of targeting regions of high need where service providers may have limited capacity and resources. DoHA's decision was also influenced by criticisms received from health service providers about too many reports being required and that data collection and monitoring needed to be simplified. This was also a recommendation of *The Overburden Report: Contracting for Indigenous Health Service*⁷³, which was released in July 2009 subsequent to the implementation of New Directions.

4.28 The planning and reporting mechanism that was adopted was the Service Development Reporting Framework (SDRF), which was a requirement for all DoHA funded health services at the time of the program's establishment. The SDRF is an organisation's 12 month negotiated action plan outlining the proposed utilisation of funds provided by DoHA. Under the SDRF, service providers are required to provide six-monthly action plan reports outlining achievements against agreed strategies and the performance indicators identified in their respective action plan. Action plan reports reviewed as part of the audit included a mixture of quantitative and qualitative performance information.

4.29 The assessments of service providers' Action Plan reports by STOs are generally undertaken for compliance monitoring purposes, with the focus being on individual service providers. Information reported by service

⁷³ Dwyer, J., O'Donnell, K., Lavoie, J., Marlina, U. & Sullivan, P. 2009, *The Overburden Report: Contracting for Indigenous Health Services*, Cooperative Research Centre for Aboriginal Health, Darwin.

providers is not being used to assess the effectiveness of individual service providers or collated and analysed to develop an aggregate view of the program's effectiveness within priority regions, across states and territories or for Australia as a whole. ANAO was advised that no information from Action Plans is routinely consolidated at the jurisdictional or national levels. Only through ad hoc requests is effort put into piecing information together to give a consolidated view of the program. An example of a worthwhile aggregation would be a state/territory and national view of the five priority activity areas which the program aims to target and which are reported against by each service provider on a biannual basis (refer to paragraph 3.2 for a list of the priority activities). Although data comparability is limited, there would also be benefit in undertaking a more in-depth review of the action plan reports to identify emerging issues across states and territories, such as problems experienced with the recruitment of suitably qualified staff, trends in accommodation shortages and the provision of services to remote locations.

4.30 The lack of adequate and comparable performance data relating to the program and individual services has hampered the ability of program managers to identify continuous improvement opportunities and inform evidence-based policy making. The extent and timing of service provider monitoring and the office assessment of aggregated performance information can be a challenge, particularly for smaller grant programs with limited resources, and for programs funding a large number of grants. However, there may be opportunities to improve the efficiency of the reporting process for both the funded service providers and DoHA by leveraging off reporting that providers must undertake to satisfy their own governance requirements. The ANAO identified several performance indicators contained in Action Plans that were similar across services and provided a direct measure of program effectiveness. Examples of such indicators include:

- number of episodes of antenatal care;
- increase in the number of pregnant women with Aboriginal babies who access antenatal care prior to 20 weeks gestation; and
- number of women accessing antenatal care.

Conclusion

4.31 There is presently little performance data available to support an assessment of the extent to which New Directions has contributed to improvements in maternal and child health and the quality and effectiveness of the services provided. The performance indicators in use relate to the number of service providers and the timeliness of enlisting new service providers. The indicators, while helpful to measure activity under the program, do not provide sufficient insight into the program's achievements with regard to improving access to, and use of, maternal and child health services as intended by the IECD NP.

4.32 The decision to minimise the performance reporting of service providers and the collection of baseline data, while assisting to reduce the administrative burden, has nonetheless limited DoHA's ability to understand the effectiveness of the program and its contribution to maternal and child health. An appropriate balance needs to be given to administrative burden and a sufficient level of performance information required by DoHA to effectively administer the program. There is scope for improving the performance framework for New Directions by developing more useful and relevant KPIs to support an accurate and reliable assessment of the program's achievements with regard to improving access to, and use of, maternal and child health services.

Recommendation No.1

4.33 To support better management of the *New Directions: Mothers and Babies Services* program, ANAO recommends that the Department of Health and Ageing review its performance framework and strengthen measures to monitor service delivery and determine whether use of services is improving in line with the program's objectives.

DoHA's response: Agreed



Ian McPhee

Auditor-General

Canberra ACT

29 May 2012

Appendices

Appendix 1: Council of Australian Governments Targets⁷⁴

The Council of Australian Governments has committed to Closing the Gap in Indigenous disadvantage by:

- closing the life expectancy gap within a generation;
- halving the gap in mortality rates for Indigenous children under five within a decade;
- ensuring all Indigenous four year olds in remote communities have access to early childhood education within five years;
- halving the gap for Indigenous students in reading, writing, and numeracy within a decade;
- halving the gap for Indigenous people aged 20–24 in Year 12 attainment or equivalent attainment rates by 2020; and
- halving the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

⁷⁴ Council of Australian Governments, *Indigenous Reform*. [Internet] available from <<http://www.coagreformcouncil.gov.au/agenda/indigenous.cfm>> [accessed 27 March 2012]

Appendix 2: National Indigenous Reform Agreement: Service delivery principles for programs and services for Indigenous Australians⁷⁵

Priority principle

Programs and services should contribute to Closing the Gap by meeting the targets endorsed by COAG while being appropriate to local community needs. The COAG targets are:

- (a) close the 17 year life expectancy gap within a generation;
- (b) halve the gap in mortality rates for children under five within a decade;
- (c) halve the gap in reading, writing and numeracy within a decade;
- (d) halve the gap in employment outcomes and opportunities within a decade;
- (e) at least halve the gap for Indigenous students in Year 12 or equivalent attainment rates by 2020; and
- (f) within five years provide access to a quality early childhood education program to all Indigenous four year olds in remote Indigenous communities.

Indigenous engagement principle

Engagement with Indigenous men, women and children and communities should be central to the design and delivery of programs and services. In particular, attention is to be given to:

- (a) recognising that strong relationships/partnerships between government, community and service providers increase the capacity to achieve identified outcomes and work towards building these relationships;
- (b) engaging and empowering Indigenous people who use Government services, and the broader Indigenous community in the design and delivery of programs and services as appropriate;
- (c) recognising local circumstances;

⁷⁵ National Indigenous Reform Agreement (Closing the Gap), Council of Australian Governments Schedule D, Page D-67.

- (d) ensuring Indigenous representation is appropriate, having regard to local representation as required;
- (e) being transparent regarding the role and level of Indigenous engagement along a continuum from information sharing to decision-making; and
- (f) recognising Indigenous culture, language and identity.

Sustainability principle

Programs and services should be directed and resourced over an adequate period of time to meet the COAG targets. In particular, attention is to be given to:

- (a) service system orientation, particularly:
 - (i) using evidence to develop and redesign programs, services and set priorities;
 - (ii) recognising the importance of early intervention; and
 - (iii) including strategies that increase independence, empowerment and self management;
- (b) ensuring adequate and appropriate resources, particularly:
 - (i) setting time-frames for meeting short, medium and longer-term targets and outcomes;
 - (ii) considering flexibility in program design to meet local needs;
 - (iii) considering workforce supply and future planning;
 - (iv) considering sustaining or redesigning services to best use existing resources, as well as the need for programs and services to meet the COAG targets;
 - (v) minimising administrative red tape to enable greater integration of program and service delivery;
 - (vi) ensuring that programs and services are efficient and fiscally sustainable; and
 - (vii) ensuring that infrastructure is appropriate and adequately maintained;
- (c) building the capacity of both Indigenous people and of services to meet the needs of Indigenous people, particularly:

- (i) developing the skills, knowledge and competencies, including independence and empowerment of Indigenous people, communities and organisations;
- (ii) supporting Indigenous communities to harness the engagement of corporate, non-government and philanthropic sectors;
- (iii) building governments' and service delivery organisations' capacity to develop and implement policies, procedures, and protocols that recognise Indigenous people's culture, needs and aspirations;
- (iv) ensuring that programs and services foster and do not erode capacity or capability of clients; and
- (v) recognising when Indigenous delivery is an important contributor to outcomes (direct and indirect), and in those instances fostering opportunities for Indigenous service delivery.

Access Principle

Programs and services should be physically and culturally accessible to Indigenous people recognising the diversity of urban, regional and remote needs. In particular, attention is to be given to:

- (a) considering appropriate and adequate infrastructure and placement of services (including transport, IT, telecommunications and use of interpreter services);
- (b) minimising administrative red tape that may be a barrier to access; and
- (c) providing adequate information regarding available programs and services.

Integration principle

There should be collaboration between and within Governments at all levels, their agencies and funded service providers to effectively coordinate programs and services. In particular attention is to be given to:

- (a) articulating responsibilities between all levels of government;
- (b) identifying and addressing gaps and overlaps in the continuum of service delivery;

- (c) ensuring services and programs are provided in an integrated and collaborative manner both between all levels of governments and between services;
- (d) ensuring services and programs do not set incentives that negatively affect outcomes of other programs and services; and
- (e) recognising that a centrally agreed strategic focus should not inhibit service delivery responses that are sensitive to local contexts.

Accountability principle

Programs and services should have regular and transparent performance monitoring, review and evaluation. In particular, attention is to be given to:

- (a) choosing performance measures based on contribution to the COAG targets and report them publicly;
- (b) ensuring mainstream service delivery agencies have strategies in place to achieve Indigenous outcomes and meet Indigenous needs;
- (c) clearly articulating the service level to be delivered;
- (d) ensuring accountability of organisations for the government funds that they administer on behalf of Indigenous people;
- (e) periodically measuring/reviewing to assess the contribution of programs and services to the above, and adapting programs and services as appropriate;
- (f) clearly defining and agreeing responsibilities of government and communities;
- (g) supporting the capacity of the Indigenous service sector and communities to play a role in delivering services and influencing service delivery systems/organisations to ensure their responsiveness, access and appropriateness to Indigenous people; and
- (h) evaluating programs and services from multiple perspectives including from the client, Indigenous communities and government perspectives and incorporating lessons into future program and services design.

Appendix 3: New Directions service provider organisations

Yerin Aboriginal Health Service
Aboriginal Medical Service Western Sydney Cooperative
Danila Dilba Health Services
Darling Downs Shared Care (T/A Carbal Medical Centre)
Marwarnkarra Health Service Aboriginal Corporation
Hunter New England Local Health Network - Lake Macquarie
Hunter New England Local Health Network - Armidale, Cessnock, Narrabri
Winnunga Nimmitjiah Aboriginal Health Service
Illawarra Shoalhaven Local Health Network - Southern Hospitals Network
Orange Aboriginal Health Service
Riverina Medical & Dental Aboriginal Corporation
Royal Hospital for Women - auspiced by South Eastern Sydney Local Health
South Western Sydney Local Health Network
Tharawal Aboriginal Corporation
Central Australian Aboriginal Congress (CAAC)
Biripi Aboriginal Corporation Medical Centre
Katherine West Health Board Aboriginal Corporation
Miwatj Health Aboriginal Corporation - Nhulunbuy Clinic
Miwatj Health Aboriginal Corporation - Ngalkanbuy Clinic
Willowra, Yuendumu, Nyirripi Health Service (WYN) - auspiced by CAAC
Wurli Wurlinjang Health Service
Aboriginal and Torres Strait Islander Community Health Service Brisbane Ltd
Aboriginal and Torres Strait Islander Community Health Service Mackay Ltd
Apunipima Cape York Health Council Aboriginal Corporation
Cunnamulla Aboriginal Corporation for Health
Gurriny Yealamucka Health Services Aboriginal Corporation
Inala Indigenous Health Service (auspiced by Queensland Health)
Mamu Health Service
Mulungu Aboriginal Corporation Medical Centre
North and West Queensland Primary Health Care Assn (including Royal
Country Health SA (Port Augusta)
Port Lincoln Aboriginal Health Service Inc
Department of Health and Human Services
Ballarat and District Aboriginal Co-op
Bendigo and District Aboriginal Co-operative

Mercy Public Hospitals Inc
 Murray Valley Aboriginal Cooperative
 Bega Garribirringu Health Service
 Ord Valley Aboriginal Health Service
 Western Australian Country Health Service (Midwest) - Carnarvon Hospital
 Western Australian Country Health Service (Midwest) - Geraldton
 Yura Yungi Medical Service
 Laynhapuy Homelands Association Incorporation
 Pintubi Homelands Health Service
 Sunrise Health Service Aboriginal Corporation
 Western Arrente Health Aboriginal Corporation - auspiced by CAAC
 Mookai Rosie Bi-Bayan
 Country Health SA (Ceduna)
 Tullawon Health Service
 Flinders Island Aboriginal Association
 Tasmanian Aboriginal Centre (North West Region)
 Kimberley Aboriginal Medical Service
 Ngaanyatjarra Health Service
 Ngunytju Tjitji Pirni Aboriginal Corporation
 Wirraka Maya Health Service
 Wuchopperen Health Services Ltd
 Mount Isa Aboriginal Community Controlled Health Service
 South Eastern Sydney Local Health Network
 Sydney Local Health Network
 Awabakal Newcastle Aboriginal Co-operative Limited
 Ampilatwatja Health Centre Aboriginal Corporation
 Northern Territory Department of Health
 Bullinah Aboriginal Health Service Aboriginal Corporation
 North West Tasmania Division of General Practice Incorporated
 Tasmanian Aboriginal Centre (South Region)
 Durri Aboriginal Corporation Medical Service
 Griffith Aboriginal Medical Service Incorporated
 Hunter New England Local Health Network - (Moree/Gwydir)
 Northern Rivers General Practice Network (NSW) Limited
 North West Slopes (NSW) Division of General Practice
 South Coast Women's Health & Welfare Aboriginal Corporation (Waminda)
 Circular Head Aboriginal Corporation
 Institute for Urban Indigenous Health

Ipswich West Moreton Division of General Practice
Townsville General Practice Network
Paupiyala Tjarutja Aboriginal Corporation
Punturkurnu Aboriginal Medical Service
Wheatbelt Aboriginal Health Service (WA Country Health Services)
Department of Health, NT Government

Appendix 4: National Key Performance Indicators

Table A1

List of agreed Key Performance Indicators (Stage 1)

Indicator	Description	Status	Original implementation date	Revised implementation date
Birth weight recorded	Number and proportion of Indigenous babies born within the previous 12 months whose birth weights were recorded	Agreed	July 2012	January 2013
Health assessment key measure	Number and proportion of regular clients who are Indigenous and who had an MBS Health Assessment (MBS item 715) within the previous 12 months (0-4 years) or 24 months (25 years and over)	Agreed	July 2012	January 2013
HbA1c recorded	Number and proportion of regular clients with Type II diabetes who are Indigenous and have had a HbA1c measurement recorded within the previous 6 months and 12 months	Agreed	July 2012	January 2013
HbA1c result	Number and proportion of regular clients with Type II diabetes who are Indigenous and have had a HbA1c measurement recorded within the previous 6 months and 12 months AND whose last recorded HbA1c was within specified ranges	Agreed	July 2012	January 2013

Indicator	Description	Status	Original implementation date	Revised implementation date
Type II diabetes clients who had a blood pressure test recorded	Number and proportion of regular clients with Type II diabetes who are Indigenous and who have had a blood pressure test recorded within the previous 6 months	Agreed	July 2012	January 2013
Type II diabetes clients with blood pressure less than or equal to 130/80 mmHg	Number and proportion of regular clients with Type II diabetes who are Indigenous whose blood pressure test was less than or equal to 130/80 mmHg within the previous 6 months	Agreed	July 2012	January 2013
GP Management Plan MBS item 721	Number and proportion of regular clients with Type II diabetes who are Indigenous and have a GP Management Plan	Agreed	July 2012	January 2013
Type II diabetes clients who have a Team Care Arrangement	Number and proportion of regular clients with Type II diabetes who are Indigenous and have a Team Care Arrangement	Agreed	July 2012	January 2013
Smoking recorded	Number and proportion of regular clients who are Indigenous with a known smoking status	Agreed	July 2012	January 2013
Body Mass Index	Number and proportion of regular clients who are Indigenous and have a BMI recorded as overweight or obese	Agreed	July 2012	January 2013
Alcohol consumption recorded	Number and proportion of regular clients who are Indigenous and have had their alcohol consumption recorded within the previous 2 years	Agreed	July 2012	January 2013

Table A2**List of proposed Key Performance Indicators (Stage 2 and 3)**

Indicator	Description	Status	Original implementation date	Revised implementation date
Birth weight result	Number and proportion of Indigenous babies born within the previous 12 months with a recorded birth weight of either low, normal, or high	Agreed (Stage 2)	January 2013	July 2013
Child immunisation	Number and proportion of Indigenous children who are fully immunised at 1, 2 and 5 years of age	Agreed (Stage 2)	January 2013	July 2013
Pap test	Number and proportion of female Indigenous regular clients aged between 20 and 69 years who are recorded as having a pap test within the previous 2, 3 and 5 years	Agreed (Stage 2)	January 2013	July 2013
First antenatal visit	Number and proportion of regular clients who are Indigenous and who had their first antenatal visit within specified periods	Agreed (Stage 2)	January 2013	July 2013
Adult immunisation	Number and proportion of regular clients aged 50 years or more who are Indigenous and are recorded as being fully immunised with influenza and pneumococcal vaccine	Agreed (Stage 2)	January 2013	July 2013

Indicator	Description	Status	Original implementation date	Revised implementation date
Adult immunisation for regular clients with chronic disease	Number and proportion of adult regular clients with Type II diabetes or COPD who are Indigenous and immunised (specification)	Agreed (Stage 2)	January 2013	July 2013
eGFR recorded	Number and proportion of regular clients who are Indigenous, have a chronic disease and who are recorded as having an eGFR AND urinary ACR OR other urinary micro albumin test result within the previous 12 months	Agreed (Stage 2)	January 2013	July 2013
Smoking status	Number and proportion of regular clients who are Indigenous and who have a smoking status of ex-smoker, current smoker, never smoked or not recorded	Agreed (Stage 2)	January 2013	July 2013
Smoking during pregnancy	Number and proportion of regular clients who are Indigenous, gave birth to a baby in the previous 12 months AND who had an antenatal visit during that pregnancy AND who smoked at that time	Proposed (Stage 3)	July 2013	July 2014
Risk of long-term harm from alcohol	Number and proportion of regular clients who are Indigenous and have been recorded as at risk of long-term harm from alcohol	Proposed (Stage 3)	July 2013	July 2014

Indicator	Description	Status	Original implementation date	Revised implementation date
eGFR result	Number and proportion of regular clients who are Indigenous, have a chronic disease and who are recorded as having an eGFR test result within the previous 12 months with a result within specified levels	Proposed (Stage 3)	July 2013	July 2014
Absolute risk assessment recorded	Number and proportion of regular clients who are Indigenous, have not had a diagnosis of cardiovascular disease and who have had an absolute risk assessment recorded	Proposed (Stage 3)	July 2013	July 2014
Absolute risk assessment result	Number and proportion of regular clients who are Indigenous, have not had a diagnosis of cardiovascular disease and who have had an absolute risk assessment with results within specified levels	Proposed (Stage 3)	July 2013	July 2014

Source: DoHA Fact Sheet OATSIH Reporting Reforms: Reporting of National Key Performance Indicators, 29 July 2011 and advice from DoHA.

Note: The original implementation date refers to the date all OATSIH funded health services, including services funding under the New Directions program, were to have commenced reporting the nKPIs

Note: The implementation date refers to the month in which service providers report the nKPIs. The reported activity is for the previous six, twelve or twenty-four months depending on each indicators specification.

Appendix 5: Evaluation strategy—key evaluation questions

The evaluation strategy for the IECD NP identifies seven overarching questions that should be addressed by the evaluation:

1. What models of partnership were used and were they effective in achieving the objectives?
2. To what extent were services integrated within Children and Family Centres and how did this impact on achieving outcomes?
3. What Aboriginal and Torres Strait Islander community consultation and engagement processes have been established, and how have they been perceived and received in the design, development and delivery of services under the NP?
4. How far have we progressed in achieving outcomes for the defined population group and what were the unintended outcomes?
5. What emerging practices have been effective in contributing to the success of the programs and in what contexts (i.e. what works, for whom, and in what circumstances)?
6. How has the NP increased the capacity of the Aboriginal and Torres Strait Islander communities in which it has been implemented to sustain outcomes?
7. What contribution has the NP investment made to achievement of the outcomes?

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