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Performance Audit

Administration of the Health and Hospitals Fund

Department of Health and Ageing

Australian National Audit Office

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Executive Director
Corporate Management Branch
Australian National Audit Office
19 National Circuit
BARTON ACT 2600

Or via email:
webmaster@anao.gov.au

Australian National
Audit Office

Canberra ACT
20 June 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 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 *Administration of the Health and Hospitals Fund*.

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

AUDITING FOR AUSTRALIA

The Auditor-General is head of the Australian National Audit Office (ANAO). The ANAO assists the Auditor-General to carry out his duties under the *Auditor-General Act 1997* to undertake performance audits, financial statement audits and assurance reviews of Commonwealth public sector bodies and to provide independent reports and advice for the Parliament, the Australian Government and the community. The aim is to improve Commonwealth public sector administration and accountability.

For further information contact:
The Publications Manager
Australian National Audit Office
GPO Box 707
Canberra ACT 2601

Telephone: **(02) 6203 7505**
Fax: **(02) 6203 7519**
Email: **webmaster@anao.gov.au**

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Audit Team

Sue Sheridan
Denis Preston
Elizabeth Cusack
Edward Macgregor
Lesley Jackman
Andrew Morris
Tom Ioannou

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Abbreviations

CGGs	Commonwealth Grant Guidelines
COAG	Council of Australian Governments
DoHA	Department of Health and Ageing
Finance	Department of Finance and Deregulation
Finance Minister	Minister for Finance and Deregulation
FMA Act	*Financial Management and Accountability Act 1997*
FMA Regulations	*Financial Management and Accountability Regulations 1997*
KPI	Key performance indicator
Health Minister	Minister for Health and Ageing (The audit covered the period when the former Health Minister, the Hon Nicola Roxon MP, was Minister for Health and Ageing. The current Health Minister, the Hon Tanya Plibersek MP, is the Minister for Health.)
HHF	Health and Hospitals Fund
PBS	Portfolio budget statements
PM&C	Department of the Prime Minister and Cabinet
Treasury	Commonwealth Department of the Treasury

Summary and Recommendations

Summary

Introduction

1. The Australian Government announced the establishment of three new funds in the 2008–09 Budget to support capital investment in infrastructure, education and health. The three new funds, with total funding of $22.4 billion, were: the Building Australia Fund; the Education Investment Fund; and the Health and Hospitals Fund (HHF)[1], all of which were given effect through the *Nation-building Funds Act 2008* (the Act), commencing on 1 January 2009. The Act, together with the *Nation-building Funds (Consequential Amendments) Act 2008*, provides the legislative basis for these funds.

2. The HHF objectives, whilst not replacing state and territory effort, are to:

- invest in major infrastructure programs that will make significant progress towards achieving the Commonwealth's health reform targets; and
- make strategic investments in the health system that will underpin major improvements in efficiency, access or outcomes of health care.

3. The 2008–09 Budget set the broad direction for the HHF, namely to fund capital investment in health facilities, including renewal and refurbishment of hospitals, medical technology equipment and major medical research facilities and projects.

4. Under the Act, the HHF is comprised of two interrelated parts: the HHF Special Account and investments of the HHF. The Department of Finance and Deregulation (Finance) has responsibility for the administration of the HHF Special Account, with the Act committing the Australian Government to crediting $5 billion to the HHF Special Account by 30 June 2009.[2] The Future

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1 Commonwealth of Australia (2008), *Budget Overview*. p.1. See <http://www.budget.gov.au/2008-09/content/overview/download/Budget_Overview.pdf> [accessed 5 January 2010].

2 *Nation-building Funds Act 2008* (Cth) s 16(1).

Fund's Board of Guardians[3], a statutory body within the Finance portfolio, is responsible for investing the financial assets of the HHF.

5. All health infrastructure proposals are to be assessed by an Advisory Board established under the Act and appointed by the Minister for Health and Ageing (Health Minister).[4] The Health Minister is also responsible for formulating the evaluation criteria to be applied by the Advisory Board in its assessment of applications for funding from the HHF. The evaluation criteria, which are made subject to a legislative instrument[5], are based on the following principles:

- **Principle 1**: projects should address national infrastructure priorities;
- **Principle 2**: projects should demonstrate high levels of benefits and effective use of resources;
- **Principle 3**: projects should efficiently address infrastructure needs; and
- **Principle 4**: projects should demonstrate that they achieve established standards in implementation and management.

6. The process for projects to receive HHF funding is complex, incorporating a number of administrative and legislatively determined steps:

- the Department of Health and Ageing (DoHA) undertakes a preliminary analysis to determine the extent to which each funding application addresses each evaluation criterion;
- the HHF Advisory Board assesses the eligibility of infrastructure project proposals against the evaluation criteria;
- following receipt of the Advisory Board's assessments, the Health Minister puts forward projects for consideration by government in the Budget context;

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3 The Future Fund Board of Guardians is established under the *Future Fund Act 2006*.

4 The audit covers the period when the former Health Minister, the Hon Nicola Roxon MP, was Minister for Health and Ageing, The current Health Minister, the Hon Tanya Plibersek MP, is the Minister for Health. The Advisory Board includes both independent experts and the Secretary of the Department of Health and Ageing.

5 *HHF Evaluation Criteria 2009*. (See <http://www.comlaw.gov.au/Details/F2009L00041> [accessed on 7 March 2012].)

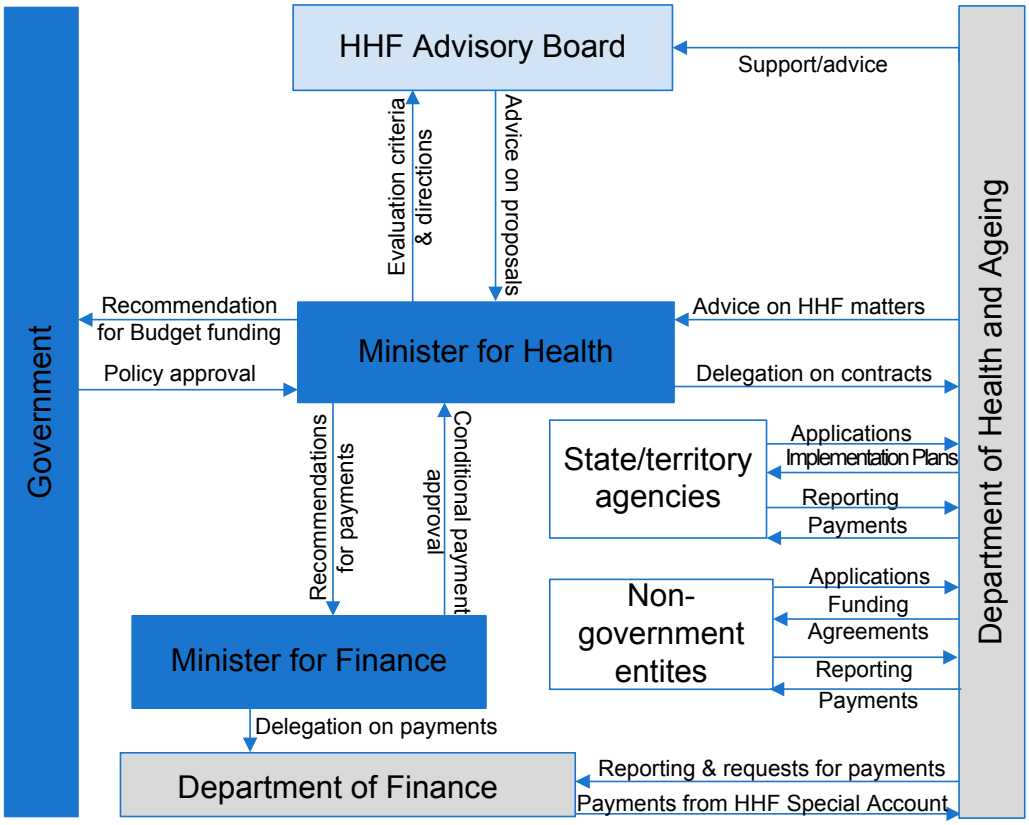
- project proposals are scrutinised in the Budget context and may receive policy approval;
- as required by the Act, the Health Minister writes to the Minister for Finance and Deregulation (Finance Minister) recommending authorisation to enable future payments to be made for those projects with policy approval;
- following receipt of the Finance Minister's authorisation, negotiations are initiated by DoHA on the details of funding agreements for projects, and the required financial management approvals are given by DoHA to enable financial commitments to be entered into through funding agreements;
- the Health Minister (or delegate) enters into the funding agreement with the entity responsible for the project to be funded;
- when a project payment milestone is reached, DoHA writes to the Finance Minister (or delegate) seeking payment. If agreed, the funds are made available by the Future Fund Management Agency into the HHF Special Account, and Finance transfers the money from that special account to the HHF Health Portfolio Special Account; and
- DoHA makes the payment to the relevant entity or to the COAG Reform Fund if the payment is for a state or territory delivery agency.

7. DoHA is responsible for administering the HHF. This includes: providing advice to the Health Minister; providing secretariat support to the HHF Advisory Board; contributing to the assessment process through its preliminary analysis; negotiating HHF funding agreements and administering their implementation.

8. Figure S 1 provides an overview of DoHA's role in administering the HHF.

Figure S 1

Overview of key roles for DoHA's administration of the HHF



Source: ANAO analysis.

9. Funded projects resulting from three HHF funding rounds were announced in May 2009, early 2010, and May 2011, involving a total of approximately $4.5 billion in Commonwealth financial assistance. Appendix 2 provides details of projects funded in Rounds 1 to 3.

10. The first round (May 2009) included projects that were identified as being 'shovel-ready' as a contribution to the Australian Government's economic stimulus strategy in response to the global financial crisis. Funding totalled approximately $2.61 billion.

11. The second round (early 2010) was targeted at regional cancer centres, with funding of approximately $540 million.

12. The third round (May 2011) focused on regional infrastructure developments in response to the agreements between the Australian Labor Party (ALP) and independent members of parliament which led to the ALP

forming a minority government in August 2010. Funding totalled approximately $1.33 billion.

13. The 2011–12 Budget included $475 million for a fourth HHF funding round, also targeting regional infrastructure development. This round was announced on 25 August 2011[6], with funding for 76 new projects announced in the 2012–13 Budget[7]; this round was not examined in this audit.

14. HHF funding has been provided to states, territories and other organisations, and this has implications for the application of the Australian Government's *Commonwealth Grant Guidelines* (CGGs). With the signing of the National Partnership Agreement on Health Infrastructure in December 2009[8], HHF funds provided to states and territories were regarded as National Partnership project payments with terms and conditions set out in implementation plans under the National Partnership Agreement. Round 3 agreements with states and territories were executed as project agreements under changes announced by the Australian Government in May 2011. For both types of arrangements with states and territories, HHF funding is not treated as a grant under the financial management regulations[9] and is therefore not subject to the CGGs.[10] However, funding to other organisations has been subject to the CGGs since these took effect in July 2009.[11]

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6 Gillard, J (Prime Minister), Crean, S (Minister for Regional Australia) and Roxon, N (Minister for Health and Ageing), *$475 Million More for Regional Health Facilities*, Parliament House, 25 August 2011. (See <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-nr-nr161.htm?OpenDocument&yr=2011&mth=08> [accessed 22 November 2011].)

7 Commonwealth of Australia (2012), *Budget Overview*. p. 21 See <http://www.budget.gov.au/2012-13/content/overview/html/overview_21.htm> [accessed 17 May 2012].

8 Under the January 2009 Intergovernmental Agreement on Federal Financial Relations, the Commonwealth committed to the provision of ongoing financial support to the states' and territories' service delivery efforts, through a range of means, including national partnership payments to support the delivery of specified outputs or projects, to facilitate reforms or reward those jurisdictions that deliver on nationally significant reforms. The National Partnership Agreement on Health Infrastructure, which was subject to the provisions of the intergovernmental agreement, provided for joint investment in high quality physical and technological infrastructure for the health sector.

9 Regulation 3A(2) of the *Financial Management and Accountability Regulations 1997* provides that certain arrangements are taken not to be grants, including payments to states and territories made for the purposes of the *Federal Financial Relations Act 2009*, including National Partnership payments.

10 Department of Finance and Deregulation (2009) *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration,* paragraph 2.8. See also Finance Circular No 2009/03 *Grants and other common financial arrangements*, p. 3.

11 Before the CGGs came into effect agencies subject to the *Financial Management and Accountability Act 1997* were required to comply with the Finance Minister's Instructions of December 2007 and January 2009.

Audit objectives and criteria

15. The audit objective was to assess the effectiveness of DoHA's administration in supporting the creation and development of health infrastructure from the HHF, including DoHA's support for the Health and the HHF Advisory Board.

16. To form its opinion, the ANAO used the following criteria drawn from the requirements and principles of the CGGs and the ANAO better practice guide on grants administration[12]:

- DoHA's administration of the planning and conduct of the funding rounds effectively supports the purpose of the HHF;
- DoHA provides appropriate support in the selection of projects for funding consistent with the requirements of the *Nation-building Funds Act 2008* and the *Financial Management and Accountability Act 1997* (FMA Act);
- DoHA's negotiation and management of funding agreements is effective in delivering projects and outcomes from projects into the future; and
- DoHA develops, collects and assesses output and outcome indicators of HHF performance and reports on them.

17. The audit focused on DoHA's role in the administration of the HHF. This included the advice and support provided by DoHA: to the Health Minister in directing the work of the Advisory Board; and to the Board and the Health Minister in the assessment and selection of projects for funding.

Overall conclusion

18. The Australian Government's commitment of $5 billion for health infrastructure through the HHF represents a substantial financial contribution to the Australian health sector, and is one of a number of recent programs intended to support the development of national health infrastructure.[13] As a consequence, the administration of programs relating to the funding and

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[12] ANAO Better Practice Guide (2010), *Implementing Better Practice Grants Administration*.

[13] Other initiatives include: National Partnership Agreement projects; medical research infrastructure projects; the GP Super Clinics program; and primary care infrastructure grants.

development of health infrastructure—traditionally a responsibility of state and territory governments and the private sector—has in recent years become an increasingly significant activity for the Department of Health and Ageing (DoHA), with the HHF by far the largest such program administered by the department.[14]

19. DoHA has generally established effective administrative processes to support the development of infrastructure funded from the HHF. The department has also established sound arrangements to support the HHF Advisory Board and has generally provided effective support to the Health Minister, although it has at times adopted a relatively narrow view of its role. Further, the department's administrative and support arrangements have improved over time.

20. The administrative arrangements adopted by DoHA have had regard to the legal requirements established by the *Nation-building Funds Act 2008* and the Australian Government's financial management framework, and have incorporated key elements of better practice for grants administration. The core evaluation criteria adopted across funding rounds provided a reasonable basis for assessing proposals against the outcomes intended by the Australian Government and Parliament in establishing the HHF, and the additional tailored guidance provided to applicants adequately supported the specific focus of funding for Rounds 2 and 3. Further, DoHA's approach to implementing the first three funding rounds resulted in proposals being brought forward by applicants that were of sufficient number and merit, including in the context of the expedited first and third rounds. The first round invited proposals from states and territories within limited timeframes, resulting from the Government's decision to expedite projects as a means of providing economic stimulus to the economy in response to the global financial crisis.[15] The third round was expedited to honour commitments made by the Australian Government to independent members of parliament following the 2010 federal election.[16]

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[14] Table 1.1 lists other capital works projects supported by DoHA.

[15] The Australian Government announced its intention to fast track infrastructure projects from the nation building funds on 14 October 2008. Letters to states and territories inviting project proposals were posted on 23 December 2008, with applicants given 27 calendar days to submit applications.

[16] The Government entered into agreements between 2 to 7 September 2010, and the invitation to apply for funding under the HHF was opened on 30 September 2010.

21. These timing pressures, exacerbated by challenges arising from resource constraints which contributed to a fragmentation of the department's administration[17], have been characteristics of the program since its inception. Notwithstanding these challenges, the department's administration has demonstrated improvement and refinement over time, informed by practical experience in administering successive funding rounds. While infrastructure expertise was initially limited to that provided by one particular member of the HHF Advisory Board, DoHA has worked with the Board to engage quantity surveyors to develop costing matrices to assist in assessing applications. The department has also established, at the Board's request, a Centre for Capital Excellence within DoHA, comprising staff with expertise in infrastructure project management.[18] The establishment of the Centre will assist with the assessment of project costing and the ongoing management of agreements for funded proposals. The Centre has strengthened the department's capacity to administer infrastructure programs, reflecting the growing importance of infrastructure-related activity within DoHA's responsibilities in recent years.

22. In addition to drawing on the expertise of the HHF Advisory Board to inform its administration of the program, DoHA established support arrangements which have facilitated the Board's ability to make a considered assessment[19] of substantial numbers of complex infrastructure proposals[20], often within truncated timeframes. The department conducted a useful preliminary analysis of all proposals received from applicants, to determine the extent to which each funding application addressed each evaluation criterion, and provided health policy and administrative expertise to the Board through the secretariat and involvement of the departmental Secretary, who served on the Board as an *ex officio* member.

23. Taken together, the administrative arrangements established by DoHA, the relevant balance of skills and expertise on the Board, the preliminary

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[17] DoHA was not allocated additional resources for HHF administration until the 2011–12 Budget, when the government allowed it to reallocate some of the savings made from a strategic review of the portfolio into functions supporting the HHF. As a consequence, the HHF was administered across a number of divisions within DoHA until the formation of a single team in 2011–12.

[18] DoHA advised that these experts were available for Round 4.

[19] The Board assessed infrastructure project proposals against the evaluation criteria to determine whether they are eligible or not.

[20] 135 proposals were considered in Round 1, 37 were considered in Round 2, and 237 were considered in Round 3.

analysis of proposals by DoHA and the assessment undertaken by the Board, have made a positive contribution to the administration of the HHF and allowed projects to be advanced. There are some administrative aspects, however, where there is scope for the department to better assist key decision-makers, particularly the Health Minister, in discharging their responsibilities.

24. Currently, the Health Minister does not receive advice on the basis for including some projects in preference to others in Budget proposals, following their assessment by the Advisory Board. The role adopted by the Advisory Board in Rounds 1 to 3 was to conduct an assessment of proposals against the evaluation criteria, determining whether they were eligible or not.[21] Following receipt of the Advisory Board's assessments, the Minister put forward projects for government consideration in the Budget context. For Rounds 1 and 3, the Health Minister was provided with a significant number of eligible projects with a value, if agreed, well in excess of the funds available in the HHF.[22] However, the Health Minister did not receive further advice—such as a merit list or scores for individual projects against the evaluation criteria—to support her assessment of the relative merits of the eligible applications; the Minister was only provided with a simple list of eligible projects and the funding sought and recommended, some brief descriptive information relating to particular characteristics of the proposals and any issues that the Advisory Board considered would need attention during negotiations, should the proposal be approved.

25. DoHA advised the ANAO that throughout all rounds it has been the Government's decision as to which of the eligible projects are to be funded, and that it has not been required that the Board or the department rank projects for the Government. While there is no such requirement, this approach reflects a relatively narrow view of responsibilities in grants administration.[23]

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[21] The Board identified eligible projects as either 'ready to go' or requiring 'clarification on details in contract negotiations'. On its face, the Board's terms of reference also made provision for a broader approach. The Board's terms of reference state that in providing advice to the Minister, the Board will provide advice regarding the extent to which proposals meet each of the evaluation criteria.

[22] The Advisory Board determined that 71 proposals from Round 1 were eligible, with a value of $6.1 billion as compared to the $5 billion available in the HHF at the time. In Round 3, the Advisory Board determined that 114 eligible proposals were eligible, with a value of $2.4 billion as compared to the $1.8 billion then available in the fund. The issue did not arise in Round 2, as all eligible projects were funded.

[23] See footnote 21.

Appropriately structured advice is particularly helpful where a Minister needs to consider a significant number of complex proposals—in this case 71 eligible proposals in Round 1 and 114 eligible proposals in Round 3.

26. There is also scope for DoHA to expand its advice to the Minister and to financial approvers[24] where early payments are proposed for spending proposals relating to the HHF, to take into account the full financial implications of such government decisions and their potential impact on the economical use[25] of HHF funds. For Rounds 1 to 3, 14 projects were provided with HHF payments in advance of project requirements, and the ANAO has estimated that the net present value of interest foregone by making payments in advance of requirements is $145 million. Some of the advance payments shifted funding from 2012–13 to earlier years. Two recent projects, the Victorian Comprehensive Cancer Centre in Melbourne and the Midland Health Campus in Perth, are being constructed for state governments under public-private partnership arrangements—the state governments receive Commonwealth funding over five years, whereas the private partners receive payments from state governments over 20 years. In consequence, the state governments in receipt of the advance payments will receive the benefit deriving from those funds—whether in the form of interest income or the ability to put the funds to other uses—rather than the Commonwealth. Further, the funding profiles for these projects were changed from the spending profiles considered by the financial approvers—effectively giving

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[24] Regulation 3 of the *Financial Management and Accountability Regulations 1997* (FMA Regulations) provides that an approver (that is, a person who may approve proposals to spend public money) means a Minister, an agency Chief Executive or other authorised person. Typically, other persons are delegates of the agency Chief Executive.

[25] FMA Regulation 8 provides that a person must not enter into an arrangement, such as a grant funding agreement, unless a spending proposal has been approved under FMA Regulation 9. FMA Regulation 9 provides that an approver must not approve a spending proposal unless the approver is satisfied, after making reasonable inquiries, that giving effect to the spending proposal would be a 'proper use' of Commonwealth resources. Proper use is defined in section 44 of the *Financial Management and Accountability Act 1997* (FMA Act) as 'efficient, effective, economical and ethical use that is not inconsistent with the policies of the Commonwealth'. While recent amendments to the FMA Act, which came into effect on 1 March 2011, added 'economical' to the definition of proper use, the Department of Finance and Deregulation has advised that the concepts of efficient and effective already encompassed the concept of economical, which was added to emphasise the requirement to avoid waste and increase the focus on the level of resources that the Commonwealth applied to achieve outcomes. (See Finance Circular No. 2011/01 *Commitments to spend public money (FMA Regulations 7 to 12)*, available at <http://www.finance.gov.au/publications/finance-circulars/2011/docs/Finance-Circular-2011-01-FMA-Regulations-7-12.pdf> [accessed 27 April 2012]).

rise to new spending proposals which were not further considered for the purposes of the financial management regulations.[26]

27. The Royal Hobart Hospital Redevelopment project also received an advance payment of $170 million in June 2011, amounting to over 70 per cent of its HHF funding. The advance payment followed a request by the Tasmanian Premier to the Commonwealth Treasurer that it be made in the 2010–11 financial year[27], and resulted in a significant amendment to the original funding profile.[28] While making advance payments was a matter for government decision, the departmental advice to government did not document the substantive reasons for the payment other than the urgency of providing the funding before the end of the 2010–11 financial year. Further, the decision to make such a substantial advance in funding has constrained DoHA's ability to manage risk in the future through regular means such as withholding payments in the event of poor progress.

28. At present, progress in implementing the program is measured and reported by DoHA on a regular basis to the Health Minister. These progress reports, focusing on individual projects, provide an interim measure of benefits realised by the program, as the outcomes achieved through HHF funding will only begin to be realised once projects are completed. The Australian Government's evaluation criteria for the HHF recognise that the construction of infrastructure is a means to an end, and provide that projects should 'result in improvements in health outcomes'.[29] To date, DoHA has advised government of its intention to implement an evaluation approach

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[26] Note 2 to FMA Regulation 9 provides that at the time the spending proposal is approved, the expectation is that an arrangement or arrangements will be entered into 'consistent with the terms of the spending proposal'. Finance has advised that Note 2 to the Regulation 'highlights the need for an arrangement to be entered into consistent with the terms of the spending proposals actually approved by the approver'. (See Finance Circular No. 2011/01, p. 22.)

[27] The Tasmanian Premier advised the Treasurer that 'the timing of these payments is an important component to facilitate the pre-planning and delivery of the project'.

[28] The original funding profile involved a spread of payments in every year from 2011–12 to 2015–16. The Royal Hobart Hospital redevelopment also received $100 million in other Commonwealth funding, $95 million of which was paid in advance of identified requirements—this advance payment has not been included in the ANAO's estimate of interest foregone.

[29] The criteria require that each proposal: 'can demonstrate that the project will contribute to significant, sustainable and measurable ongoing improvements in health care; is supported by a good evidence-base that the project will lead to health outcomes; provides an indication of the relevant economic, social and environmental costs, and relevant health, economic, social and environmental benefits of the proposal; and demonstrates, comparing benefits and costs, that the proposal represents value for money'.

focusing on the measurement of progress against construction milestones. While this is a reasonable approach, it is always going to be challenging to measure, in any tangible way, improvements to health outcomes at a project level. There would accordingly be benefit in further developing the evaluation strategy to determine the program's overall contribution to improving health outcomes.

29. The ANAO has made three recommendations to improve the effectiveness of DoHA's administration of the HHF: to support the transparency of decision-making around the selection of projects for consideration in the Budget context; to advise the Health Minister and financial approvers of the financial implications of significant payments in advance of need; and to assess the overall contribution of the HHF to improving health outcomes.

Key findings by chapter

Planning and conducting funding rounds (Chapter 2)

30. Effective planning can contribute to realising the full benefit of the Australian Government's funding for health infrastructure through the HHF.

31. The limited time and resources available to DoHA to establish processes for Round 1 militated against the adoption of a more structured approach to the planning and conduct of that round. At the local and state level, DoHA relied on the infrastructure needs and gaps identified by state and territory governments—a 'bottom-up' approach. While the focus of the round at the national level was decided by government, with extra time and resources devoted to the administration of the HHF the department could have utilised a more formal 'top-down' strategic planning approach, including independently assessing health infrastructure needs and gaps against government priorities. Where an analysis of needs and gaps was undertaken, it occurred on a project-by-project basis once applications were received.

32. Notwithstanding these time and resource constraints, DoHA's work in planning and implementing the funding rounds facilitated the identification of projects with potential to achieve improvements in health care. DoHA developed additional selection guidance for particular rounds and identified persons with significant expertise, in areas pertinent to the HHF, to participate on the HHF Advisory Board. The department also worked with the Advisory Board to implement process improvements for Rounds 2 and 3.

Supporting the selection of projects for funding (Chapter 3)

33. The HHF is a hybrid program with grant funding for states and territories not subject to the CGGs, but required for other recipients. However, it is prudent for departments to apply the sound practice principles set out in the CGGs to the fullest extent possible in these circumstances. DoHA advised that in the HHF context, the timeframe and resource constraints in which the department operated meant that the department was restricted in its ability to fully apply these principles.

34. DoHA supported the Health Minister and the Advisory Board in the assessment of projects and its administrative arrangements had regard to the requirements of the *Nation-building Funds Act 2008*. In addition, many aspects of DoHA's support to the Minister and Advisory Board were consistent with good practice.[30] Where this support fell short, there was an impact on the transparency of the selection processes. The ANAO identified two areas where the transparency of decision-making processes could have been improved. These related to:

- the funding guidelines. While the funding guidelines advise applicants of certain elements of the decision-making process for selecting projects, they do not refer to the processes undertaken within government after the Health Minister has received the Advisory Board's advice on the eligibility of proposals against the evaluation criteria—specifically, the role played by the Health Minister in deciding on which applications will be submitted for policy approval in the Budget context. To improve the transparency of the selection process, there would be merit in reviewing the funding guidelines to inform applicants of all key aspects in decision-making; and
- advice to the Health Minister in the context of selecting eligible projects to propose for Budget consideration. The Health Minister was only provided with limited information on each eligible proposal, and could have been supported further by being given advice on the relative merits of the eligible applications. Information such as a recommended priority or ranking of projects for funding would have further

[30] As set out in the CGGs and ANAO Better Practice Guides, *Implementing Better Practice Grants Administration* (June 2010) and *Administration of Grants* (May 2002).

contributed to the achievement of transparent and defensible selection decisions. The department has advised that it has not been required that the Board or the department rank projects for the Government, reflecting a relatively narrow view of responsibilities in grants administration.

35. While the Board has interpreted its terms of reference as requiring it to provide advice to the Health Minister on whether or not proposals met the evaluation criteria, its terms of reference also provide that it advise the Minister on 'the extent to which proposals for HHF funding ... meet each of the evaluation criteria'.[31] Advising on the extent to which proposals met each of the evaluation criteria would have provided a basis for advice to the Minister on the relative merits of proposals, and there would have been merit in the department encouraging such an approach or separately informing the Minister.

36. The distribution of projects and funding over the first three HHF rounds has not resulted in any Federal electorate type[32] being favoured over others.

Negotiating and managing funding agreements (Chapter 4)

37. Since Round 1, DoHA has progressed a number of process improvements in consultation with the HHF Advisory Board. The improvements have been informed by experience from Round 1 and include the development and implementation of a sound framework to provide guidance to project managers on a range of matters pertaining to the negotiation and management of funding agreements, including a number of difficult administrative aspects of the HHF, such as land tenure and project scope. In addition, DoHA has established a unit with specific construction expertise to provide guidance to project managers. DoHA has also substantially improved the reporting and monitoring arrangements, including through the use of independent certifiers for projects managed by non-government entities.

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[31] The Advisory Board's Terms of Reference are reproduced at Appendix 1.

[32] Classified on a two-party preferred basis and by seat status of 'safe', 'fairly safe' and 'marginal', as defined by Australian Electoral Commission, and by whether seats were held by the Australian Labor Party, the Coalition or were held by elected members who sat on the cross-benches.

38. Nonetheless, the negotiation of funding agreements has often taken a significant period of time—in some cases over two years from the time successful projects were announced.[33] In addition, in a sample of 13 projects from across the three rounds examined by the ANAO, the resulting funding agreements for two projects (totalling $350 million) did not reflect the project scope as assessed by the Advisory Board, limiting assurance that the projects continued to satisfy the HHF Evaluation Criteria. A further high profile Round 3 project, the redevelopment of the Royal Hobart Hospital, was assessed by DoHA as having one risk at a level that would suggest additional risk management measures should be considered. However, the risk mitigation approach was not reflected in the funding agreement, limiting DoHA's ability to manage the risk.

39. In the case of 14 projects, the ANAO also identified a misalignment of funding profiles, with DoHA entering into funding agreements that did not match the funding required by recipients to meet their project costs. These projects received substantial payments in advance of requirements which, in the case of two projects, the Victorian Comprehensive Cancer Centre and Midland Health, amounted to $232.9 million and $72.6 million respectively. A third project, the Royal Hobart Hospital Redevelopment, received $170 million in advance payments. The net present value of interest foregone[34] by making prepayments for these 14 projects is estimated by the ANAO to be $145 million.

Monitoring and reporting HHF performance (Chapter 5)

40. The Australian Government's intended outcomes for HHF funded projects were 'significant, sustainable and measurable ongoing improvements in health care'[35] through investment in specific reform priorities. The progress reports received for individual projects provide an interim measure of benefits

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[33] DoHA advised that 'there are many examples where negotiations were protracted because the Department would not compromise on issues where this would create an unreasonable risk or exposure to the Commonwealth, and this was frequently supported by legal, accounting and other advice'. The ANAO identified a range of factors affecting the time taken to negotiate funding agreements, such as: the size and complexity of the project; degree of advance planning for the project at the time of application; resolution of land tenure; significant changes in project scope or size following funding announcement; and advice required from other Commonwealth agencies.

[34] Through investments of HHF capital by the Future Fund Board of Guardians.

[35] Criterion 2(a) of the HHF Evaluation Criteria and specified in the application guidelines for Rounds 1 to 3.

realised by the program, and DoHA has informed recipients that they will be required to participate in evaluations. However, DoHA has not yet identified key performance indicators to measure outcomes, or settled an evaluation strategy. To date, DoHA's approach to evaluation has focused on the progress of individual projects against construction milestones, and there would be benefit in further developing the evaluation strategy to determine the program's overall contribution to improving health outcomes.

Summary of agency response

41. The Department acknowledges the ANAO report and its recommendations.

42. While the HHF was allocated $5 billion in the 2008–09 Budget, the Department was not allocated additional resources for the administration of the HHF until the 2011–12 Budget when departmental funds were reallocated from the savings made from the strategic review of the portfolio. The Department is now managing a portfolio of 224 major, medium and small scale health infrastructure projects situated across Australia in metropolitan, rural and remote locations.

43. As the ANAO report notes, the Department has improved and refined its administration of the HHF over time. Specifically, the Department has:

- centralised and consolidated the management of HHF projects;
- established specific construction expertise and knowledge in the Department through the Centre of Excellence for Capital Works;
- developed the online Capital Works Online Reporting Portal and an independent certification process to monitor the key risks associated with individual projects more closely, independently and accurately; and
- implemented project management and funding arrangements that better reflect the risk, costs and stages of the construction process.

44. The Department will continue to improve and strengthen the administration of the HHF if resources can be identified to do this, taking into account a constrained resource environment and other competing priorities and, in this context, is supportive of the ANAO's recommendations.

Recommendations

Recommendation No. 1

Paragraph 3.71

To maximise transparency in decision-making, the ANAO recommends that, for all future HHF assessment and selection processes, the Department of Health and Ageing:

(a) includes all significant aspects of the selection process in funding guidelines; and

(b) advises the Health Minister on priorities for funding proposals assessed as eligible by the HHF Advisory Board.

DoHA response: Agreed.

Recommendation No. 2

Paragraph 4.62

To enable decision-makers to form a considered view on the proper use of Commonwealth resources to fund Health and Hospitals Fund projects, the ANAO recommends that the Department of Health and Ageing provides advice to:

(a) the Health Minister on the risks, if any, and opportunity costs of making payments to funding recipients in advance of need; and

(b) the FMA Regulation 9 approver on government decisions, if any, relating to payments in advance of need and the implications of those decisions for spending proposals requiring consideration under FMA Regulation 9.

DoHA response: Agreed.

Recommendation No. 3

Paragraph 5.36

To improve the transparency and accountability of reporting on the outcomes achieved through HHF funding, the ANAO recommends that the Department of Health and Ageing further develops its evaluation strategy to determine the program's overall contribution to improving health outcomes, in addition to measuring progress against project milestones.

DoHA response: Agreed.

Audit Findings

1. Introduction

This chapter provides background information on the Health and Hospitals Fund, including in the context of the framework of Commonwealth/state responsibilities for health in Australia and the circumstances in which it was established. It outlines the audit objective, criteria, scope, and methodology, and the structure of the report.

Commonwealth/state responsibilities for health in Australia

1.1 In Australia, a range of intergovernmental arrangements define national health priorities and arrangements for the funding and delivery of health services.

1.2 On 29 November 2008, the Council of Australian Governments (COAG) reaffirmed its commitment to cooperative working arrangements through an historic new intergovernmental agreement that provided an overarching framework for the Commonwealth's financial relations with states and territories.[36] The objective of the Intergovernmental Agreement on Federal Financial Relations was the improvement of the wellbeing of all Australians through improvements in the quality, efficiency and effectiveness of government service delivery by:

- reducing Commonwealth prescriptions on service delivery by the states and territories;
- clarifying the roles and responsibilities of the parties in the delivery of government services that are the subject of national agreements set out in schedules to the intergovernmental agreement; and
- enhancing accountability to the public for the outcomes achieved or outputs delivered under national agreements or national partnerships.

1.3 Under the intergovernmental agreement, the Commonwealth committed to the provision of ongoing financial support to the states' and territories' service delivery efforts, through a range of means, including national partnership payments to support the delivery of specified outputs or

[36] COAG (2008) *Communique 29 November 2008*. (See <www.coag.gov.au/coag_meeting_outcomes/2008-11-29/index.cfm> [accessed 16 November 2011].)

projects to facilitate reforms or reward those jurisdictions that deliver on nationally significant reforms.

1.4 A year later, in December 2009, the Commonwealth, states and territories signed a National Partnership Agreement on Health Infrastructure, which was subject to the provisions of the intergovernmental agreement. The National Partnership Agreement provided for joint investment in high quality physical and technological infrastructure for the health sector.[37]

1.5 The National Partnership Agreement was also developed to contribute to the outcomes agreed in the National Healthcare Agreement in effect at the time[38]; this agreement locked in annual increases in funding to reflect the increasing cost of providing hospital services. It also defined the objectives, outcomes, outputs and performance measures, and clarified the roles and responsibilities that would guide the Commonwealth, states and territories in the delivery of services across the health sector.[39] The Health and Hospitals Fund (HHF) makes payments to the states and territories under this National Partnership Agreement.

Commonwealth responsibilities in health

1.6 The Department of Health and Ageing (DoHA) is responsible for achieving the Australian Government's priorities for health services and payments, aged care, and population ageing. In 2011–12, DoHA is responsible for administered funds amounting to some $46 billion. Of these, almost $40 billion is estimated to be paid through special appropriations on entitlements such as rebates on medical fees and pharmaceutical benefit subsidies. The balance of $6.2 billion largely comprises programs directly administered by DoHA.

1.7 The programs administered by DoHA were, in the past, primarily focused on funding the delivery of services. Increasingly, DoHA has been involved in administering programs and projects that deliver infrastructure,

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[37] COAG (2008), *National Partnership Agreement on Health Infrastructure*. See <www.federalfinancialrelations.gov.au/content/national_partnership_agreements/health/health_infrastructure/national_partnership.pdf> [accessed 16 November 2011].

[38] This was the National Healthcare Agreement that came into effect on 1 July 2009 after being agreed by COAG in November 2008. It was replaced by a new agreement in August 2011.

[39] Department of Health and Ageing (2010), *Annual Report 2009–10*, p. 9.

including major construction projects. Of late, DoHA has been managing a significant number of funding projects for the construction of facilities related to its health and ageing portfolio responsibilities. As at 31 December 2011, 620 such capital works projects were underway, with funding through DoHA of almost $5.1 billion, as shown in Table 1.1.

Table 1.1

Capital works projects supported by DoHA funding under development as at 31 December 2011

Project type	Number	Project expenditure committed by DoHA	
		$ million	Share of total (%)
Health and Hospitals Fund projects[1]	64	2837.4	55.7
National Partnership Agreement projects	62	798.8	15.7
Medical research infrastructure projects (nei)[2]	24	592.2	11.6
Health and medical education and training facilities (nei)[2]	92	343.1	6.7
GP Super Clinics Program	27	132.4	2.6
Office of Aboriginal & Torres Strait Islander Health projects	50	128.1	2.5
Aged Care projects	57	111.4	2.2
Primary Care Infrastructure grants	214	55.6	1.1
Radiation oncology project (nei)[2]	2	23.3	0.5
Budget-funded hospital projects (nei)[2]	1	15.0	0.3
National Rural & Remote Health Infrastructure Program grants	20	8.0	0.2
Other	3	48.6	1.0
TOTAL	**616**	**5093.9**	**100.0[3]**

Note 1: These HHF projects are those in progress, but not completed, as at 31 December 2011.

Note 2: nei = not elsewhere included.

Note 3: Total may not add to 100.0% due to rounding.

Source: ANAO analysis of DoHA documents.

1.8 Of the capital works projects under development at 31 December 2011, 64 projects (10 per cent) were funded from the HHF, with HHF funding of $2.8 billion. Overall, these HHF projects contributed approximately 56 per cent of the total value of capital works projects under construction as funded by

DoHA. The funding for HHF projects ranges from approximately $100 000 to $426.1 million.

Purpose and key characteristics of the Health and Hospitals Fund

The three nation-building funds

1.9 The Australian Government announced the establishment of three new funds in the 2008–09 Budget to support capital investment in infrastructure, education and health. Funding for the funds, totalling $22.4 billion, came largely from the 2007–08 and 2008–09 Budget surpluses. The three new funds were: the Building Australia Fund; the Education Investment Fund; and the HHF[40], all of which were given effect through the *Nation-building Funds Act 2008* (the Act), which commenced on 1 January 2009. The Act, together with the *Nation-building Funds (Consequential Amendments) Act 2008*, provides the legislative basis for these funds.

1.10 The intention was that, from 2009 onwards, capital and earnings from the three funds would be available for investment once projects had been identified and evaluated. The Future Fund's Board of Guardians[41], a statutory body within the Finance portfolio, was to be responsible for investing the financial assets of the three funds, subject to certain limitations. Independent bodies would assess the projects for each portfolio before they were approved for funding.

1.11 Where monies from the nation-building funds were to be used to finance capital projects with the states and territories, they would be distributed through the new COAG Reform Fund.[42]

Key characteristics of the HHF under the Nation-building Funds Act

1.12 The Act prescribes that the object of the HHF is to: 'enhance the Commonwealth's ability to make payments in relation to the creation or

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[40] Commonwealth of Australia (2008), *Budget Overview*. p. 1. See <http://www.budget.gov.au/2008-09/content/overview/download/Budget_Overview.pdf> [accessed 5 January 2010].

[41] The Future Fund Board of Guardian is established under the *Future Fund Act 2006*.

[42] The COAG Reform Fund would also distribute funding provided in future budgets to the states for recurrent expenditure in areas of COAG national reforms, through new National Partnership Payments.

development of health infrastructure'.[43] The second reading speech for the *Nation-building Funds Bill 2008* identified that the Government's focus on infrastructure development is as a primary mechanism for ensuring future economic sustainability.[44] The Government subsequently specified that the HHF objectives, while not replacing state and territory effort, are to:

- invest in major infrastructure programs that will make significant progress towards achieving the Commonwealth's health reform targets; and
- make strategic investments in the health system that will underpin major improvements in efficiency, access or outcomes of health care.

1.13 Under the Act, the HHF is comprised of two interrelated parts: the HHF Special Account and investments of the HHF. The Department of Finance and Deregulation (Finance) has responsibility for the administration of the HHF Special Account, with the Act committing the Government to crediting $5 billion to the HHF Special Account by 30 June 2009.[45]

The HHF Advisory Board and evaluation criteria

1.14 Proposals for funding have had a variety of sources since the inception of the HHF. These have included proposals internal to the Government, applications for other sources of Government funding, and selected and publicly advertised invitations to apply.

1.15 Under the legislation, all health infrastructure proposals are to be assessed by an Advisory Board established under the Act and appointed by the Minister for Health and Ageing (Health Minister).[46]

1.16 Under the terms of the Act, the Health Minister is also responsible for formulating the evaluation criteria to be applied by the Advisory Board in its assessment of applications for funding from the HHF. The evaluation criteria

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[43] *Nation-building Funds Act 2008* (Cth) s 221.

[44] Commonwealth, Second Reading Speech, House of Representatives, 13 November 2008, 10841 (Lindsay Tanner, Minister for Finance and Deregulation).

[45] *Nation-building Funds Act 2008* (Cth) s 16(1). (At the time of the initial Budget announcement, $10 billion was allocated to the HHF; this figure was revised to $5 billion in October 2008.)

[46] The audit covers the period when the former Health Minister, the Hon Nicola Roxon MP, was Minister for Health and Ageing, The current Health Minister, the Hon Tanya Plibersek MP, is the Minister for Health. The Advisory Board includes both independent experts and the Secretary of the Department of Health and Ageing.

are made subject to a legislative instrument[47] and are based on the following principles:

- **Principle 1**: projects should address national infrastructure priorities;
- **Principle 2**: projects should demonstrate high levels of benefits and effective use of resources;
- **Principle 3**: projects should efficiently address infrastructure needs; and
- **Principle 4**: projects should demonstrate that they achieve established standards in implementation and management.

Approving proposals for HHF funding

1.17 Once a proposal is determined by the Advisory Board as satisfying the evaluation criteria, the Health Minister may support the funding of the proposal. Proposed projects are brought to Government for policy approval.

1.18 Once policy approval is provided by Government, under the Act the Health Minister makes a recommendation to the Minister for Finance and Deregulation (Finance Minister) to authorise future payments for project/s with policy approval.[48] The Finance Minister may then accept the recommendation, allowing funding for the project to be drawn from the HHF Special Account and credited to the HHF Health Portfolio Special Account. This transfer takes place on a specified date, and must be paid to the funding recipient as soon as practicable. As allowed under the Act, the Finance Minister has put in place delegations to officers in Finance and other administrative requirements allowing conditional ministerial approval on an occasional basis for a package of projects. Consequently, DoHA, as delegate for the Health Minister, is able to commence negotiation and finalisation of an appropriate funding agreement/implementation plan with the entity responsible for the project.

1.19 Figure 1.1 depicts the process through which proposals for funding from the HHF are approved and funded.

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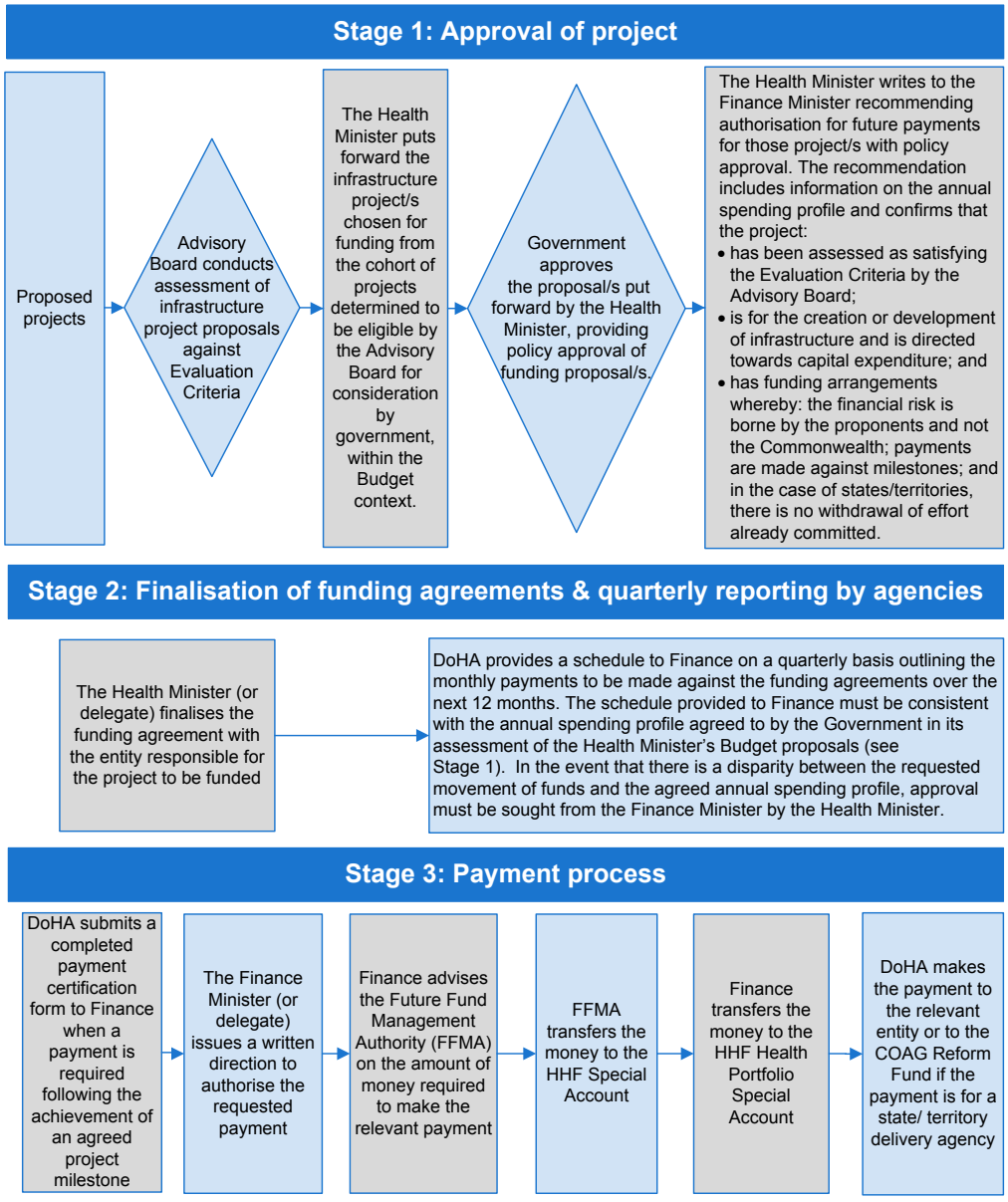
[47] *HHF Evaluation Criteria 2009*. (See <http://www.comlaw.gov.au/Details/F2009L00041> [accessed on 7 March 2012].)

[48] The information included with the recommendation is outlined in Figure 1.1.

Figure 1.1

Process for approving and funding HHF projects



Source: ANAO analysis of Finance documents.

DoHA's role in administering the HHF

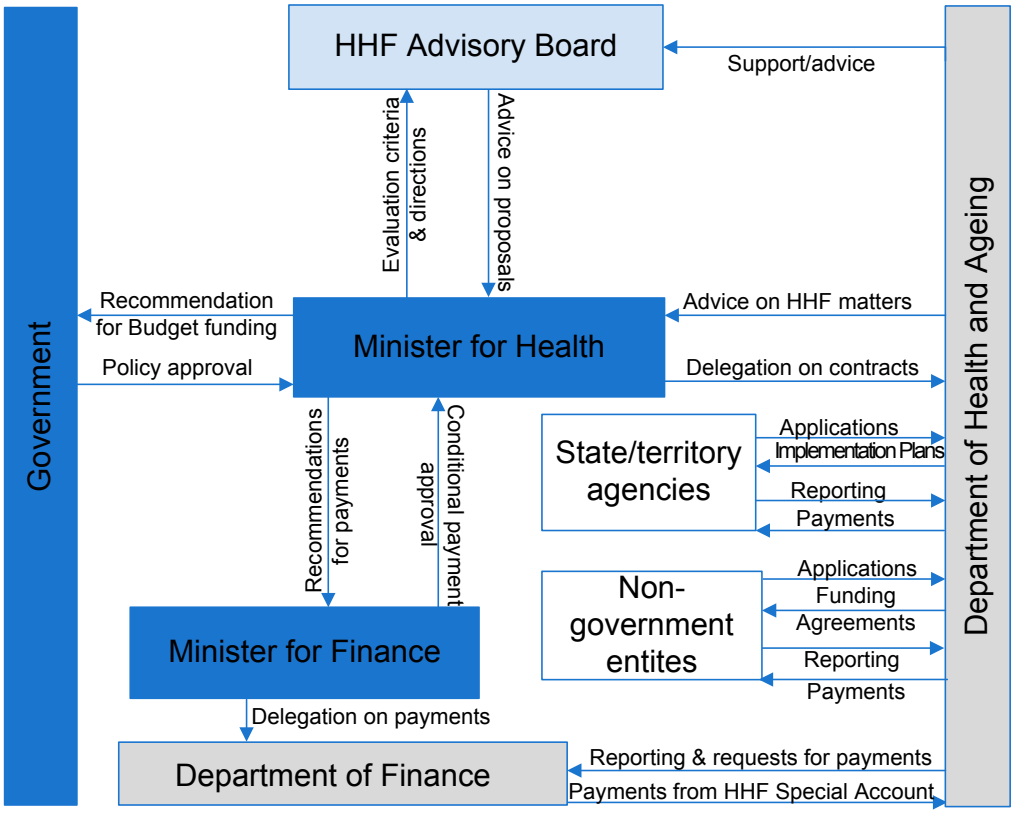
1.20 DoHA is responsible for administering the HHF. This includes: providing advice to the Health Minister and administrative support to the Advisory Board; and administering HHF grants, including entering into

contracts, making payments and monitoring HHF grants. DoHA also provides advice on eligibility, as well as background and contextual information to the Advisory Board during the proposal assessment process.[49]

1.21 Figure 1.2 provides an overview of DoHA's role in the administration of the HHF.

Figure 1.2

Overview of key roles for DoHA's administration of the HHF



Source: ANAO analysis.

1.22 Funded projects resulting from three funding rounds were announced in May 2009, early 2010, and May 2011, for a total of $4.5 billion. The first round included projects that were identified as 'shovel-ready' as a contribution to the economic stimulus strategy adopted by the Australian Government in response to the global financial crisis. The second round was targeted at

[49] DoHA's role is drawn from the HHF Advisory Board Terms of Reference at Appendix 1.

regional cancer centres. The third round focused on regional infrastructure developments in response to the agreements between the ALP and the independent members of parliament which allowed the ALP to form a minority government in August 2010.[50] The 2011–12 Budget included $475 million for a fourth HHF funding round also targeting regional infrastructure development. This round was announced on 25 August 2011[51], with funding for 76 new projects announced in the 2012–13 Budget.[52]

1.23 The HHF funding round guidelines do not restrict the type of recipients who are eligible for funding. Recipients have included state and territory governments, not-for-profit health care providers, universities, community-based organisations and local governments.

1.24 HHF funding agreements with recipients set out the terms and conditions. With the signing of the National Partnership Agreement on Health Infrastructure in December 2009 (see paragraph 1.4), HHF funds to states and territories were regarded as National Partnership project payments with the terms and conditions set out in implementation plans under the National Partnership Agreement. Round 3 agreements with states and territories were executed as project agreements under changes announced by the Commonwealth Government in May 2011. For both types of arrangements with states and territories, funding is not treated as a grant under the financial management regulations[53] and is therefore not subject to the Commonwealth Grant Guidelines (CGGs).[54] Funding to other organisations is subject to the CGGs.

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[50] The projects for funding from all three rounds, as announced by government, are at Appendix 2.

[51] Gillard, J (Prime Minister), Crean, S (Minister for Regional Australia) and Roxon, N (Minister for Health and Ageing), *$475 Million More for Regional Health Facilities*, Parliament House, 25 August 2011. (See <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-nr-nr161.htm?OpenDocument&yr=2011&mth=08> [accessed 22 November 2011].)

[52] Commonwealth of Australia (2012), *Budget Overview*. p. 21 See <http://www.budget.gov.au/2012-13/content/overview/html/overview_21.htm> [accessed 17 May 2012].

[53] Regulation 3A(2) of the *Financial Management and Accountability Regulations 1997* provides that certain arrangements are taken not to be grants, including payments to states and territories made for the purposes of the *Federal Financial Relations Act 2009*, including National Partnership payments.

[54] Department of Finance and Deregulation (2009) *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration,* paragraph 2.8. See also Finance Circular No 2009/03 p. 3.

Audit approach

Audit objective and criteria

1.25 The audit objective was to assess the effectiveness of DoHA's administration in supporting the creation and development of health infrastructure from the HHF, including DoHA's support for the Health Minister and the HHF Advisory Board.

1.26 To form its opinion, the ANAO used the following criteria drawn from the requirements and principles of the CGGs and the ANAO better practice guide on grants administration[55]:

- DoHA's administration of the planning and conduct of the funding rounds effectively supports the purpose of the HHF;
- DoHA provides appropriate support in the selection of projects for funding consistent with the requirements of the *Nation-building Funds Act 2008* and the *Financial Management and Accountability Act 1997* (FMA Act);
- DoHA's negotiation and management of funding agreements is effective in delivering projects and outcomes from projects into the future; and
- DoHA develops, collects and assesses output and outcome indicators of HHF performance and reports on them.

Audit scope and methodology

1.27 The audit focused on DoHA's role in the administration of the HHF relating to Rounds 1 to 3. This included the advice and support provided by DoHA: to the Health Minister in directing the work of the Advisory Board; and to the Board and Health Minister in the assessment and selection of projects for funding.

1.28 In order to form an opinion against the audit objective, the ANAO undertook the main component of evidence collection at DoHA's central office. Audit testing included:

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[55] ANAO Better Practice Guide (2010), *Implementing Better Practice Grants Administration*.

- interviews with:
  - DoHA managers and staff involved in all aspects of DoHA's administration of the HHF;
  - stakeholders, including state and territory agencies, health sector peak organisations, and a professional health infrastructure expert representing the Australian Institute of Architects;
  - other Commonwealth agencies with a role in HHF administration, including Finance and the Department of the Treasury (Treasury) in its role to provide policy advice on Federal Financial Relations; and
  - a range of HHF funding recipients, including related site visits;
- examination of DoHA documentation relating to the HHF; and
- assessment of:
  - advice provided by DoHA to the Advisory Board on a sample of funding proposals;
  - management of a sample of funding agreements; and
  - distribution of funding in relation to the location of funded proposals.

1.29 The audit was conducted in accordance with ANAO auditing standards at a cost to the ANAO of around $450 000.

Structure of the report

1.31 The audit findings are reported in the following chapters, as outlined in Table 1.2

Table 1.2

Structure of report

Chapter 2 Planning and Conducting Funding Rounds	Assesses DoHA's administration of the planning and conduct of funding rounds to support the delivery of HHF projects and the achievement of outcomes from projects into the future.
Chapter 3 Supporting the Selection of Projects for Funding	Assesses DoHA's administration in supporting the HHF Advisory Board in selecting projects for HHF funding consistent with Government policy and legislative requirements.
Chapter 4 Negotiating and Managing Funding Agreements	Assesses DoHA's negotiation and management of funding agreements to support the completion of HHF projects and the achievement of project outcomes into the future.
Chapter 5 Monitoring and Reporting HHF performance	Assesses DoHA's monitoring and reporting of HHF performance against the mandatory and sound practice set out in CGGs of program achievements.

Source: ANAO.

2. Planning and Conducting Funding Rounds

This chapter assesses DoHA's administration of the planning and conduct of funding rounds to support the delivery of HHF projects and the achievement of outcomes from projects into the future.

Introduction

2.1 Demand for health services and associated costs are rising with the growing and ageing population, and improved medical technologies. By way of illustration, the Australian Institute of Health and Welfare has estimated that, in the 20 years to 2009–10, Australia's expenditure on health grew at an average real rate of 5.3 per cent per annum, with an expenditure of over $120 billion in 2009–10.[56] Infrastructure, in the form of capital and equipment, is required to support this growing demand.

2.2 In meeting its objectives, the HHF is expected to have a significant impact on the efficiency, access and outcomes of health care for Australians into the future. The Government's commitment of $5 billion to the HHF is considerable when viewed in the context of overall expenditure on health infrastructure. For example, state and territory budgets for health infrastructure in 2011–12 amounted to $5.6 billion.

2.3 Effective planning necessarily plays a key role in the management of funding rounds and realising the full benefit of the Government's significant investment through the HHF. To assess the extent to which DoHA planned and conducted funding rounds in order to support the achievement of stated outcomes for health care from the HHF, the ANAO examined how DoHA:

- supported the Government in setting the strategic direction for the HHF overall and the aims for individual rounds;
- designed and implemented the funding rounds; and
- managed the funding rounds.

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[56] Australian Institute of Health and Welfare (2011), *Health expenditure Australia 2009–10*. (See <http://www.aihw.gov.au/media-release-detail/?id=10737420426> [accessed 5 January 2012].)

Setting the strategic direction for the HHF and the aims for individual rounds

2.4 In announcing its intention to establish the three national building funds to invest in Australia's productive future[57], the Government stated that:

> where governments invest in infrastructure assets, it is essential that they seek to achieve maximum economic and social benefits, determined through rigorous cost-benefit analysis including ex post evaluation and review.[58]

2.5 The Government subsequently announced that it would establish Infrastructure Australia to advise on nationally significant infrastructure. Based on rigorous cost-benefit analysis, the agency's first priority would be to complete a National Infrastructure Audit and develop an Infrastructure Priority List for COAG's consideration in March 2009.[59] In an assessment of Infrastructure Australia, the ANAO concluded that the frameworks for the National Audit and development of the Infrastructure Priority lists were sound, while identifying some areas for improved processes and practices.[60]

2.6 Health and hospital infrastructure was not within scope of the National Infrastructure Audit undertaken by Infrastructure Australia and was not included in its Infrastructure Priority List. DoHA therefore could not draw on this information for the HHF in developing the strategic direction for overall funding and the aim and focus of individual rounds. To determine the extent to which DoHA supported the Government in maximising the health care benefits from the HHF, the ANAO examined DoHA's approach to advising the Health Minister on the strategic direction for the HHF, including the aims of individual rounds, based on:

- identifying health infrastructure needs, gaps and priorities;

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57 The funds are the Building Australia Fund, the Education Investment Fund, and the HHF.

58 Commonwealth of Australia, *Budget Strategy and Outlook – Budget Paper No. 1 2008–09*, pp. 4–13. (See <http://cache.treasury.gov.au/budget/2008-09/content/download/bp1.pdf> [accessed 5 January 2012].)

59 ibid.

60 ANAO Report No.2 2010–11, *Conduct by Infrastructure Australia of the First National Audit and Development of the Infrastructure Priority List*, pp. 21–23. (See <http://www.anao.gov.au/~/media/Uploads/Documents/2010%2011_audit_report_02.pdf> [accessed 6 January 2012].)

- developing the evaluation criteria for the HHF and additional selection criteria relating to the aim and focus of individual rounds, for use in determining eligible proposals; and
- identifying relevant membership of the Advisory Board.

Identifying health infrastructure needs, gaps and priorities

2.7 The 2008–09 Budget set the broad direction for the HHF, namely to fund capital investment in health facilities, including renewal and refurbishment of hospitals, medical technology equipment and major medical research facilities and projects.[61] Based on advice from Treasury and Finance, the Government agreed in September 2008 that the legislation governing the three infrastructure funds announced in the 2008–09 Budget would have evaluation criteria decided by relevant portfolio ministers by legislative instrument, based on the four principles outlined in paragraph 1.16.

2.8 Within this broad framework, there is no evidence that in the establishment of the HHF, DoHA undertook research, consultation or assessment to identify infrastructure needs, gaps and the associated priorities with a view to informing the design of the process used to source proposals, or developing a priority list of projects. DoHA was limited in its work in this regard by two key factors. Firstly, the department has advised that it was not allocated any extra resources to administer the HHF until the 2011–12 Budget[62], curtailing its ability to adequately resource such work. The second factor was the compressed timeframe in which the program was developed and initial assessments for Round 1 were undertaken. The Government announced its intention on 14 October 2008 to fast-track infrastructure projects, including those from the HHF, as a means of 'secur(ing) economic activity in the short term and expand(ing) growth potential in the medium to long term', in response to the global financial crisis.[63] Letters to states and territories were

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61 Commonwealth of Australia, op cit., pp. 1–20.

62 While DoHA was not provided with extra funding for administrative costs, the Government determined that the department could reinvest some of the savings from efficiencies arising from a strategic review of the Health and Ageing Portfolio into functions including HHF administration and the Centre for Capital Excellence (see paragraph 2.55). (The strategic review is outlined at <http://www.health.gov.au/internet/budget/publishing.nsf/Content/673376782D27CBEACA257881000680FD/$File/2011-12_Health_PBS_05_StrategicReview.pdf> [accessed 23 February 2012].)

posted on 23 December 2008, with applicants given 27 calendar days to submit applications.

2.9 In the time available, DoHA identified, for consideration by the Health Minister, five priority areas in which infrastructure projects should be given preference. The following priority areas were subsequently reflected in the *Funding Application and Assessment Guidelines* for Round 1. These were:

- improved acute care facilities, including hospitals, paediatric and specialised mental health facilities, and equipment;
- health service infrastructure—primary and community care—focusing on facilities or equipment to support a more integrated approach. A balanced program that included rural, indigenous and outer-metropolitan services was considered to be important;
- workforce training infrastructure—to support innovative approaches to improve the health and medical workforce, to deal with the increase in numbers of people training to be health professionals, and to assist in improving distribution;
- specialised cancer care—development of integrated cancer care facilities; and
- research facilities that are integrated with improving clinical care and/or health workforce training.[64]

2.10 These priority areas provided an infrastructure focus to most of the Government's health and hospital reform priorities announced as part of the 2008–09 Budget.[65]

2.11 DoHA did not provide the Health Minister with a documented briefing on the inclusion of a HHF funding round (Round 2) focused on regional cancer centres as part of the 2009–10 Budget. However, the ANAO noted that this

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[63] Rudd, K (Prime Minister), Albanese A (Minister for Infrastructure), *Fast tracking the nation-building agenda*. 14 October 2008. (See <http://parlinfo.aph.gov.au/parlInfo/download/media/pressrel/YRTR6/upload_binary/yrtr60.pdf;fileType%3Dapplication%2Fpdf> [accessed on 8 April 2012].) Fast-tracked HHF projects were originally expected to be included in a potential infrastructure statement in December 2008 but ultimately were not included.

[64] DoHA (2008), *Health and Hospitals Fund—Funding Application and Assessment Guidelines*, pp. 4–5.

[65] Commonwealth of Australia (2008), *Budget 2008–09: Budget Paper No. 2,* p. 201. (See <http://www.budget.gov.au/2008-09/content/bp2/download/bp2.pdf> [accessed 16 February 2012].)

priority is consistent with the health service infrastructure and specialised cancer care priorities identified for the initial funding round. The concept of a network of regional cancer centres was at the time the central means identified by the Cancer Council and Clinical Oncological Society of Australia of bringing cancer mortality rates in rural and remote areas into line with those in metropolitan areas.[66]

2.12 For Round 3, DoHA's advice to the Health Minister was to maintain the five priority areas identified for Round 1, but to focus on rural and remote areas. This approach was aimed at meeting the Government's commitments to Independent Members of Parliament.[67] Again, there was a compressed timeframe from when the Government made these agreements (2 to 7 September 2010) to when the invitation to apply for funding was opened (30 September 2010), limiting DoHA's ability to undertake work to identify infrastructure gaps and prioritise needs. While the Health Minister's feedback to DoHA was a preference for the first three priorities listed at paragraph 2.9, those preferences were not progressed through further written advice from DoHA. The Health Minister subsequently agreed to the funding guidelines, which were not amended to reflect her preferences, but did include a further priority, 'eHealth', for projects aimed at expanding the use of eHealth as a means of increasing connectedness between providers and patients.

2.13 In summary, DoHA did not have a clear internal strategy to inform the consideration of funding priorities for Rounds 1 and 3 that was based on the identification of service delivery needs or infrastructure gaps. Adopting such a strategic approach would have had the further benefit of informing the design of the process used to source proposals for all the rounds. In the absence of such an approach, DoHA advised that to a large extent it relied on states and territories to identify infrastructure gaps and needs in both Rounds 1 and 3, and expected the states and territories to demonstrate how their proposals would address them. The department considered that this approach was consistent with state and territory government responsibility for health

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[66] Cancer Council of Australia/Clinical Oncological Society of Australia (2008), *How the national health reform process can deliver a sustainable, evidence-based National Cancer Plan: submission to the National Health and Hospitals Reform Commission*, p. 36. (See <http://www.cancer.org.au/File/PolicyPublications/Submissions/CancerCouncilCOSAsubmissiontoNHHRC.pdf> [accessed 16 February 2012].)

[67] See paragraph 1.22.

planning. In addition, and at the request of the Advisory Board, for Round 3 state and territory health agencies were asked to comment on the extent to which applications from non-government organisations would help address known areas of need and contribute to the achievement of jurisdictional priorities. States and territories were also asked to identify whether such proposals would duplicate or impede other current or planned projects.

2.14 In the case of Round 2, which focused on funding for regional cancer centres, a key guiding principle was demonstrated need to address current gaps in cancer services at the regional level. As an assessment tool, the Advisory Board also drew on maps identifying the location of existing linear accelerators[68], to assist in identifying areas of need against applications.

Developing the evaluation criteria for the HHF and additional selection criteria for individual rounds

The HHF evaluation criteria

2.15 At the end of September 2008, the Government agreed that the Health Minister, in consultation with the Finance Minister and the Treasurer, develop interim evaluation criteria for projects funded by the HHF based on the principles agreed by the Government for all the nation-building funds.[69] This timing was to allow for projects to be identified for a potential infrastructure statement by the Government. The interim HHF evaluation criteria were developed by DoHA in collaboration with Finance. These criteria, which were subsequently refined and have been used by the Advisory Board since 1 January 2009, provide a sound basis for assessing whether the provision of funding for specific proposals would be a proper use of Commonwealth resources, consistent with the financial management framework.[70] In

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[68] Linear accelerators are treatment machines generating very high energy X-rays or electrons, used to provide most radiotherapy treatment for cancer.

[69] See paragraph 1.16.

[70] Section 44 of the *Financial Management and Accountability Act 1997* (FMA Act) and Regulation 9 of the *Financial Management and Accountability Regulations 1997* provide that 'proper use' means efficient, effective, economical and ethical use that is not inconsistent with the policies of the Commonwealth. While recent amendments to the FMA Act, which came into effect on 1 March 2011, added 'economical' to the definition of proper use, the Department of Finance and Deregulation has advised that the concepts of efficient and effective already encompassed the concept of economical, which was added to emphasise the requirement to avoid waste and increase the focus on the level of resources that the Commonwealth applied to achieve outcomes. (See Finance Circular No. 2011/01 *Commitments to spend public money (FMA Regulations 7 to 12)*, available at http://www.finance.gov.au/publications/finance-circulars/2011/docs/Finance-Circular-2011-01-FMA-Regulations-7-12.pdf [accessed 27 April 2012].)

particular, under the evaluation criteria[71], infrastructure proposals need to (among other requirements):

- significantly progress the Commonwealth's health reform targets;
- contribute to significant, sustainable and measurable ongoing improvements in health care;
- represent value for money through comparing relevant economic, social and environmental costs and benefits;
- maximise the impact of the project through leveraging other funding sources;
- meet current health sector standards within the project design; and
- identify the means by which the infrastructure will be operated and maintained into the future.

Additional selection criteria for individual rounds

2.16 In Round 1, there were no additional selection criteria or guidance specific to assessment for the round. However, in advice to the Health Minister, DoHA emphasised that, following assessment by the Advisory Board, infrastructure funding proposals were to be brought forward for government consideration as part of its economic stability package. In this context, DoHA advised the Minister as to the 'readiness for implementation' of each of the proposals considered by the Advisory Board as meeting the evaluation criteria.[72] While there is no documentation as to whether proposals that were ready for implementation were prioritised over others[73], this factor was the basis for early finalisation of particular funding agreements and early payments in June 2009 totalling $185 million.[74]

2.17 In June 2009, DoHA provided advice to the Health Minister on establishing a small panel of experts to develop principles for regional cancer centres to provide the basis for developing criteria for Round 2. The panel of

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71 The evaluation criteria are at Appendix 3, Table A 2.

72 Applicants were required to include an implementation plan as part of criterion 5(d), and identify a proposed timeframe as part of the application template.

73 The means by which applications were selected for funding is discussed in Chapter 3.

74 See paragraph 4.48.

experts was formed, chaired by the Commonwealth Medical Officer, with membership drawn from the cancer community (practitioners, researchers and consumers), HHF Advisory Board nominees and principal advisors from relevant areas within DoHA. In September 2009, the draft guiding principles were released for public consultation with key stakeholders directly invited to provide feedback. On the basis of the work of the expert panel and subsequent feedback from stakeholder consultation, DoHA drew up application guidelines for the Regional Cancer Centre Initiative HHF funding round. These guidelines incorporated Regional Cancer Centre Guiding Principles against relevant HHF evaluation criteria[75], and were subsequently approved by the Minister.

2.18 With regard to the focus for Round 3, the Government reached the following agreements with the Independent Members of Parliament on a new HHF funding round.

- Mr Andrew Wilkie MP—the Government agreed that the new round would be used for 'investments in major hospital projects, commencing 1 October 2010. All states and territories, major hospitals, health research institutes and universities will be able to apply for funding to upgrade hospital infrastructure'.
- Mr Rob Oakeshott MP and Mr Tony Windsor MP—it was agreed that the new round would be a regional priority round, to 'provide capital funding to support upgrades to regional health infrastructure, expansions to regional hospitals and help support the clinical training capacity of our regional hospitals into the future'.

2.19 To address both requirements, DoHA developed for Ministerial consideration a scope that addressed the geographic factors, and eligible infrastructure and applicant types for a regional priority funding round. Following agreement on the scope by the Health Minister, prime ministerial approval was sought and provided. As the Government had decided that the funding round would commence by 1 October 2010, less than a month after reaching agreement with the Independent Members of Parliament, there was limited time for DoHA to further research and consult on the guiding principles specific to this round. To develop such guiding principles, the

[75] Table A 3, Appendix 3, outlines these guiding principles for the regional cancer centre round.

department drew on the geographic factors agreed by the Health Minister and the Prime Minister, and two of the guiding principles developed for the Regional Cancer Centre round, appropriately generalised to address the broader infrastructure types for the round. These principles related to linkages with other health services to provide comprehensive multidisciplinary care and the provision of equitable and affordable access.[76] Within the constraints of scope and a very tight timeframe, DoHA provided a reasonable basis for assessing the regional priority round applications.

Identifying relevant membership of the Advisory Board

2.20 Under subsection 245(1) of the *Nation-building Funds Act 2008*, 'a person is not eligible for appointment to the HHF Advisory Board unless the Health Minister is satisfied that the person has substantial experience or knowledge in a field relevant to the HHF Advisory Board's function'. This includes the ability to assess projects against the evaluation criteria.

2.21 In late 2008, the Government agreed with a proposal by the Health Minister that the membership of the Advisory Board would cover the following areas:

- a person with expertise in economics;
- a health practitioner;
- a clinician;
- a person with expertise in health and medical research;
- an eminent community or business leader;
- a person with experience in strategic health policy; and
- a person with experience in infrastructure financing.

2.22 Given the scope and focus of Round 1 on the five priority areas outlined at paragraph 2.9, this range of expertise provided the potential to undertake effective assessments against the evaluation criteria.

2.23 DoHA provided the Minister with a proposed list of persons for appointment to the Advisory Board. Included on the list was the DoHA

[76] Table A 4, Appendix 3, outlines the additional guidance for the regional priority round.

Secretary on the basis of her expertise in strategic health policy. There is no documentation as to how the remaining individuals were identified over others. The briefing to the Minister included an outline of each individual's background, identifying that each had significant expertise in one or more of the areas listed at paragraph 2.21, and together covered all required areas. This list was then submitted for approval to the Prime Minister and approved by the Government with nominated individuals subsequently appointed.

Conclusion—setting the strategic direction for the HHF and aims for individual rounds

2.24 Overall, there have been restricted timeframes and resources for DoHA to undertake the necessary research and consultation to support the HHF strategic direction and aims of individual rounds. Where this has been possible, for example, for the development of guiding principles for the regional cancer centre round, a reasonable process was facilitated by DoHA. On other aspects, such as the membership of the HHF Advisory Board, the content of the HHF evaluation criteria and regional priority round additional guidance, DoHA assisted in achieving relevant results, within these constraints.

2.25 A key constraint on DoHA's advisory work was the tight timeframes available to identify infrastructure needs, gaps and priorities to maximise the economic and social benefits from HHF funding. As a result there was a reliance on needs and infrastructure gaps identified by the states and territories, without further DoHA or independent assessment. The analysis of needs and gaps was undertaken on a project-by-project basis once applications were received. There was limited opportunity, therefore, to design the funding round to ensure that proposals addressing areas of particular need for health infrastructure would be brought forward for consideration by the Advisory Board. This issue is further discussed in paragraphs 2.28 to 2.35.

Designing and implementing the funding rounds

2.26 The core objective in implementing any grant program is to maximise the cost-effective achievement of the outcomes sought by government, while providing transparent and equitable access to grants.[77] A range of factors

[77] ANAO Better Practice Guide (2010), *Implementing Better Practice Grants Administration*, p. 42.

therefore need to be considered in designing funding rounds to achieve value for money outcomes. These include:

- determining the structure of the application process by which potential HHF recipients are able to access funding;
- clearly identifying necessary and sufficient information required from applications; and
- supporting applicants to submit quality applications.

2.27 The audit assessed DoHA's administration of these factors for the first three rounds of the HHF.

Determining the application process

2.28 DoHA recognised early in the development of the HHF, the importance of obtaining proposals for HHF funding consideration through a planned process. This is reflected in a departmental briefing to the Health Minister in July 2008 which identified the need to engage with COAG and the National Health and Hospitals Reform Commission.[78]

2.29 A planned approach to determining the structure of the application process was overtaken by the requirement for DoHA to contribute to the management of the Government's response to the global financial crisis in mid-October 2008. The Government's initial intention to include HHF projects in a December 2008 infrastructure statement precluded any application process that sought proposals from organisations. Rather, the only proposals able to be considered by the Interim Advisory Board were those that DoHA had at hand. A subsequent decision by the Government to then announce HHF projects in an infrastructure statement in late January/early February 2009[79], again provided limited opportunities to purposefully design an application process. Further funding proposals were gained through:

- letters from the acting Health Minister to state/territory health ministers;

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[78] In February 2008, the Government established the National Health and Hospitals Reform Commission within the Health and Ageing portfolio, to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term. The Commission reports to the Health Minister and, through her, to the Prime Minister and COAG.

[79] This statement was subsequently included in the 2009–10 Budget announcement.

- letters from the DoHA Secretary to state/territory health administrators;
- departmental contact with organisations whose proposals had previously been considered by the Interim Advisory Board as having merit, but without sufficient detail to determine whether they met the evaluation criteria. These organisations were asked to resubmit applications against the application guidelines; and
- telephone contact by DoHA with other health research facilities.

2.30 As a result, funding proposals submitted for consideration were:

- those available through states' and territories' forward planning processes; and
- institutional projects that had already been subject to some level of planning and costing.

2.31 Information on the regional cancer centre funding round to potential applicants was through two main processes. As part of the consultation on the guiding principles[80], state and territory governments, and cancer practitioner and consumer groups, became aware of the funding round and its focus. Once the application guidelines had been finalised, this was followed by an invitation to apply for funding which was advertised in national and state major newspapers, letters of advice from the Health Minister sent to state/territory health ministers and key cancer stakeholders, and departmental contact with all other parties involved in the consultation process.

2.32 In Round 3, DoHA advised the Minister that an open process would attract a greater range of applications and, provided that access, equity and affordability issues for patients were addressed, would involve projects from both the private and non-government sectors. DoHA also advised that such a process could assist in providing a greater range of services to regional patients. Following Ministerial agreement to this approach, an invitation to apply was advertised nationally.

2.33 The department also had a list of unsuccessful applicants from the previous two funding rounds, in addition to those who had submitted

[80] See paragraph 2.17.

unsolicited applications. These applicants were contacted and advised of the new funding round, consistent with previous advice from DoHA.

2.34 Across each of the rounds, a range of applications was received and assessed by the Board. In particular, applications seeking combined funding of $12 billion were assessed in Round 1, representing 140 per cent more than the total HHF funding available. In Round 2, applications seeking $1.1 billion were approximately double the funding approved through the 2009–10 Budget, and in Round 3, applications sought $5.3 billion in funding, almost three times the maximum available funding. There was also a spread of organisations seeking funding. Across the rounds, applications were received from all state and territory governments, and directly from a range of other bodies, such as universities, major hospitals, health research institutes as well as community-based organisations.

2.35 As outlined earlier in this chapter, identified infrastructure needs and gaps did not inform the development of the three funding rounds. If available, such information could have informed the approaches adopted for seeking applications, including the options of more tightly targeting the funding rounds and specifically inviting proposals in line with a needs/gap analysis. In the absence of such information, the approach adopted by DoHA was generally reasonable as a means to identify a spread of projects that could result in improved health care in line with the Government's health reform priorities, but this approach did not necessarily maximise the potential benefits.

Seeking necessary and sufficient information in funding applications

2.36 The information required from applicants in support of their proposals was detailed in the funding application and assessment guidelines. Guidelines were issued for each of the three rounds which identified the necessary and sufficient information required from applicants against each of the evaluation criteria. In addition, for Rounds 2 and 3, applicants were required to address guiding principles specific to the particular focus of each of these rounds.

2.37 The issues covered in guidelines were largely unchanged across the rounds, except for the addition of information on the guiding principles for regional cancer centres, and the additional guidance for the regional priority round. However, the level of detail provided to, and required from, applicants to ensure that they adequately addressed each of the evaluation criteria increased across rounds.

2.38 Three areas of concern were raised by stakeholders interviewed as part of the audit with respect to the guidance provided in the funding guidelines. These related to:

- the costing basis used in the assessment of applications;
- appropriate inclusions for particular facilities to ensure that each was being assessed on a common basis; and
- the identity of health reform targets.

2.39 In Rounds 1 and 2, the costing basis was not identified in the funding guidelines. This led to concerns by some state government stakeholders that their costings, based on a cost benchmark model developed by the Victorian Government and licensed to other states for use prior to the involvement of architects and quantity surveyors, were being questioned by and discounted through the assessment process. This issue was addressed in Round 3 by including a standard costing template, developed with expert input from the Advisory Board, and reference to the need for applicants to justify their costings against relevant benchmarks.[81] One of the Advisory Board members suggested that a further improvement would have been the inclusion of a quantity surveyor's plan with the application.[82]

2.40 In Rounds 1 and 2, the guidelines did not include any information about what elements and characteristics should be included in particular types of facilities. This led to state government stakeholders questioning whether the funded infrastructure facilities met good practice standards. These stakeholders cited the value of the Australasian Health Facilities Guidelines in assisting health facilities being planned against better practice. While reference to these guidelines was not included in Round 3, it was identified as a source of best planning practices for health facilities in *Frequently Asked Questions and Answers* published by DoHA on their website during the application period.

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[81] Round 3 Funding Applicant and Assessment Guidelines gave an example of benchmark costing information as included in Rawlinsons Australian Construction Handbook. This publication identifies, among other information, costs per square metre for various building types, including general hospitals by location. (See <http://www.rawlhouse.com/aust_construction_cost_guide.html> [accessed 22 February 2012].)

[82] While there is value in such a suggestion, the investment required of applicants would need to have been balanced against the size of infrastructure projects, to ensure that proponents with small projects with potential merit were not discouraged from applying for funding. For Rounds 3 and 4, applicants were requested to submit a professional quantity surveyor's report with their application if available.

2.41 Stakeholders interviewed in the audit also expressed difficulties in Round 1 in identifying the Commonwealth health reform targets in order to address the following evaluation sub-criterion, 1(a)—'ensures significant progress will be made in achieving the Commonwealth's reform targets'. While DoHA expected applications to address the five priorities listed at paragraph 2.9, there was not an explicit link to these priorities, and the priorities were expressed very generally rather than in the form of reform targets. Since that time, more guidance on criterion 1 has been provided to applicants, largely addressing this issue.

Planning for quality applications

2.42 A risk in the design and implementation of funding rounds was the impact of the funding rounds' timeframes on the ability of applicants to submit quality applications. This was a risk drawn to the attention of the Health Minister by DoHA in Round 1 in advice on options for the structure of the round following the fast-track process[83], with the Minister deciding to proceed with a tight timeframe. There was, therefore, an implicit assumption that applicants would be in a position to submit sound applications for priority projects within the tight timing parameters set for the funding round.

2.43 Feedback from stakeholders during the audit identified that the time available to submit applications affected: the level of detail in their applications; and/or their ability to submit applications for projects which addressed their greatest priorities and had been sufficiently scoped and costed to best meet needs. This view varied, however, for those applicants who had priority projects reasonably progressed prior to the opening of the project round.

2.44 The time available for applicants to apply increased from Round 1, as outlined below:

- Round 1—applicants had 27 calendar days in which to submit applications. As letters were posted on 23 December 2008, some state government health agencies did not receive the advice until after the New Year's Day public holiday, further restricting the time available to respond;

[83] See paragraph 2.8.

- Round 2—applicants had 55 calendar days in which to submit applications. This timeframe also included the public holidays over the Christmas/New Year period. In addition, the guiding principles for the application round were released for consultation. Further, two months prior to the opening of the invitation to apply period, a public consultation was launched to obtain feedback on the draft guiding principles for the round. While this extra information assisted some applicants with the early preparation of proposals, one stakeholder advised the ANAO that this did not assist as the agency could not risk investing in proposal development against guidance which might change significantly from the draft to that finally released; and
- Round 3—applicants had 64 calendar days in which to submit applications.

2.45 State/territory government applicants were further restricted in their time to develop applications as they required their government's approval as to the proposals to put forward. One stakeholder advised the ANAO that, in Round 1, executive staff at one major hospital were given a week to develop requirements for a specialist facility that is expected to be in operation for 50 years.

2.46 The limited timeframes made available to submit applications, some of which were of significant size, had an impact on the quality of some applications and potentially affected the success of applications, while noting that the Advisory Board is able to draw on information additional to the application in informing its decision. Timing was a factor identified by DoHA in briefing the Health Minister on the need for an extended period for applications in Rounds 2 and 3. Table 2.1 shows the applications that were submitted during the invitation to apply process, those that met the evaluation criteria, and those that were regarded by the Board as only partially meeting the evaluation criteria. Comments from the Board against applications in this latter group indicates that, while many of these had merit, the applications were not sufficiently developed.

Table 2.1

Extent to which applications submitted during the invitation to apply process met the evaluation criteria

Round	Compliant applications submitted[1]		Fully met evaluation criteria		Partially met evaluation criteria	
	number	percentage	number	percentage	number	percentage
Round 1[2]	116	100	58	50	43	37
Round 2	37	100	21	57	7	19
Round 3	237	100	114	48	40	17
Total	**390**	**100**	**193**	**49**	**90**	**23**

Note 1: Compliant applications are those that have submitted all necessary information requirements in their applications within the specified timeframe.

Note 2: This assessment does not include those Round 1 proposals that were obtained from means other than through an invitation to apply; that is, those assessed by the Interim Advisory Board as discussed at paragraph 2.29.

Source: ANAO analysis of DoHA data.

2.47 The rate of applications which met all evaluation criteria has remained largely unchanged across the funding rounds. However, the percentage of applications that only partially met the evaluation criteria, largely due to the quality of the application, has halved since Round 1. This significant improvement suggests that the extra time available to prepare submissions has, in some measure, assisted applicants to submit applications with greater alignment with the evaluation criteria.

Managing the funding round from design to announcement

2.48 A project planning approach to managing each funding round from design to the announcement of successful proposals provides the potential to assist DoHA successfully meet required timelines within the Budget context. It also contributes to providing the necessary support to the HFF Advisory Board and the Minister.

2.49 A structured project planning approach addresses matters such as tasks, timelines, roles and responsibilities, resourcing, risk management and implementation review. The audit assessed the extent to which DoHA developed and managed against such a plan across the three funding rounds.

2.50 There is no documentation that DoHA explicitly developed and managed against such a plan. However, there were particular elements that

together could have assisted in the development of a project plan, as discussed below.

Tasks and associated timelines

2.51 As part of each round, DoHA identified tasks and associated timelines for briefing the Health Minister and the HHF Advisory Board. These briefings identified the requirements for decisions by the Health Minister and assessments by the Advisory Board by particular dates in order to meet timeframes set externally to the department. Examples of such timeframes included: the potential national infrastructure statement in early December 2008 set by the Department of the Prime Minister and Cabinet (PM&C) for Round 1; the 2010–11 Budget timeframe for Round Two; and the 2011–12 Budget timeframe for Round Three. DoHA provided relevant updates on these as necessary.

2.52 The tasks and associated timelines in the briefing material appropriately did not include all the management tasks required to be undertaken by DoHA to manage each funding round from design to announcement of successful proposals. There was, however, no alternative detailed listing of tasks to be managed for the administering officers to use in any of the funding rounds.

Roles, responsibilities and resourcing

2.53 While there was no documentation of roles and responsibilities, the management of the funding rounds clearly reflected the particular roles and responsibilities of the Health Minister, Advisory Board and the department.

2.54 Within the department, until 2011, HHF administration was split across a number of divisions. The management of each of the funding rounds, however, was largely centralised, as was the secretariat to the Advisory Board.[84] While this assisted in providing a clear understanding of responsibilities for the funding round at a departmental level, it affected DoHA's ability to provide adequate resources to support the Advisory Board. This was particularly evident in DoHA's capacity to develop contingencies for undertaking analysis of applications[85] when the expected number of

[84] The negotiation and management of funding agreements was allocated to relevant divisions with responsibility for particular health reform priority areas.

[85] DoHA analyses the extent to which an application addresses evaluation criteria prior to the application's consideration by the Advisory Board.

applications was unknown. The means by which DoHA put together the team to undertake to analyse the extent to which applications addressed each evaluation criteria for Round 3, for which there was over six times the number of applications as for Round 2, is described in Chapter 3.[86]

2.55 Infrastructure expertise was initially limited to that provided by one particular member of the Advisory Board. However, DoHA has subsequently worked with the Board to engage quantity surveyors to develop costing matrices to assist in assessing applications. Further, the Advisory Board urged the Health Minister to provide a more robust means of monitoring funded projects. On this basis, DoHA let a consultancy which resulted in recommendations, accepted by Government, for the establishment of a Centre for Capital Excellence[87] within DoHA, which comprised staff with expertise in infrastructure project management. DoHA advised that these experts were available for assessments in Round 4.

2.56 A further outcome of DoHA's review of the monitoring arrangements for funded projects has been the formation of a single area within the department that brings together the administration of the HHF. The consequence is that for Round 4 and any subsequent rounds, DoHA is able to draw from a greater pool of staff with HHF expertise to assist the Board in assessing applications.

2.57 For Rounds 2 and 3, the Board's assessments were also informed by the views of expert panels formed to assist in the process. Panel members included professionals, consumers and researchers with expertise in cancer and rural health respectively.

Risk identification, assessment and management

2.58 There was no formal identification, assessment and management of risks associated with the management of the first three funding rounds. Nonetheless, in the context of briefing the Minister, DoHA identified one key risk associated with limited timeframes for applicants to respond[88], and sought to manage that risk by advising the Health Minister of the value of longer

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[86] See paragraph 3.34.

[87] The work of the Centre for Capital Excellence in developing project compliance and reporting arrangements is described in paragraphs 4.79 to 4.84.

[88] See paragraph 2.46.

application periods. This risk was also brought to the attention of government as part of a broader risk mitigation strategy following the announcement of Round 3 projects and prior to the invitation to apply for Round 4 funding.

Project implementation review

2.59 There has been no formal project implementation review undertaken against each funding round to inform subsequent rounds. There were, however, improvements in management across the rounds, informed by the experience of DoHA directly and through advice from the Advisory Board. These improvements related to:

- the guidance included in the application guidelines;
- timeframes for applicants to submit proposals;
- resourcing, including improvement in the skills base relating to infrastructure development, and the development of a pool of staff to assist the Board in its assessment task; and
- costing benchmarks to assist in the assessment of applications.

Consequences of limited project planning

2.60 Each funding round was completed within the required timeframes, and the Advisory Board was complimentary of the support provided by DoHA in their work.[89] Nonetheless, two key tasks were not completed within the assessment phase. These related to: specific guidance to departmental officers on their analysis of the extent to which applications addressed the evaluation criteria to inform the Advisory Board; and briefing the Advisory Board on the sound practice requirements of the CGGs (following their release in July 2009) and adherence to Member Guidelines.[90] The development of, and management against, a project planning approach, would have provided greater certainty that these important matters would be addressed. There would be benefit in DoHA adopting such a planning approach in designing and implementing any future HHF funding rounds.

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[89] See paragraph 3.46.

[90] These are discussed at paragraph 3.43, Chapter 3.

Conclusion

2.61 Effective planning can contribute to realising the full benefit of the Australian Government's funding for health infrastructure through the HHF.

2.62 The limited time and resources available to DoHA to establish processes for Round 1 militated against the adoption of a more structured approach to the planning and conduct of that round. At the local and state level, DoHA relied on the infrastructure needs and gaps identified by state and territory governments—a 'bottom-up' approach. While the focus of the round at the national level was decided by government, with extra time and resources devoted to the administration of the HHF the department could have utilised a more formal 'top-down' strategic planning approach, including independently assessing health infrastructure needs and gaps against government priorities. Where an analysis of needs and gaps was undertaken, it occurred on a project-by-project basis once applications were received.

2.63 Notwithstanding these time and resource constraints, DoHA's work in planning and implementing the funding rounds facilitated the identification of projects with potential to achieve improvements in health care. DoHA developed additional selection guidance for particular rounds and identified persons with significant expertise, in areas pertinent to the HHF, to participate on the HHF Advisory Board. The department also worked with the Advisory Board to implement process improvements for Rounds 2 and 3.

3. Supporting the Selection of Projects for Funding

This chapter assesses DoHA's administration in supporting the HHF Advisory Board and the Health Minister in selecting projects for HHF funding consistent with Government policy and legislative requirements.

Introduction

3.1 The *Nation-building Funds Act 2008* and associated government decisions set out a number of assessment and decision steps that need to be undertaken in order for HHF proposals to be approved. These are, principally, that:

- the Health Minister is to appoint members of a HHF Advisory Board and may give the Board directions on the way it carries out its functions;
- the Health Minister may develop HHF evaluation criteria in consultation with ministerial colleagues;
- the HHF Advisory Board is to advise the Health Minister on proposals for funding under the HHF referred by the Health Minister that meet the evaluation criteria;
- the Government approves the total amount able to be drawn down from the HHF through the annual Budget process;
- the Health Minister may make recommendations to the Finance Minister to authorise the transfer of funds from the HHF Special Account to the HHF Health Portfolio Special Account for payment for proposals that, in the view of the Advisory Board, meet the evaluation criteria; and
- the Finance Minister may then the authorise the transfer of funds to a HHF Health Portfolio Special Account for this purpose, taking into account the limits set by government through the Budget.[91]

[91] *Nation-building Funds Act 2008*, ss 245–246, 251, 252, 257, 258, 262, 263 and 270.

3.2 Not all proposals for funding assessed by the Advisory Board are identified as meeting the evaluation criteria, with fewer again receiving funding. Table 3.1 outlines the numbers and values of proposals assessed, meeting the HHF evaluation criteria, and subsequently funded.

Table 3.1

Number and value of proposals assessed and funded

		All proposals[1]	Meet evaluation criteria[2]	Funded[3]
Round 1	Number	135[4]	71	35[5]
	HHF funding ($m)	12 048.7	6067.4	2639.8
Round 2	Number	37	21	21
	HHF funding ($m)	1127.3	547.7	512.0
Round 3	Number	237	114	63
	HHF funding ($m)	5342.2	2422.6	1329.0
Total	**Number**	**409**	**206**	**119**
	HHF funding ($m)	**18 518.2**	**9037.7**	**4480.8**

Note 1: Funding in this column refers to proposals referred to the Advisory Board for assessment and associated funding sought.

Note 2: Funding in this column refers to funding recommended by the Advisory Board. Included in this category are proposals identified as 'satisfying the evaluation criteria' by the Interim Advisory Board, and rated either 'A' or 'B' by the Advisory Board.

Note 3: Funding in this column refers to funding approved by government.

Note 4: The number and value of proposals do not double count those that were resubmitted. The HHF funding sought is based on the resubmitted proposal, where applicable.

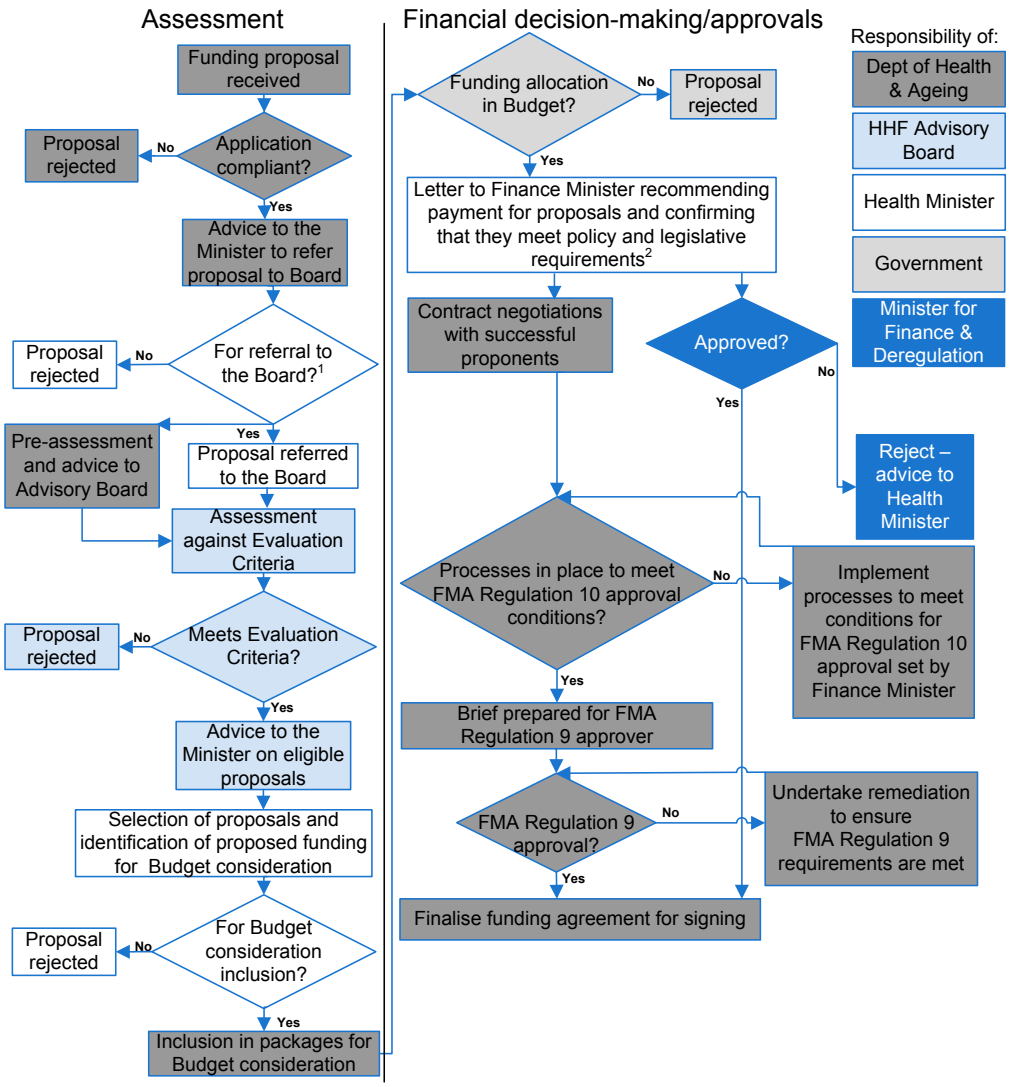
Note 5: The number and value include a proposal comprising a package of 23 small rural and remote primary health care projects, the digital mammography proposal (a single proposal which resulted in eight separate funding agreements), and the ACT Capital Regional Cancer Centre, with funding announced as part of Round 2.

Source: ANAO analysis of DoHA documents.

3.3 Proposals are subject to a number of processes and decision points prior to the completion of funding agreements for funded infrastructure projects. Figure 3.1 outlines the steps involved in assessing and approving proposals for funding.

Figure 3.1

Process and decision-points for selecting and approving funding proposals



Note 1: Proposals rejected at this decision point have only been some of those put forward by DoHA.

Note 2: These requirements are that the proposal: has been assessed as eligible by the Advisory Board; is for the creation and development of infrastructure; and will have a funding agreement with funding risk borne by the proponent, payments made against milestones and requiring no withdrawal of effort already committed by the states and territories.

Source: ANAO analysis of DoHA and Finance information.

3.4 This chapter assesses DoHA's administration with respect to the assessment of proposals, leading to the selection of proposals for government consideration in the Budget context. Chapter 4 includes an assessment of the

department's responsibilities in the financial decision-making/approval stages within the process.

3.5 In assessing DoHA's administration relating to the selection of proposals, the ANAO examined the extent that DoHA supported:

- the establishment of arrangements for selecting funding proposals;
- the Advisory Board in assessing HHF applications for funding, including the provision of information on applications; and
- the Health Minister in identifying HHF funded projects for inclusion in the packages for Budget consideration and the proposed funding for these projects.

Establishing arrangements for selecting funding proposals

3.6 The CGGs apply to a defined category of financial arrangements known as 'grants', and establish the grants policy framework within which agencies are required to determine their own specific grants administrative practices. The CGGs include matters of sound practice which the Government considers agencies should have careful regard to, as well as mandatory requirements. The HHF is a funding program that is a hybrid of financial arrangements. In particular, payments to states and territories are National Partnership payments, channelled through the COAG Reform Fund. Such payments are not regarded as grants under Regulation 3A of the *Financial*

Management and Accountability Regulations 1997 (FMA Regulations)[92], but payments to other bodies are grants and therefore subject to the CGGs.[93]

3.7 In June 2009, the Finance Minister drew the Health Minister's attention to the Finance Minister's Instructions on grants pending the implementation of the CGGs from 1 July 2009. These instructions included similar provisions on the approval of grants to the mandatory provisions of the CGGs. The Finance Minister asked that the Health Minister consider how these instructions applied to the HHF payments.

3.8 With respect to decisions relating to the assessment of grants, the CGGs set out mandatory requirements regarding:

- decisions by Ministers for a grant within their own electorate;
- decisions by Ministers to award a grant that the agency has recommended be rejected; and
- the responsibility on agencies to advise their Minister on the requirements of the CGGs.[94]

3.9 In addition, there are particular sound practices on the selection of proposals, included in the principles of 'governance and accountability', 'probity and transparency', and 'achieving value for public money', namely that:

(a) adequate training and procedural instructions are available to assessors, with care exercised to ensure that competing demands on

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[92] Under Regulation 3A, 'a *grant* is an arrangement for the provision of financial assistance by the Commonwealth:

a) under which public money is to be paid to a recipient other than the Commonwealth; and
b) which is intended to assist the recipient achieve its goals; and
c) which is intended to promote one or more of the Australian Government's policy objectives; and
d) under which the recipient is required to act in accordance with any terms or conditions specified in the arrangement.'

Regulation 3A also excludes a number of different payment types from the definition of a grant. Examples of these are: entitlement payments under legislation; tax concessions; compensation; assistance to schools, higher education institutions and local governments; and a range of payments to state and territory governments.

[93] The JCPAA has recommended that with respect to the CGGs that inconsistencies of grants payment arrangements between payments to the states and territories and other recipients be addressed. (See: The Parliament of the Commonwealth of Australia (2011), *Report 427—Inquiry into National Funding Agreements, Joint Committee of Public Accounts and Audit.* p. 23.)

[94] Department of Finance and Deregulation (2009), *Commonwealth Grant Guidelines—Policies and Principles for Grants Administration,* paragraphs 3.20 to 3.21.

time and scarcity of expertise do not lead to variations in the standards of appraisal and administration;

(b) program grant guidelines should include information on (among other things) funding and selection processes;

(c) decisions relating to granting activity are impartial, appropriately documented and publicly defensible;

(d) appropriate mechanisms are put in place for identifying potential conflicts of interest; and

(e) the objective of the appraisal process should be to select projects/activities that best represent value for public money in the context of objectives and outcomes of the granting activity.[95]

3.10 Adherence or otherwise to the above sound practices has a subsequent impact on the approval of payments under FMA Regulation 9. Under FMA Regulation 9, 'an approver must not approve a spending proposal unless the approver is satisfied, after making reasonable inquiries, that giving effect to the spending proposal would be a proper use of Commonwealth monies'. 'Proper use' is defined under section 44 of the FMA Act to mean 'efficient, effective, economical[96] and ethical use that is not inconsistent with the policies of the Commonwealth'. As discussed in paragraph 4.28, the financial approver may rely on sound assessment processes as part of their reasonable enquires in giving approvals under FMA Regulation 9.

3.11 In terms of establishing the arrangements for assessing funding proposals, the ANAO drew on the sound administrative practices from the CGGs and the requirements of the *Nation-building Funds Act 2008* in examining DoHA's support for the Health Minister in:

- including adequate information on the selection processes in the grant guidelines; and
- setting the direction for the HHF Advisory Board in assessing applications.

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[95] ibid. pp. 23, 27, 28 and 30.

[96] 'Economical' use was added as a requirement from 1 March 2011.

3.12 A further issue relating to DoHA's support for the Health Minister consistent with the CGGs, is the advice provided to the Health Minister on the process for selecting eligible proposals for government consideration in the Budget context. Across none of the rounds did DoHA provide such advice, either in the development of the arrangements for the round or in advice to the Health Minister accompanying the formal advice from the Board on eligible proposals.[97] As discussed at paragraphs 3.59 to 3.62, there was also limited advice to the Health Minister on the relative merits of eligible proposals—together, these have affected the transparency of the selection, including whether the projects proposed for Budget consideration were those that maximised value for money.

Selection processes identified in the HHF Guidelines

3.13 For each of the three rounds, DoHA provided the Health Minister with draft funding application and assessment guidelines, which were subsequently approved by the Health Minister. These were then made available to potential applicants.

3.14 In each case, the guidelines addressed the following factors with respect to the assessment process:

- DoHA's compliance checks of applications for completeness;
- the Advisory Board's role in advising the Health Minister about whether proposals for funding through the HHF satisfy the evaluation criteria, and, in the case of Round 3, any other guiding principles;
- DoHA's role in supporting the Advisory Board, including providing it with background, technical advice and contextual information;
- the Advisory Board's ability to seek clarifying and supplementary information as required to inform its decisions; and
- the Advisory Board's advice to the Health Minister as to which proposals satisfy the evaluation criteria and, for Round 3, the regional priority round additional guidance. This advice may include conditions that need to be met before an application satisfies these conditions. In

[97] As no proposals assessed by the Advisory Board were located in the Health Minister's electorate, there was no need to invoke the provisions of paragraph 3.20 of the CGGs, which establish a process for advising the Finance Minister.

addition, advice may include proposals which, due to the potential benefits to the nation of the proposals, need more work to meet the evaluation criteria.

3.15 For each of the funding rounds, the guidelines were consistent with the requirements of the *Nation-building Funds Act 2008*. There was no advice to the Health Minister, however, that the guidelines should address all stages of the selection process. In particular, advice to the Minister did not address the issue of the process or the basis for selecting applications and their levels of funding if the applications, determined as eligible by the Board, together exceeded the funding that the Government was prepared to approve through the Budget for the funding round. As a result, the funding guidelines for each of the rounds did not address a key stage in the assessment and selection process. To this extent, the HHF funding guidelines do not fully align with the sound practice for funding guidelines outlined at paragraph 3.9(b)—that program grant guidelines should include information on funding and selection processes.

Setting the direction for the HHF Advisory Board in assessing applications

3.16 Under sub-section 246(6)(a) of *the Nation-building Funds Act 2008*, the Health Minister may give the Board directions on the way it carries out its functions. There have been two key means by which the HHF Advisory Board has been directed by the Health Minister in undertaking its assessment of HHF proposals; namely, through its Member Guidelines (including terms of reference) and, for each of the funding rounds, letters from the Health Minister referring applications to the Board for consideration and advice. In each case, DoHA provided the Health Minister with drafts (subsequently signed off as finals) and accompanying advice on the content of these drafts.

Member Guidelines

3.17 In its Member Guidelines[98], the Advisory Board is directed to provide advice to the Health Minister on: the extent to which HHF funding proposals align with current reform directions and meet each of the evaluation criteria; recommendations as to which proposals should be rejected when they do not

[98] The Member Guidelines were originally signed off by the Health Minister in December 2008. Changes subsequently were made to reflect Remuneration Tribunal determinations on remuneration and allowances.

meet the evaluation criteria; and proposals that need more work to meet the evaluation criteria. This advice needs to take into consideration issues relating to geographic diversity to ensure maximum benefit from HHF expenditure, as well as the HHF Application and Assessment Guidelines. Given the content of the evaluation criteria, particularly criterion 2 with its emphasis on value for money in achieving health outcomes, this indicates alignment with sound practice for the objective of the appraisal process identified at paragraph 3.9(e)—that the objective of the appraisal process should be to achieve value for money in the context of the objectives and outcomes of the granting activity. Furthermore, these requirements are consistent with the assessment and decision points specified in the *National-building Funds Act 2008*.[99]

3.18 The Member Guidelines outline the processes for addressing conflicts of interest which may arise in the course of considering proposals or other matters referred to the Board. Advisory Board members are also required to complete a Conflict of Interest form in order to participate in Board business. This is consistent with the sound practice identified for managing conflicts of interest at paragraph 3.9(d) and ensuring the impartiality in decision-making identified at paragraph 3.9(c), as well as section 249 of the *Nation-building Funds Act 2008*.[100]

3.19 The sound practice of assessor training and procedural instructions (paragraph 3.9(a)) is not addressed. However, the underpinning reasons for this practice, competing demands on time and scarcity of expertise, are potentially addressed through the role of the department in supporting the Board, as included in the guidelines.

3.20 The sound practice relating to 'transparency and probity' of ensuring that decisions are appropriately documented and publicly defensible (paragraph 3.9(c)) is not fully addressed. The Member Guidelines outline that the DoHA secretariat to the Advisory Board will prepare 'a concise and focused report of decisions and actions taken', but the more detailed content of this report is not identified.

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[99] See paragraph 3.1.

[100] Section 249 of the Act requires Board members: to disclose any personal interests in matters being considered by the Board and advise the Health Minister accordingly; and to record the interests in the meeting minutes. The Health Minister must terminate the appointment of a Board member who fails to declare a personal interest without a reasonable excuse.

3.21 The advice that DoHA provided to the Health Minister relating to directions to the Advisory Board on Member Guidelines generally provide the potential for Board assessments to be undertaken in line with the sound practices of the CGGs. The level of detail on Board decisions to be documented by the secretariat to the Board in order to ensure transparency of decision-making, however, was left to the Advisory Board's discretion.

Letters referring applications to the Advisory Board

3.22 Draft letters were prepared by the department for the Health Minister's signature referring compliant applications to the Board. In the signed letters for each round, the Health Minister requested that the Board 'consider the (compliant) applications and advise me as to whether these proposals meet the HHF evaluation criteria'. For Rounds 2 and 3, the Health Minister also requested that the Board, in undertaking this work, have regard to the Guiding Principles for the Regional Cancer Centres and Regional Priority Round respectively. Taken with the Member Guidelines on the content of advice to the Minister, these letters provide reasonable guidance on the expectations of the Board in application assessment advice.

Supporting the application assessment work of the HHF Advisory Board

3.23 The HHF Advisory Board has had limited time in which to assess the applications for funding, especially when this work needs to be balanced against the demands of individual members' employment. Such limitations were particularly noted for Rounds 1 and 3, with an average of 0.23 and 0.32 days per application respectively for the assessment of detailed documents, some of which were over 200 pages in length. Table 3.2 provides details of the application numbers and timeframes for the Board's assessment for each of the three rounds.

Table 3.2

Applications for Advisory Board assessment and associated timelines

		Applications (No.)	Date referred to the Board	Date advice to Minister from Board	Elapsed days per application
Round 1	Interim	20[1]	18 November 2008[2]	26 November 2008	0.23
	Tranche 1	116[3]	28 January 2009	9 February 2009	
	Tranche 2	9[4]	14 April 2009	27 April 2009	
Round 2		37	22 January 2010	10 March 2010	1.27
Round 3		237	23 December 2010	9 March 2011	0.32

Note 1: 23 projects unfunded from the National Rural and Remote Health Infrastructure Program were assessed as a single proposal.

Note 2: Applications were not directly referred by the Health Minister. This is the date of the first meeting of the Interim Advisory Board, five days after the members were offered appointments.

Note 3: Seven applications were resubmissions initially assessed by the Interim Board.

Note 4: Three applications were resubmissions initially assessed in Tranche 1.

Source: ANAO analysis of DoHA documents.

3.24 The time constraints facing the Board in completing its assessments indicates that the Board requires a high level of support to undertake this work. The department undertakes an analysis of applications prior to their consideration by the Board, scoring each application on how well it addressed each evaluation criterion and any additional requirements for particular funding rounds. In order to assess DoHA's support for the Board, the ANAO examined the following with respect to the Round 3 assessment process:

- the range of information provided to the Board to assist them in their assessments;
- DoHA's adherence to sound practice in undertaking analysis of applications; and
- DoHA's secretariat support for the Board meets sound practice, including that outlined in its Member Guidelines.

Information provided to the Board

3.25 DoHA provided the Advisory Board with a range of information to assist members to assess proposals against a standard assessment tool. In particular, for Round 3, DoHA prepared 'gold briefs', state/territory government views on each proposal, costings against benchmarks, and contextual information.

3.26 The 'gold briefs' were prepared by the department for all compliant applications. Each of these briefs was based on a standard template and included a summary of the application, and strengths and areas of concern as identified by DoHA and an expert panel.[101] For each of the evaluation criteria and regional priority round additional guidance principles[102], DoHA included: a qualitative analysis against each of the sub-criteria, based on the application; an overall summary; and a score as follows:

1 = does not address criteria;

2 = partially addresses criteria;

3 = addresses criteria; and

4 = significantly addresses criteria.

3.27 Each of the applications was allocated an overall score in the range '8' to '32', by adding the scores of each of the five evaluation criteria and the three additional guidance principles. From DoHA's perspective, the purpose of this analysis was to assist the Board in its thinking and in forming its own views on the eligibility of applicant's projects.

3.28 For all proposals that were not submitted by a state/territory government, the department sought feedback from the relevant state/territory government health agencies. This feedback related to whether the proposal would help address known areas of need and contribute to jurisdictional health priorities, while not duplicating or impeding other current or planned projects. The results from these consultations were provided to the Board.

3.29 The department analysed the costings within proposals against benchmarks. While the Board was not asked to assess the consistency of Round 1 costings with industry standards, they did so for Round 2 applications. In order to ensure that this assessment could be more defensible for Round 3, the Board sought industry input. At the Board's request, DoHA engaged quantity surveyors with expertise in the construction of health and hospital facilities to develop benchmarks. Benchmark ranges were developed for each category type defined by: purpose of facility (such as general hospitals

[101] The expert panel was convened by DoHA at the request of the Advisory Board. It comprised research, practitioner and consumer experts in the areas of acute care, cancer care, rural and remote health, indigenous health, and mental health, and with groups of panel members assessing each application.

[102] See Appendix 3 for evaluation criteria and guidance principles related to Round 3.

and mental health facilities); type of construction (such as new heavy construction, fittings, furnishings and equipment); and geographic location (based on the Australian Standard Geographical Classification–Remoteness Areas[103]).

3.30 In addition to information provided on individual applications, DoHA developed briefing materials on a range of factors. In particular, for each of the priority areas identified in the guidelines for Round 3[104], DoHA prepared a context paper. These papers included an overview of the Commonwealth policy, programs and priorities for funding, a summary of state/territory infrastructure priorities, an overview of gaps or particular needs, and related issues which should be considered in assessing relevant applications. In addition, a list of relevant funded infrastructure projects was provided, with maps identifying the location of proposals by type.

3.31 Together with individual proposals, the information provided by DoHA was adequate to inform the Advisory Board in making their assessments, and improved over time with the inclusion of input from outside experts.

DoHA's analysis of applications

3.32 The ANAO examined the analysis process to determine the extent to which DoHA adhered to sound practice to: maintain impartiality in analyses; and minimise variation in the standards of appraisal and adequacy of documentation.

3.33 The analysis of applications on the extent to which each addressed each evaluation criteria was a key component of the 'gold briefs'. These were undertaken on the 'gold brief' template, requiring a score against each of the evaluation criteria and the guidance principles with associated justification, and an overall score, as described in paragraphs 3.26 to 3.27.

3.34 In order to undertake these analyses for Round 3 applications, the department formed a dedicated team of 43 staff (ongoing and temporary) and contractors, with staff drawn from across DoHA, including some with

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[103] See <http://meteor.aihw.gov.au/content/index.phtml/itemId/466873> [accessed 18 January 2012].

[104] Priorities were for infrastructure supporting: acute care; primary and community health services; workforce training; e-Health; specialised cancer care; and research integrated with clinical care and/or health workforce training.

previous knowledge and experience of the HHF. Over three-quarters of these staff and contractors were from the Executive Level 1 equivalent or higher rankings. To assist probity and the management of conflicts of interest, staff were required to complete a specific declaration of interest, with contractors obliged to complete a conflict of interest and confidentiality deed. In addition, all contacts with applicants by those undertaking the analyses were recorded.

3.35 Team members were provided with an information pack that included a briefing on the HHF funding process, a copy of the *Nation-building Funds Act 2008* and examples of 'gold briefs' from previous rounds to assist them to undertake the analyses. In addition, DoHA advised that their permanent staff on the team were given training and information sessions on procurement. There were, however, no documented processes for quality assurance of application analyses to test and improve the consistency of outcomes from the analysis.[105]

3.36 The ANAO assessed the quality of DoHA's scoring of applications based on the consistency and justification of scoring, by selecting a sample of 30 application 'gold briefs' across the range of 237 compliant proposals. The ANAO rated the quality of the scoring on the following basis:

- assessment by individual evaluation criterion/additional guidance principle:
    - 'superior'—robust analysis against the criteria supporting the score, applied consistently;
    - 'sufficient'—a reasonable level of explanation with references to the application to justify the departmental score, applied consistently; and
    - 'insufficient'—limited justification of the departmental score or a score which is inconsistent with that generally applied across the sample or with its definition;
- overall assessment for each application 'gold brief':

[105] The briefing material provided to the teams did not address the need to sufficiently justify scores against criteria and addition guidance principles. Nor did it provide definitions and examples to clarify the differences between scores. These are key elements typically included as part of quality assurance documentation for application analyses.

- ‘superior’—where there are three or more ‘superior’ grades assigned to evaluation criterion/additional guidance items analyses;
- ‘insufficient’—where there are three or more ‘insufficient’ grades assigned to evaluation criterion/additional guidance items analyses; and
- ‘sufficient’—the balance of the sampled analyses.

3.37 The results of these assessments, both at the individual evaluation criterion/additional guidance principle level and at the application ‘gold brief’ level, are outlined at Table 3.3.

Table 3.3

Quality of DoHA’s analyses of applications as rated by the ANAO, based on a sample of HHF ‘gold briefs’

Quality rating	By individual evaluation criterion/ additional guidance principle (per cent)	By application ‘gold brief’ (per cent)
Superior	37	33
Sufficient	36	40
Insufficient	27	27
Total	100	100
Total (Number)[1]	**180**	**30**

Note 1: The ANAO separately examined each of the evaluation criteria assessments and the additional guidance principles as a whole, resulting in six assessments per application.

Source: ANAO analysis of DoHA documents.

3.38 Based on the sample, almost three-quarters of the analyses by individual evaluation criterion and overall scores undertaken by DoHA were adequately supported and consistent across applications (that is, they were rated by the ANAO as either ‘superior’ or ‘sufficient’). There were no particular distinguishing features of proposals that characterised those that were identified by the ANAO as having an ‘insufficient’ basis for DoHA’s score; these proposals ranged in value from under $0.5 million to over $100 million, covered most of the health priority categories, resulted in the full range of ratings by the Advisory Board and included those subsequently funded and not funded by Government. The reasons for the analyses being determined as ‘insufficient’, also varied across the three factors as assessed by the ANAO, and included: limited justification for scores; scoring inconsistent

with that generally applied over the sample; and scoring inconsistent with the content of applications.

3.39 The ANAO did not identify issues relating to the quality of DoHA scoring in the 'gold briefs' for proposals to upgrade hospitals in the electorates of Independent members of the House of Representatives who had signed agreements with the Government after the August 2010 election. The ANAO found that these applications were analysed by DoHA and that the department's analysis of the applications[106] was consistent with the guidelines, and the quality of analysis was 'superior'. As with other proposals, these applications were then referred by the Health Minister to the Advisory Board for assessment.

DoHA's secretariat support for the Board

3.40 DoHA is required to provide secretariat support to the Advisory Board. For Round 3, part of that support was the provision of information to assist in assessment, including the analysis of applications in the 'gold briefs'. The Advisory Board was proactive in specifying the content of this information to assist in its assessment of Round 3 proposals, by:

- providing input into the content requirements and format of 'gold briefs';
- seeking the views of experts on proposals; and
- requesting the assistance of appropriately qualified quantity surveyors to develop costing benchmarks.

3.41 In addition to providing information, DoHA:

- arranged the Board meetings;
- distributed applications for assessment by individual members;
- took minutes of the Board meetings, which included a record of conflicts of interest;
- followed up further information required by the Board with respect to particular proposals; and

[106] These applications were for the upgrading the Royal Hobart Hospital in the electorate of Denison, the Tamworth Hospital in the electorate of New England, and the Port Macquarie Hospital in the electorate of Lyne.

- provided the Board with templates for declaring interests and for assessing applications. The assessment template was similar to that used in DoHA's analysis of applications, with advice on each of the criteria and guidance principles consistent with the funding application and assessment guidance.

3.42 Further, DoHA provided their Secretary with a single page briefing on all applications to support her as a member of the Advisory Board. This briefing summarised the key points of the 'gold brief' and recommended whether the Secretary should: support; seek further information on particular aspects; or not support the proposal.

3.43 The department did not provide the Board with documented briefing on the value of adhering to the sound practices of the CGGs relating to the principles[107] of 'governance and accountability' and 'probity and transparency', including that strict adherence to the Member Guidelines would go some way in meeting these practices.[108] It is not clear whether the Board considered these issues independently of DoHA's advice.[109]

3.44 In assessing the applications, the Board used the following classification of proposals:

A: satisfies the HHF evaluation criteria, ready to go;

B: satisfies the HHF evaluation criteria, subject to clarification on details in contract negotiations;

C: does not fully satisfy HHF evaluation criteria and would benefit from further development before consideration by the Board; and

D: does not satisfy HHF evaluation criteria.

3.45 In the minutes of Board meetings, DoHA recorded the outcome of Board assessments against this classification, as well as a summary of the

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[107] The CGGs establish seven key principles for grants administration, and outline aspects of sound practice which agencies should have regard to in implementing the key principles. The principles are: robust planning and design; an outcomes orientation; proportionality; collaboration and partnership; governance and accountability; probity and transparency; and achieving value for public money. (Department of Finance and Deregulation (2009), *Commonwealth Grant Guidelines—Policies and Principles for Grants Administration,* p. 14)

[108] See paragraph 3.21 regarding the link between the Members Guidelines and the CGG sound practices.

[109] The ANAO notes that the recording of, and decisions on, conflicts of interest were a key item included by DoHA in the Board's meeting minutes.

broad reasons for the classification. There is no indication in the Board minutes that DoHA advised and supported the Board to record 'the extent to which HHF funding proposals…meet each of the evaluation criteria' to facilitate Board advice to the Minister consistent with requirements in the Board Member Guidelines.[110]

Board members' views on departmental support

3.46 The views of the Chair of the Board and the construction industry expert on the Board were sought on the level and quality of support they received in assessing applications. In both cases, the Board members expressed high regard for this support, particularly given that until recently, DoHA did not have an area specifically dedicated to HHF administration. They also noted that the department had been responsive in meeting their requests for gaining expert opinions on Round 3 applications and the development of costing benchmarks, both of which were considered important improvements over previous rounds.

3.47 The Board members noted that the significant workload involved in having each member separately assess each application had prompted revisions in their processes. In particular, for rounds subsequent to Round 1, the work of reviewing individual applications was divided across the Board, with each member required to review all 'gold briefs' and supporting material. Applications were then discussed to form a consensus view on the rating to be applied. Such a process indicates that, at a minimum, Board members place some reliance on the quality of departmental analyses.

Conclusion—supporting the application assessment work of the HHF Advisory Board

3.48 The HHF Advisory Board members interviewed as part of the audit were complimentary of the support they received from DoHA in undertaking their assessment of proposals, both in terms of the briefing material and responsiveness to requests for improvement over previous rounds. There was an adequate range of information provided to the Board for Round 3. However, the quality of analysis on the extent to which applicants addressed each evaluation criterion undertaken by DoHA varied considerably across

[110] See paragraph 3.17 regarding Member Guidelines.

applications and, based on a sample, analysis of limited quality was identified in over a quarter of cases. The Board relied on these briefings, but not exclusively, forming their own independent views as to whether a proposal met the HHF evaluation criteria.

3.49 Given the importance of DoHA's analysis to the Board's work, it would be desirable for the department to improve the quality of its analysis process by providing briefing material to analysts on scoring applications and implementing a documented quality assurance process for analyses.

3.50 While the Board has interpreted its terms of reference as requiring it to provide advice to the Health Minister on whether or not proposals met the evaluation criteria, its terms of reference also provide that it advise the Minister on the extent to which each proposal meets each of the evaluation criteria. Doing so would have provided a basis for advice to the Minister on the relative merits of proposals.[111]

Identifying proposals for funding through the Budget

3.51 With regard to determining the proposals that will receive HHF funding, the Board's role is limited to providing advice to the Health Minister on the extent to which the proposals align with current reform directions and meet each of the HHF evaluation criteria.

3.52 In giving effect to the legislative requirements outlined in paragraph 3.1, the Government required that the Health Minister develop proposals for HHF funding that had been determined by the Advisory Board as meeting the evaluation criteria, and bring these forward for consideration in the Budget process.

3.53 In order to assess the support that DoHA provides to the Health Minister in determining funding proposals and the associated value of that funding to bring forward, the ANAO examined the process by which projects were funded, focusing on:

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[111] The CGGs provide that 'the objective of the appraisal process is to select projects/activities that best represent value for public money in the context of the objectives and outcomes of the granting activity'. (Department of Finance and Deregulation (2009), *Commonwealth Grant Guidelines—Policies and Principles for Grants Administration*, p. 30)

- selecting proposals for Budget consideration in line with the sound practices of the CGGs; and
- the distribution of funded projects.

Selecting proposals for Budget consideration

3.54 For Rounds 1 and 3, fewer projects were funded than were identified as eligible by the Advisory Board (see Table 3.1), and a process was adopted for selecting eligible projects following the receipt of advice from the Advisory Board. For Rounds 1 and 3, a sub-set of eligible projects identified by the Advisory Board was put forward for consideration in the Budget process, and the recommended funding levels put forward for consideration differed for some projects from those recommended by the Advisory Board. DoHA advised that this further assessment process, which occurred following the receipt of the Board's advice and prior to Budget consideration, was undertaken by the Health Minister.

3.55 There were similarities in the advice given to the Health Minister across the three funding rounds. In particular, for each round the Advisory Board wrote to the Health Minister identifying projects against the criteria described in paragraph 3.44, that is:

- rated as either 'A' (satisfies the HHF evaluation criteria, ready to go) or 'B' (satisfies the HHF evaluation criteria, subject to clarification on details in contract negotiations).[112] Against each project, the Board included comment addressing, for example, changes in recommended funding and recommendations regarding co-contributions; and
- rated as either 'C' (does not fully satisfy HHF evaluation criteria and would benefit from further development before consideration by the Board) or 'D' (does not satisfy HHF evaluation criteria). For these projects no further details were provided.

3.56 In addition, information included on each project comprised: the state or territory in which the project was to be located; a brief description of the project; overall cost; and funding sought, but not individual applications nor DoHA's 'gold briefs' including its scoring against the evaluation criteria and

[112] The Interim Advisory Board did not use this classification, and instead identified such projects as 'satisfies the evaluation criteria'.

guidance principles. For Rounds 1 and 3, the theme or national health priority area was also identified.[113]

3.57 DoHA provided the Health Minister with advice regarding the Advisory Board's letter, foreshadowing the next steps for government consideration. This advice differed across funding rounds, as follows:

- Round 1 advice included for eligible projects the distribution of funding sought by jurisdiction by theme for projects proposed by state and territory governments and other projects;
- Round 2 advice included recommended funding levels for each eligible project to meet the funding approved in the 2009–10 Budget, and an accompanying letter for Ministerial signature for broader government consideration; and
- Round 3 advice included an illustration of how funding might be distributed across jurisdictions based on population share, government and non-government split of eligible projects, location, proposed outcomes and project themes. DoHA advice also included discussion on the following factors for government consideration of the projects:
  - commitments made to the Independent members of the House of Representatives whose support the Australian Labor Party required to form Government;
  - leverage available from specific applications and the leverage that might be negotiated from jurisdictions that had offered low, or no, co-contributions;
  - the opportunity to redress some of the imbalance in HHF funding allocated under previous funding rounds; and
  - the interrelationships amongst certain proposals that, if funded as a package, could provide greater benefits over and above those that would be realised if considered individually.

3.58 For Round 3, the first factor is consistent with public announcements, and the other factors align with particular evaluation criteria. For Rounds 1 and 3, both of which had a sub-set of eligible projects put up for Budget

[113] Round 2 projects were required to align with the Government's priority for better cancer care.

consideration, there was, however, no advice as to the process by which such projects were to be selected, or advice on implementing the sound practices of the CGGs for Round 3. Furthermore, neither the Advisory Board nor DoHA included any recommended priority or ranking of projects for funding. The Health Minister therefore was presented with an undifferentiated list of eligible projects, without sufficient information with which to rank or prioritise them on merit.

3.59 For Round 1, DoHA's advice to the Health Minister accompanying the papers for Budget consideration indicates that DoHA worked with the Health Minister's office to identify eligible projects to include in the Budget proposals. With the exception of a limited number of projects, there is no documentation as to why some projects were included and others excluded from these proposals.

3.60 For Round 3, DoHA had no documentation as to the basis for the Health Minister including some projects, but not others in the Budget proposal. Rather, the Minister's office identified which eligible projects should be included in particular options put up for government consideration in the Budget context.

3.61 There is no documentation to indicate that any of the HHF rounds was meant to be competitive. However, in announcing the three nation building funds (including the HHF), the Government announced its expectation that in investing in infrastructure assets, governments should 'seek to achieve maximum economic and social benefits'.[114] The acting Health Minister's correspondence to states and territories inviting proposals for Round 1 funding, also highlighted that 'I expect strong competition for the available funding and only proposals of the highest calibre can expect to be supported'.[115] Further, the requirement for applicants to address evaluation criteria and the process of formal assessment by an independent panel suggested that funding would be based on merit.

3.62 For Rounds 1 and 3, the Health Minister was provided with a significant number of eligible projects with a value, if agreed, well in excess of

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[114] Commonwealth, *Budget Strategy and Outlook – Budget Paper No. 1 2008–09*, pp. 4–13. (See <http://cache.treasury.gov.au/budget/2008-09/content/download/bp1.pdf> [accessed 5 January 2012].)

[115] Correspondence dated 23 December 2008.

the funds available in the HHF.[116] However, the Health Minister was not provided with further advice—such as a merit list or scores for individual projects against the evaluation criteria—to support her assessment of the relative merits of the eligible applications. While the department advised that it has not at any stage been tasked by the Government with providing a priority ranking to the Minister, this reflects a relatively narrow view of responsibilities in grants administration, and there would have been benefit in providing addition support to the Minister in this respect.

Distribution of funded projects

3.63 Following receipt of the HHF Advisory Board's assessments, the Health Minister put forward projects for consideration in the Budget context. Project proposals were scrutinised in the Budget context as a prelude to receiving policy approval. While projects receiving policy approval were subsequently announced, they were then required to progress through formal negotiation and financial approval processes before funding agreements were entered into.

3.64 The ANAO assessed the distribution of Rounds 1 to 3 project funding announced by Government across electorates in terms of the location of the projects and expected catchments for projects, given that a significant proportion were aimed at serving a wider population than those in their immediate vicinity. Electorates were classified on a two-party preferred basis and by seat status (safe, fairly safe, and marginal), as defined by the Australian Electoral Commission, taking into account changes that occurred between the 2007 and 2010 Federal Elections. Based on this assessment, the ANAO concluded that funding was not weighted to type of electorate.

3.65 The ANAO also assessed the distribution of Round 1 to 3 project funding, against electorates held by the Australian Labor Party (ALP), the Coalition, and Members of Parliament who sat on the cross-benches in the House of Representatives.[117] The assessment excluded the funding for the two projects agreed by the Independent Members of Parliament and the ALP as

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[116] See Table 3.1.

[117] The Members of Parliament who sat on the cross-benches at the time of the funding round announcements were as follows: following the 2007 election, Mr Bob Katter MP, Member for Kennedy, and Mr Tony Windsor MP, Member for New England, and following the 2010 election, Mr Andrew Wilkie MP, Member for Denison, Mr Bob Katter MP, Member for Kennedy, Mr Rob Oakeshott MP, Member for Lyne, Mr Adam Brandt MP, Member for Melbourne, Mr Tony Windsor MP, Member for New England, and Mr Tony Crook MP, Member for O'Connor.

part of the agreement with those members in forming a minority government in 2010, as those commitments had been publicly announced in September 2010.[118] The analysis found that funding was not weighted to electorates held by either the ALP or the Coalition. Based on a comparison of the proportion of electorates held by members sitting on the cross-benches with the proportion of HHF funding to those electorates[119], funding was slightly weighted towards electorates that were held by members who sat on the cross-benches.[120] This outcome largely related to the following Round 3 projects:

- $21 million extra for Port Macquarie Hospital upgrade. This project is in the electorate of Lyne, currently held by the Independent, Mr Rob Oakeshott, MP;
- $120 million for the Tamworth Hospital Redevelopment, currently held by the Independent, Mr Tony Windsor MP; and
- $45.8 million for renal services in remote Western Australia. These services will be split across the electorate of Durack, held by the Liberal Party, and the electorate of O'Connor, held by the National Party member, Mr Tony Crook MP, who at the time of the Round 3 announcement sat on the cross-benches.

3.66 All three projects were brought forward by the respective state governments, as was the Royal Hobart Hospital Redevelopment, and were assessed by the HHF Advisory Board.[121] The three hospital projects located in electorates held by the Independents had costings that were at the lower end of

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[118] The Australian Labor Party committed up to $240 million for the redevelopment of the Royal Hobart Hospital to Mr Andrew Wilkie, Independent Member for Denison, and $75 million for the expansion and redevelopment of Port Macquarie Hospital to Mr Rob Oakeshott, Independent Member for Lyne. Funding was promised on the basis that applications for these projects met the evaluation criteria as assessed by the HHF Advisory Board. The NSW Government's subsequent application relating to the Port Macquarie Hospital upgrade sought an additional $21 million from the HHF—a total of $96 million for the project—which was assessed as meeting the evaluation criteria and was funded for $96 million. While the ANAO's analysis excluded the funding as originally agreed ($75 million), the additional $21 million in funding was included as part of the ANAO's analysis of funding against electorate types.

[119] These results take account of changes between the 2007 and 2010 elections. Funding is allocated to electorates to reflect the allegiance or independence of the sitting member at the time of funding announcements. The methodology and detailed results of these analyses are provided at Appendix 4.

[120] While 2.1 per cent of electorates were held by cross-bench Members of Parliament, 3.9 per cent of funding was for projects located in those seats.

[121] See footnote 118.

the Advisory Board's benchmark range, as did the renal services project. All these projects were assessed by the Advisory Board as meeting the evaluation criteria. In addition, the Advisory Board advised the Health Minister that, for the Tamworth Hospital Redevelopment for which the state government had sought $191.5 million in funding, a greater co-contribution should be sought from the state government. As a consequence, the Australian Government announced a lower level of HHF funding for this project of $120 million.

Conclusion

3.67 As noted in an earlier ANAO report[122], it is prudent for departments to apply the sound practice principles set out in the CGGs to the fullest extent possible in grants administration. While the grant funding to the states and territories from the HHF is not subject to the CGGs, these principles nevertheless represent good practice for the administration of grants programs such as the HHF.[123] DoHA advised that in the HHF context, the timeframe and resource constraints in which the department operated meant that the department was restricted in its ability to fully apply these principles.

3.68 DoHA supported the Health Minister and the Advisory Board in the assessment of projects and its administrative arrangements had regard to the requirements of the *Nation-building Funds Act 2008*. In addition, many aspects of DoHA's support to the Minister and Advisory Board were consistent with good practice.[124] Where this support fell short, there was an impact on the transparency of selection processes. The ANAO identified two areas where the transparency of decision-making processes could have been improved. These related to:

- the funding guidelines. While the funding guidelines advise applicants of certain elements of the decision-making process for selecting projects, they do not refer to the processes undertaken within government after the Health Minister has received the Advisory

[122] ANAO Audit Report No.30 2009–10, *Management of Strategic Regional Program/Off-Network Program*, p. 23. (See <http://www.anao.gov.au/~/media/Uploads/Documents/2009%2010_audit_report_30.pdf> [accessed 13 March 2012].)

[123] FMA Regulation 3A provides that certain grants such as those provided to states and territories under the intergovernmental relations framework, are not subject to the CGGs.

[124] As set out in the CGGs and ANAO Better Practice Guides, *Implementing Better Practice Grants Administration* (June 2010) and *Administration of Grants* (May 2002).

Board's advice on the eligibility of proposals against the evaluation criteria—specifically, the role played by the Health Minister in deciding on which applications will be submitted for policy approval in the Budget context. To improve the transparency of the selection process, there would be merit in reviewing the funding guidelines to inform applicants of all key aspects in decision-making; and

- advice to the Health Minister in the context of selecting eligible projects to propose for Budget consideration. The Health Minister was only provided with limited information on each eligible proposal, and could have been supported further by being given advice on the relative merits of the eligible applications. Information such as a recommended priority or ranking of projects for funding would have further contributed to the achievement of transparent and defensible selection decisions. The department has advised that it has not been required that the Board or the department rank projects for the Government, reflecting a relatively narrow view of responsibilities in grants administration.

3.69 While the Board has interpreted its terms of reference as requiring it to provide advice to the Health Minister on whether or not proposals met the evaluation criteria, its terms of reference also provide that it advise the Minister on 'the extent to which proposals for HHF funding ... meet each of the evaluation criteria'.[125] Advising on the extent to which proposals met each of the evaluation criteria would have provided a basis for advice to the Minister on the relative merits of proposals, and there would have been merit in the department encouraging such an approach or separately informing the Minister.

3.70 The distribution of projects and funding over the first three HHF rounds has not resulted in any Federal electorate type[126] being favoured over others.

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[125] The Advisory Board's terms of reference are reproduced at Appendix 1.

[126] Classified on a two-party preferred basis and by seat status of 'safe', 'fairly safe' and 'marginal', as defined by Australian Electoral Commission, and by whether seats were held by the Australian Labor Party, the Coalition or were held by elected members who sat on the cross-benches.

Recommendation No.1

3.71 To maximise transparency in decision-making, the ANAO recommends that, for all future HHF assessment and selection processes, the Department of Health and Ageing:

(a) includes all significant aspects of the selection process in funding guidelines; and

(b) advises the Health Minister on priorities for funding proposals assessed as eligible by the HHF Advisory Board.

DoHA response

3.72 The Department of Health and Ageing agrees with this recommendation.

4. Negotiating and Managing Funding Agreements

This chapter assesses DoHA's negotiation and management of funding agreements to support the completion of HHF projects and the achievement of project outcomes into the future.

Introduction

4.1 In order to achieve the outcomes required from each of the HHF funding rounds in an efficient and effective manner, suitable arrangements need to be put in place to establish a common understanding relating to the completion of projects. A well designed funding agreement helps to establish the basis for a constructive and cooperative relationship between relevant parties, providing clarity of objectives and a shared set of understandings and expectations.[127]

4.2 Following the announcement of successful Round 1 applications by the then Health Minister in May 2009, DoHA commenced the negotiation of agreements with state and territory governments and other entities.[128] Funding agreements based on standard templates prepared by DoHA's Legal Services Branch were used to formalise agreements with non-government agencies for this and subsequent rounds.

4.3 Agreements with states and territories for Round 1 projects were initially executed on the basis of funding agreements. However, as a result of the National Partnership Agreement on Health Infrastructure[129], these funding agreements were replaced with implementation plans. Where relevant, implementation plans were subsequently used for other Round 1 projects and Round 2 projects. An implementation plan is a relatively brief document with some of its terms and conditions specified within the National Partnership Agreement. Execution is achieved when the implementation plan proposed by

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[127] Department of Finance and Deregulation, (2009), *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration*, p. 20.

[128] Successful other entities included non-government agencies and local governments.

[129] National Partnership Agreement on Health Infrastructure, 7 December 2009. (Available at <www.federalfinancialrelations.gov.au/content/national_partnership_agreements/health/health_infrastructure/national_partnership.pdf> [accessed 16 November 2011].)

the Health Minister is formally agreed by the responsible state minister through an exchange of letters.

4.4 In December 2009, COAG tasked the Heads of Treasury to review national agreements, national partnerships and implementation plans. In line with this group's recommendations, the Commonwealth Government announced in May 2011 that implementation plans were to be replaced with project agreements. A project agreement is similar to an implementation plan, but is executed when signed by the Health Minister and the responsible state minister. Project agreements are to be used for successful Round 3 and 4 projects proposed by states and territories.

4.5 To determine the effectiveness of DoHA's negotiation and management of funding agreements[130], the ANAO assessed:

- the timeliness of the negotiation processes for funding agreements;
- the extent to which the funding agreements were consistent with the proposals assessed by the Advisory Board as eligible against the evaluation criteria;
- the extent to which funding agreements:
  - meet financial management requirements, and
  - adequately manage project risks; and
- ongoing management of funding agreements, including ensuring compliance with agreements.

Timeliness of contract negotiation processes

4.6 In order to provide legal protection for both parties, a funding agreement (or its equivalent) should be executed prior to the provision of HHF funding to approved recipients. The timely negotiation and execution of funding agreements is essential if the benefits of providing additional infrastructure are to be realised promptly. Timeliness in expending program funds was particularly critical for Round 1 to achieve the Government's objective of using nation-building funds to stimulate the economy.[131]

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[130] Funding agreements in this context include funding agreements with non-government agencies, implementation plans and project agreements.

[131] House of Representatives, *Second Reading Speech*, *Nation-building Funds Bill 2008*, 13 November 2008, p. 10841 (Hon Lindsay Tanner, Minister for Finance and Deregulation).

Progressing from project proposals to legally enforceable agreements was not always straightforward, however, given the size and complexity of projects and the need to take account of all the risks.

4.7 ANAO analysis of Round 1 projects found that the time taken to execute funding agreements ranged from 35 to 926 days from the date of the announcement of the funding. The average time taken was 318 days, and as at 31 December 2011, three projects were yet to be agreed. For Round 2 projects, the time taken to execute agreements ranged from 97 to 355 days, with an average of 237 days and five projects still to be agreed.[132] Table 4.1 shows the passage of time from announcement to achieving a signed agreement.

Table 4.1

Time taken to execute funding agreements from funding announcement

Time	Round 1[1]		Round 2	
	No. of Projects	Value ($m)	No. of Projects	Value ($m)
Less than 3 months	9	855.2	-	-
3 to less than 6 months	3	410.4	2	15.4
6 to less than 12 months	10	475.5	14	410.0
1 to less than 2 years	13	183.6	-	-
2 years or more	3	640.4	-	-
Not yet agreed	3	87.5	5	114.5
Total	**41**	**2 652.6**	**21**	**539.9**

Source: ANAO analysis of DoHA data.

Note 1: Twenty-three small rural projects funded in Round 1 had funding agreements signed prior to the announcement of Round 1 and have not been included in this analysis.

[132] Two of the projects from Round 1 which are yet to be agreed required significant re-scoping as co-contribution funding expected at the time the application was agreed by Government for funding is not being provided. The third Round 1 project has been delayed pending state government agreement to funding the infrastructure's ongoing operations. The five Round 2 projects still to be agreed are proposals from states and territories, where project agreements rather than implementation plans are being negotiated. As agreement had been reached on only seven of the 63 projects approved under Round 3 as at 31 December 2011, these projects were not included in the analysis.

4.8 DoHA advised that 'time taken to finalise funding arrangements in many cases demonstrated the thorough and prudent management of these negotiations by the Department. There are many examples where negotiations were protracted because the Department would not compromise on issues where this would create an unreasonable risk or exposure to the Commonwealth and this was frequently supported by professional legal, accounting and other advice'. Factors identified by the ANAO as having affected the time taken to negotiate funding agreements include:

- the size and complexity of the project;
- the degree of advancement of the planning for the project at the time of application. This was an issue particularly for Round 1 projects given the limited time to respond[133];
- resolution of land tenure of the project site;
- significant changes in project scope or payment profiles after funding announcement;
- the need to obtain extensive advice from the Treasury, Finance, and PM&C during the negotiation of implementation plans and project agreements with states and territories, given the requirements of the national partnership agreements with these jurisdictions; and
- resourcing constraints devoted to the administration of the HHF in DoHA, particularly when HHF staff were reallocated to HHF application assessment requirements.

4.9 The following case study illustrates how these factors arose in the negotiation process for a project that took almost three years to achieve an agreement from announcement.

[133] See paragraph 2.44.

Case Study
Victorian Comprehensive Cancer Centre

Following the announcement of funding of $426.1m for the Victorian Comprehensive Cancer Centre by the Health Minister in May 2009, on 5 June 2009 DoHA provided a draft funding agreement to the Victorian Department of Human Services (DHS).

In its response, DHS raised the issue that the Victorian Government would use a public private partnership (PPP) model to deliver this project and that the funding agreement proposed was inconsistent with the PPP model. The essence of this arrangement was that the Commonwealth would provide funding to the Victorian Government over five years whereas payments to a private partner would be made by Victoria over 20 years.

During the period June to September 2009, discussions between DoHA, Finance and Infrastructure Australia led to the conclusion that the PPP arrangement proposed was acceptable provided payments were made against agreed milestones. Following this decision, a draft implementation plan was prepared in response to the proposed National Partnership Agreement on Health Infrastructure at the time and agreed in principle between officers of DoHA and DHS.

Other than an exchange of emails in December 2009, there is no documented contact between DoHA and DHS until early May 2010. This period coincides with the application and assessment stages for Round 2 of the HHF.

From May 2010 to October 2010, negotiations—primarily relating to construction milestones and cash flow—continued between DoHA and DHS. DoHA received advice from Finance, Treasury and PM&C in respect of a suitable form for the implementation plan.

Following a further period where there was no contact between DoHA and DHS, the Health Minister proposed an implementation plan to the Victorian Minister for Health and Ageing on 15 March 2011. The period October 2010 to March 2011 approximately coincides with the application and assessment stages for Round 3 of the HHF.

On 1 November 2011, the Health Minister agreed to a revised Implementation Plan offered by the Victorian Minister for Health and Ageing on 25 August 2011.

4.10 Of the 14 funding recipients interviewed by the ANAO, five expressed concerns with the time taken to negotiate funding agreements and implementation plans. Those that expressed concerns had responsibility for major projects—representing 40 of the 49 projects managed by the interviewees and 84 per cent of the HHF funding.

4.11 As outlined in Figure 1.1, DoHA provides Finance with a schedule on a quarterly basis outlining the monthly payments to be made against the funding agreements over the next 12 months. This schedule must be consistent with the annual spending profile agreed to by Government in approving HHF proposals brought forward for consideration as part of the Budget process. In the event of any disparity between the requested movement of funds and the agreed annual spending profile, approval must be sought from the Finance Minister by the Health Minister. Delays in reaching agreement with proponents resulted in DoHA having to frequently approach the Health Minister with the necessary documentation to seek the Finance Minister's

agreement, increasing the administrative workload for ministers and their departments. The combination of delays in negotiating agreements and projects falling behind schedule also influenced the Commonwealth's ability to accurately forecast expenditure.

4.12 Until mid-2011, the responsibility for negotiating and managing HHF project agreements within DoHA was spread across several divisions with responsibility for particular health reform priorities. This distribution fragmented HHF administration. In May 2011, re-assigned funding for DoHA allowed the formation of a consolidated HHF administration area.[134] In order to align HHF project management practices, the HHF management team is currently preparing a Best Practice Framework. This framework will provide project managers with a standardised approach to managing and monitoring individual HHF project funding agreements. The framework is being progressed in stages and is intended to cover the entire HHF project management lifecycle.

4.13 The Best Practice Framework is expected to consist of templates and guidelines that managers can use for all aspects of the HHF project management lifecycle. In particular, project managers will be provided with written instructions on negotiating funding agreements, reviewing project status reports, and the project acquittal process. This approach provides the potential for DoHA to improve the timeliness of executing funding agreements for announced projects.

Consistency of funding agreements with eligible proposals as determined by the Advisory Board

4.14 Following the assessment of applications for HHF funding against the evaluation criteria and guiding principles relating to particular rounds, the HHF Advisory Board provides advice to the Health Minister as to whether

[134] See footnote 62 regarding this funding.

proposals for funding satisfy these requirements.[135] This is a key condition for funding eligibility under the *Nation-building Funds Act 2008* (the Act).[136]

4.15 Where there is a change to the scope of an approved project prior to the execution of a formal agreement, and that change is such that the outputs included in the proponent's application and assessed by the HHF Advisory Board can no longer be achieved, the project's eligibility against the evaluation requirements could be called into question. A prudent approach in this situation is for the Health Minister to refer the re-scoped proposal back to the HHF Advisory Board for assessment against the evaluation criteria and relevant guiding principles, to be confident that the project remains eligible.[137]

4.16 The ANAO examined a sample of 13 projects where an agreement had been executed from Rounds 1, 2 and 3 to determine if significant changes of scope had occurred and, if so, whether the project had been referred to the HHF Advisory Board for reassessment against the evaluation criteria. The sample broadly reflected the overall distribution of program funds and included projects agreed with states and territories and with non-government agencies across a variety of geographical locations.

4.17 No change in scope had occurred between the time of application and execution of an agreement for 11 projects in the sample. The remaining two projects required major changes in scope as described in the following paragraphs.

4.18 The Townsville Hospital project was initially referred to the HHF Advisory Board by the Health Minister in April 2009 and was recommended as meeting the evaluation criteria and that the proposal should be funded for the requested amount of $325 million. The Minister subsequently proposed a lesser amount of $250 million for consideration by government in the Budget context. This was agreed, and led to a re-scoping of the proposal by the Queensland Government to reduce the original outcomes, mainly a reduction

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[135] An outline of the Board's advice to the Minister is provided at paragraphs 3.44 and 3.45.

[136] Sub-section 252(2) of the Act provides that 'the Health Minister must not make a recommendation (to the Finance Minister on the authorisation of a payment) unless the HHF Advisory Board has advised under paragraph 246(1)(a) (which provides that the Board is to advise the Minister on matters relating to making payments on the creation or development of infrastructure as referred by the Minister) that the payment satisfies the HHF evaluation criteria'.

[137] On face value, sub-section 252(2) of the Act indicates that a referral back to the HHF Advisory Board should occur through the Health Minister.

in the number of beds from 100 to 74. Despite a significant change in scope, this project was not referred to the Board for reassessment; and no reasons were documented for this decision.

4.19 At the time of application, the Chris O'Brien Lifehouse at the Royal Prince Alfred Hospital[138] project was submitted on the basis that $100 million would be provided by a co-contributor and from public donations. This non-HHF funding failed to eventuate, with the result that in July 2009 the applicant proposed to implement the project in stages. The original total project budget of $310 million was reduced to $181 million with the key change that there would be no in-patient facilities within the Lifehouse. The HHF Advisory Board's initial support for this project was conditional on receiving a guarantee by the co-contributor that funds would be provided and by the proponent providing an assurance that, in the event the public funds could not be raised, there was an alternative viable option to ensure the project could still be progressed. The re-scoped proposal was not resubmitted to the Board as DoHA, without reference to the Board, considered that the staging of the project represented an 'alternative viable option'.

4.20 Upon learning in September 2009 that an agreement had been executed on the basis of a staged project, the HHF Advisory Board requested that, in future, where there was a significant re-scoping of a project it be referred back to the Board for reconsideration.

4.21 DoHA has advised that in order to address these inconsistencies in the treatment of changes in scope, the department intends to provide clear guidance to assist project managers to determine whether a proposed change to a project constitutes a 'scope change' or 'project variation'.[139] A project variation will arise where the agreed outputs will still be delivered and the matter is able to be resolved in writing at the officer level. A change in scope will arise if there is an impact on the project's agreed outputs, and will require referral to the Health Minister and potentially the HHF Advisory Board for reassessment. Following the development of this guidance, DoHA arranged

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[138] This facility will house the Sydney Cancer Centre once construction is completed.

[139] This guidance is part of DoHA's Best Practice Framework, which is an ongoing piece of work, as DoHA intends that it will continue to evolve as it is implemented and used. The Framework is broken down into a series of modules which, as at 1 May 2012, DoHA advised that a number were in use, with others still awaiting for sign-off from the department's legal area and review by other stakeholders.

for two other projects with major changes to their scope to be referred back to the Board for reassessment.

Meeting financial management requirements for funding agreements

4.22 The Australian Government's financial management framework applies to the HHF. The FMA Act and FMA Regulations provide the accountability framework for grants administration, and establish specific requirements for the approval of all commitments to spend public money. Compliance with the financial management requirements is an important part of ensuring the proper use of Commonwealth resources, as required by section 44 of the FMA Act. 'Proper use' means efficient, effective, economical and ethical use that is not inconsistent with the policies of the Commonwealth.[140]

4.23 FMA Regulations 7 to 12 establish the approval and recording requirements for FMA Act agencies relating to any commitment to spend public money.[141] In particular, FMA Regulation 9 provides that an approver[142] must not approve a spending proposal unless they are satisfied, after making reasonable enquiries, that giving effect to the spending proposal would be a proper use of Commonwealth resources.[143] FMA Regulation 3 defines a spending proposal as one that could lead to the creation of an arrangement under which public money is payable or may become payable. Under the HHF, such arrangements are formalised as funding agreements, implementation plans and project agreements which must be consistent with the terms of the approval given under FMA Regulation 9.

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[140] Sub-section 44(3). The requirement for 'economical' use was added in amendments to the FMA Act which came into effect on 1 March 2011. However, Finance has advised that the concepts of efficient and effective already encompassed the term economical. The intent of this change is discussed at paragraph 4.36.

[141] Department of Finance and Deregulation, *Finance Circular 2011/01*.

[142] Regulation 3 of the *Financial Management and Accountability Regulations 1997* (FMA Regulations) provides that an approver (that is, a person who may approve proposals to spend public money) means a Minister, an agency Chief Executive or other authorised person. Typically, other persons are delegates of the agency Chief Executive.

[143] Under the financial framework, the overall test whether public money should be spent is 'proper use'. Often, this is referred to as a 'value for money' test.

4.24 FMA Regulation 10 requires the Finance Minister's written agreement for expenditure that might become payable under an arrangement with insufficient appropriation. As money credited to the HHF is invested by the Future Fund Board of Guardians until it is needed to make payments, the only time that money will be available in the portfolio Special Account is when a payment is due. As a result, sufficient appropriation will not be available to cover the full cost of an infrastructure project when the approver is considering approval of a spending proposal. FMA Regulation 10 therefore applies to HHF payments.

4.25 The Finance Minister wrote to the Health Minister on 18 February 2009 providing FMA Regulation 10 agreement. In that letter, the Finance Minister stated that provided DoHA submitted quarterly advice on the forward commitment profile for agreed projects, no further FMA Regulation 10 agreement was required. The ANAO notes that these reports have been provided to Finance as required.

4.26 To assess the extent to which DoHA met the FMA Regulation 9 requirements, the ANAO examined:

- the process for approving HHF spending proposals; and
- the extent to which FMA Regulation 9 delegates exercised their delegations in line with requirements, including ensuring that payments were in line with project cost requirements.

Approving HHF spending proposals

4.27 DoHA officials have delegated responsibility for FMA Regulation 9 approvals and for entering into agreements with successful proponents for proposals that had been approved by the Government through the Budget process.

4.28 In briefing the FMA Regulation 9 approvers about proposals, DoHA addressed a range of factors that would inform the approver that the spending proposal was a proper use of Commonwealth resources. In particular, the following were addressed:

- the policy level approval of the proposal through the Budget process;

- the legislative requirements under the *National-building Funds Act 2008* relating to advice from the Advisory Board and agreement from the Finance Minister on payments from the HHF[144];
- value for money considerations undertaken by the Advisory Board through their assessment of individual proposals against evaluation criterion 2(d)[145]; and
- risk assessment and management plans to mitigate significant risks to meeting the outcomes required from the spending proposal.

4.29 This information provided a reasonable basis for the FMA Regulation 9 approvers to make their decisions.

4.30 Under FMA Regulation 8, FMA Regulation 9 approvals need to occur prior to entering into an arrangement, such as a grant funding agreement, under which public money is payable or may become payable. All projects in Rounds 1 to 3 where formal agreement had been achieved had received FMA Regulation 9 approval prior to execution of the agreement.

Advising on and approving spending proposals that have been varied

4.31 FMA Regulation 9 notes that at the time a spending proposal is approved, the expectation is that an arrangement will be entered into, consistent with the terms of the spending proposal. If there is a variation to the spending proposal, agencies are required to seek a further FMA Regulation 9 approval on the variation, taking into account factors such as additional costs associated with the new arrangement.[146] While this has been the case for most funding agreements, two key exceptions were noted, as outlined below.

4.32 Both the Victorian Comprehensive Cancer Centre and the Midland Health Campus projects were subject to extensive delays in finalising the

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[144] This requirement is outlined at paragraph 1.18 and in Figure 1.1.

[145] Evaluation criterion 2(d) states that the proposal 'demonstrates, comparing benefits and costs, that the proposal represents value for money'.

[146] Note 2 to FMA Regulation 9 provides that at the time the spending proposal is approved, the expectation is that an arrangement or arrangements will be entered into 'consistent with the terms of the spending proposal'. Finance has advised that Note 2 'highlights the need for an arrangement to be entered into consistent with the terms of the spending proposals actually approved by the approver'. Finance also advised that 'a proposed change to a spending proposal before an agreement is entered into or an amendment to an arrangement, such as a contract variation, will give rise to a new spending proposal, unless the change fits within the scope of the existing Regulation 9 approval, and if applicable, the Regulation 10 agreement.' (See Department of Finance and Deregulation Finance Circular No. 2011/01, *Commitments to spend public money (FMA Regulations 7 to 12)*, p. 16 (paragraph 8) and pp. 20, 22.)

implementation plans associated with the respective state jurisdiction having engaged in a public private partnership for the development of the facility. There was a considerable period of time between the FMA Regulation 9 approval and the subsequent execution of the implementation plan. Further, just prior to the finalisation of the implementation plans in late 2011, the Health Minister offered her state counterparts an option to bring forward payments from 2012–13 to 2011–12, 'to allow construction to commence as soon as possible'.[147] Progress on these sites by mid-April 2012 was as follows:

- Victorian Comprehensive Cancer Centre: bulk excavation of the site had commenced; and
- Midland Health Campus: period for public comment on the master plan had closed, with the final construction schedule due for submission to DoHA in June 2012.

4.33 As a consequence, there was a significant difference in the funding profile between that approved under FMA Regulation 9 and that specified in the implementation plans, as outlined in Table 4.2.[148]

[147] These offers were made in correspondence to the Victorian Government on 1 November 2011, and to the Western Australian Government on 8 November 2011.

[148] The quantum of the funding did not vary.

Table 4.2

FMA Regulation 9 approved, and implementation plan, funding profiles ($m)

Year	Victorian Comprehensive Cancer Centre		Midland Health Campus	
	Approved	Implementation Plan	Approved	Implementation Plan
2008–09	9.2	9.2	-	-
2009–10	-	-	-	-
2010–11	98.9	-	9.5	-
2011–12	67.0	232.9	18.1	72.6[1]
2012–13	67.0		45.0	
2013–14	67.0	67.0	56.9	56.9
2014–15	67.0	67.0	50.0	50.0
2015–16	50.0	50.0	0.6	0.6
Total	**426.1**	**426.1**	**180.1**	**180.1**

Note 1: The funding is against four separate milestones, with the fourth being the submission of the final construction schedule, due in March 2012, and now expected to be achieved in June 2012.

Source: ANAO analysis of DoHA data.

4.34 The significant prepayment for the Midland Health Campus project resulted in a final funding profile that shifted the expenditure from 2012–13 and will lead to estimated net present value of interest foregone by the Commonwealth of $0.9 million.[149]

4.35 While advance payments are a matter for government decision, there was scope for DoHA, in its advice, to further support the Minister and financial approvers where early payments were proposed for spending proposals relating to the HHF, to take into account the full financial implications of such decisions and their potential impact on the economical use of HHF funds. In the case of the Midland Health Campus project, the revised funding profile had the effect of giving rise to opportunity costs for the Commonwealth in the form of interest foregone, which materially altered the original spending proposal as originally considered by the approver. In advising the Minister, there would have been merit in considering relevant

[149] The methodology for this calculation is outlined at Appendix 5. In the case of the Victorian Comprehensive Cancer Centre, while the funding profile set out in the final implementation plan differed from that originally approved by the financial approver, the change did not result in a detriment to the Commonwealth in terms of interest foregone.

policies of the Commonwealth, including the potential implications of long-standing guidance on prepayments and early payments contained in Finance Circular 2004/14.[150] While that Finance Circular relates specifically to the consideration of prepayments made for the purpose of receiving a discount for goods or services performed or delivered, it also contains prudent advice on the general subject of making early payments, informed by the requirements of the financial management framework. In particular, Finance observes that:

> Efficient, effective and ethical management of Government resources includes making payments no earlier than necessary having regard to programme and service delivery objectives. As such, prepayments and early payments should only be made where there is a benefit to the Australian Government after taking all costs and risks into account.
>
> If agencies pay suppliers or contractors earlier than required, the interest on the Australian Government's money held centrally with the Reserve Bank of Australia is reduced. Agencies should take this whole of government impact into consideration when assessing prepayments and early payments.[151]

4.36 The ANAO has also emphasised the importance of ensuring that where payments are made in advance there should be a demonstrated net benefit from such a payment profile.[152] Having careful regard to the opportunity costs of early payments and prepayments is a practical means of satisfying the financial framework requirement for 'economical' use of resources. Further, in cases where a revised funding profile has the effect of altering a spending proposal approval for the purposes of FMA Regulation 9, there is a need for the spending proposal to be reconsidered and if necessary varied by the approver for the purposes of FMA Regulation 9.[153]

Exercising delegations in line with FMA Regulation 9 requirements

4.37 The ANAO assessed the extent to which FMA Regulation 9 approvers properly exercised their delegations by examining:

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[150] Department of Finance and Deregulation Finance Circular No. 2004/14, *Discounts for prepayment and early payment*. (See <http://www.finance.gov.au/publications/finance-circulars/2004/14.html> [accessed 16 March 2012].)

[151] ibid, p.1.

[152] ANAO Better Practice Guide, *Implementing Better Practice Grants Administration*, June 2010, pp. 92–93.

[153] Finance advice to agencies is that 'if a spending proposal is changed before an arrangement is entered into, officials must check whether the change fits within the scope of the existing Regulation 9 approval'. (See Finance Circular No. 2011/01, p. 22.)

- management of the risks of achieving value for public money (value for money); and
- approval of payment profiles consistent with requirements.

Managing risks to value for money

4.38 Risks to achieving value for money were not considered significant for most HHF funding proposals submitted to the delegate.

4.39 In one agreement, however, for the redevelopment of the Royal Hobart Hospital, the assessment for the identified risk of 'co-contribution from the Tasmanian Government is not received' was rated at a level that would suggest additional risk management measures should be considered. The risk assessment for this project proposed a risk mitigation approach that included active monitoring of the project, early advice to the Health Minister in the event of this risk eventuating and, if necessary, prompting the temporary suspension of work through withholding Commonwealth funds. However, conditions reflecting this approach were not included in the project agreement as signed by the Minister. Furthermore, there is no documentation to indicate that such agreement provisions were brought to the attention of the Minister.

4.40 It was open to the approver to only provide conditional approval for the spending proposal, subject to inclusion of the mitigation approach as a condition within the project agreement. The form of the project agreement meant that DoHA is limited in its ability to manage the successful completion of this project should these risks eventuate.

Approval of payment profiles consistent with project cost requirements and milestones

4.41 Making payments consistent with specified project cost requirements and milestones supports the Commonwealth to:

- achieve value for money by maximising the interest payable on HHF capital through investments by the Future Fund's Board of Guardians; and
- minimise the risk that the infrastructure requirements identified in the funding agreement are not delivered.

4.42 For project-based grants, value for money and sound risk management is promoted by Commonwealth funds becoming payable largely upon the demonstrated completion of work that represents a significant milestone defined in the relevant funding agreement. In order to minimise interest

foregone by the Commonwealth through the payment of funds in advance of the needs of a funded project, the funding paid upon reaching a milestone should be determined, where possible, by reference to actual project expenditure incurred to date.[154]

4.43 Funding agreements negotiated with successful applicants for HHF funding contain schedules which outline milestones that are required to be achieved and reported against by funding recipients in order to receive the payment for that milestone. The ANAO's examination of all the projects in Rounds 1, 2 and 3 where formal agreement had been reached at 31 December 2011 identified that a number of payments had been made in advance of the original project cash flow expectations expressed by proponents in their funding applications. Advance payments were made as a result of:

- the fast-tracking of first milestone payments for some Round 1 projects; and
- a particularly large first payment for one Round 3 project.

4.44 Table 4.3 shows the results of this examination. In summary, projects with a value of 65 per cent of total HHF funding committed to 31 December 2011 received prepayments. The HHF funding for projects in receipt of prepayments was $2107 million, while projects with HHF funding of $1131 million did not receive prepayments.

[154] ANAO Better Practice Guide, *Implementing Better Practice Grants Administration*, June 2010, p. 92.

Table 4.3

Projects with either aligned payment profiles or significant upfront payments compared to signed HHF funding agreements, as at 31 December 2011

		HHF Project Funding		HHF Project Agreements	
		$m	Percentage	Number	Percentage
Round 1	Payments Aligned[1]	695.8	27	25	66
	Significant Prepayments[2]	1867.1	73	13	34
	Total Signed Agreements[3]	2562.9	100	38	100
Round 2	Payments Aligned	425.4	100	16	100
	Significant Prepayments	0	0	0	0
	Total Signed Agreements	425.4	100	16	100
Round 3	Payments Aligned	10.0	4	6	86
	Significant Prepayments	240.0	96	1	14
	Total Signed Agreements	250.0	100	7	100
Rounds 1 – 3 Totals	**Payments Aligned**	**1131.2**	**35**	**47**	**77**
	Significant Prepayments	**2107.1**	**65**	**14**	**23**
	Total Signed Agreements	**3238.3**	**100**	**61**	**100**

Source: ANAO analysis of DoHA data.

Note 1: Agreed payment profile aligns with cash flow requested by proponents.

Note 2: Amounts shown are net of GST and represent the total approved value of projects where prepayments occurred. These include the two projects for the Victorian Comprehensive Cancer Centre and Midland Health Campus discussed at paragraphs 4.32 to 4.34 and Table 4.2.

Note 3: Twenty–three small rural projects with total funding of $9.2 million are not included as these were well advanced at the time funding was announced.

Fast-tracked projects

4.45 In the 2009–10 Budget[155], a Government decision was taken to bring forward expenditure of $186 million into 2008–09 in respect of approved HHF projects. This decision was in line with the Government's intention to fast-track infrastructure projects, including those funded from the HHF, as a means of 'secur(ing) economic activity in the short term and expand(ing) growth

[155] Commonwealth of Australia (2009), *Portfolio Budget Statement 2009–10: Health and Ageing Portfolio*, p. 51.

potential in the medium to long term', in response to the global financial crisis.[156]

4.46 On 11 June 2009, the DoHA FMA Regulation 9 delegate approved HHF payments totalling $1484.5 million to 12 funding recipients.[157] The payment profile for 2008–09 matched that approved through the Budget. In the advice provided to the Health Minister and the FMA Regulation 9 delegate, no reference was made to the potential for interest to be foregone on HHF investments made by the Future Fund Board of Guardians as a result of bringing forward this expenditure.[158] The advice to the delegate included a statement that the projects were selected as the applicants required funding to enable project work to commence.

4.47 In order to meet the Budget approved expenditure for 2008–09, DoHA reached agreement with 10 approved funding recipients for first milestone payments totalling $185 million being brought forward to be paid before 30 June 2009.[159] At the time of submitting funding applications, only two of the 10 proponents anticipated that funding would be required in 2008–09 for a total of $8 million. One recipient of the fast-tracked funding advised the ANAO that despite requiring $100 000 for the first milestone, DoHA offered and paid $29.8 million. The ANAO estimates that the interest foregone from HHF investment was $2.5 million from making payments prior to those required for these particular projects.[160]

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[156] The Government's announcement is discussed at paragraph 2.8. Of HHF projects with funding of $2611.9 million announced as part of the 2009–10 Budget, 10 projects with funding of $995.2m were provided with initial payments totalling $185 million prior to 30 June 2009, suggesting that these projects were to some extent expected to contribute to short term economic activity. Consistent with this contribution, five of these projects had milestones set in 2009–10 indicating that work on site had commenced. A further project had a milestone relating to completion of site works by 31 July 2010, work which would have required commencement in 2009–10. All but one of these projects achieved these construction milestones. Such progress is in line with the Government's aim for fast-tracking infrastructure projects from the nation-building funds, while recognising that large infrastructure projects generally require significant lead times.

[157] The payment profile for the Victorian Comprehensive Cancer Centre project was approved at this time but subsequently changed, as discussed at paragraph 4.32.

[158] In advising the Health Minister on the administrative steps required to implement this decision, DoHA commented that bringing forward large scale expenditure into 2008–09 may draw some criticism by the Auditor-General, the Senate and others.

[159] The remaining $1 million related to a project where agreement could not be reached in time to meet the 30 June 2009 deadline.

[160] The methodology for this calculation is outlined at Appendix 5.

4.48 A further Round 1 project, included in the FMA Regulation 9 approvals of 11 June 2009, had its funding agreement signed in 2009–10 with a substantial upfront payment. The net present value of cumulative interest foregone on this project is estimated by the ANAO to be $2.9 million from this payment prior to project expenditure requirements.

Large upfront payment for a Round 3 project

4.49 The redevelopment of Royal Hobart Hospital by the Tasmanian Government was a successful projected announced by the Government for funding from Round 3.[161] The application for HHF funding included a funding schedule with proposed payments totalling $240 million spread over the period 2011–12 to 2015–16. Following representations by the Tasmanian Premier to the Commonwealth Treasurer in late May 2011, the funding profile was changed to make a first payment in 2010–11 of $170 million and payments of $20 million in 2011–12 and $50 million in 2015–16. Table 4.4 shows the original funding profile as identified in the HHF application, compared to the revised funding profile.

[161] The risks relating to funding the redevelopment of Royal Hobart Hospital are discussed at paragraph 4.39.

Table 4.4

Required and agreed funding profiles for the Royal Hobart Hospital ($m)

Year	Original funding profile[1]			Revised funding profile[2]	
	HHF funding	C'wealth contribution[3]	State contribution	HHF funding	C'wealth contribution[3]
2010–11		5	37	170	100
2011–12	25	50	13	20	
2012–13	50	45	22		
2013–14	95		22		
2014–15	50		46		
2015–16	20		85	50	
Total	**240**	**100**	**225**	**240**	**100**

Source: ANAO analysis of DoHA data.

Note 1: As proposed in the Tasmanian Government's application for HHF funding.

Note 2: The funding profile for the Tasmanian Government's contribution remained unchanged.

Note 3: The 2010 post-election agreement between the Australian Labor Party and the Independent, Mr Andrew Wilkie, MP, included an agreement that the Government would contribute $100 million to enable the construction of the Women's and Children's Hospital, part of the larger redevelopment of the Royal Hobart Hospital. An implementation plan was approved in November 2010 by the Health Minister to this effect. This funding is separate from the HHF funding from the Commonwealth.

4.50 The rationale provided for the early transfer of funds by the Tasmanian Premier in correspondence to the Commonwealth Treasurer dated 26 May 2011, was that:

> the timing of these payments is an important component to facilitate the pre-planning and delivery of the project.

4.51 No further substantive reasons for early payment were set out in subsequent correspondence between Tasmania and the Commonwealth, between Commonwealth ministers[162] and in briefings from Commonwealth Government departments[163] other than the urgency of ensuring the

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[162] Following receipt of the Tasmanian Premier's letter, the Commonwealth Treasurer made representations to the Health Minister. The Health Minister sought and gained approval for a change to the funding profile from that approved in the 2011–12 Budget from the Prime Minister, and subsequently sought and gained authorisation from the Minister for Finance and Deregulation to enable payments to be made for the project, a requirement of the *Nation-building Funds Act 2008*.

[163] DoHA briefed the Health Minister on 2 and 18 June 2011 on requirements to execute the Tasmanian Premier's request before 30 June 2011. Finance briefed the Minister for Finance and Deregulation on 2 June 2011 on matters relating to responsibilities under the *Nation-building Funds Act 2008*.

prepayment was made before the end of the 2010–11 financial year.[164] On 9 June 2011, the Commonwealth Treasurer wrote to the Tasmanian Premier confirming that funds would be available by 30 June 2011. The requested profile was included in the project agreement executed between the Commonwealth and the Tasmanian Government on 17 June 2011.[165] The net present value of interest foregone by the Commonwealth in bringing forward the $170 million payment is estimated by the ANAO to be $12.3 million.

Public-private partnership arrangements

4.52 In addition to not considering interest foregone or risks to the completion of the projects from large upfront payments, the FMA Regulation 9 approvers for HHF projects were not provided with information about the funding profiles relating to state government projects involving public-private partnership arrangements.

4.53 The Victorian Comprehensive Cancer Centre and Midland Health Campus HHF projects[166] had funding models that involved public-private partnerships between the state government funding recipients and private partners.[167] In the case of these projects, state governments would receive funding from the Commonwealth over five years whereas the private partners would receive payments from the state governments over 20 years, delivering a potential windfall to the relevant state governments.[168] In respect of the Victorian Comprehensive Cancer Centre project, Finance and Infrastructure Australia advised DoHA that, provided payment milestones were agreed and the Victorian Department of Human Services met those milestones, under the new Federal Financial Relations Framework it was a Department of Human

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[164] DoHA advised the ANAO that there is no documentation detailing the substantive reasons.

[165] The management of risks associated with this project is discussed at paragraph 4.39.

[166] The Victorian Comprehensive Cancer Centre is previously discussed as a case study on the factors affecting the time to execute a funding agreement (after paragraph 4.9). Both projects have been previously discussed in the context of having funding profiles different from those approved by the FMA Regulation 9 approver (paragraphs 4.32 to 4.35)

[167] DoHA advised that 'in appropriately managing projects entering into public-private partnership arrangements, the Department sought advice from Infrastructure Australia and the Department of Finance and Deregulation. They did not provide any advice about the issue of interest foregone'.

[168] The state governments in receipt of the advance payments will receive the benefit derived from those funds—whether in the form of interest income or the ability to put the funds to other use—rather than the Commonwealth.

Services decision as to when and how to expend the funding received from the Commonwealth.

4.54 Given that the state governments will be required to make payments to the private partner over an extended period, the payment by the Commonwealth of funds totalling $606.2 million for these projects over a relatively short period of time is particularly generous. The ANAO compared the estimated interest that would accumulate if invested by the Future Fund's Board of Guardians and paid in equal amounts to the state over a 20-year period, with that which would accumulate over five years (consistent with the payment profiles in the implementation plans). The estimated net present value of interest foregone is $79.9 million for the Victorian Comprehensive Cancer Centre project and $47.7 million for the Midland Health Campus project, or a total of $127.6 million for the two projects. There is no evidence that advice on the magnitude of these opportunity costs was provided to the Health Minister prior to agreeing to the Implementation Plans, or to the FMA Regulation 9 delegate prior to the delegate approving the spending proposals.

An earlier opportunity to align payments to project expenditure

4.55 A review conducted by DoHA Internal Audit of a sample of Round 1 funding agreements found that a significant percentage of funding was attached to earlier milestones when the majority of work was being delivered in later milestones.

4.56 The July 2011 report on this internal audit recommended that DoHA ensure that future funding payments attached to milestones reflect the best estimate of the costs incurred to achieve that milestone. In response to this recommendation and a report by an independent consultancy firm, DoHA strengthened HHF management measures, such as project management and funding arrangements, to better reflect the risk, costs and stages of the construction process, and advised that it continues to work with central agencies to further define preferred milestone payment schedules for project agreement with state and territory governments.[169] In addition, DoHA

[169] DoHA advised that agreements with states and territories are cleared by the Commonwealth Treasury and Department of Prime Minister and Cabinet before they can be offered by the Minister to a jurisdiction.

established a Centre for Capital Excellence with the role of providing a capital works advisory function.[170]

4.57 Flowing from these management arrangements and the work of the Centre for Capital Excellence, in commencing negotiations for Round 3 projects DoHA has established a structured milestone and payment model. This model provides guidance on the milestones that should be included for particular types of projects, such as construction, refurbishment and purchase of equipment, and also reflects the complexity and length of the project. The model also provides guidance on appropriate payment amounts to attach to certain milestones during the life of a project.

4.58 These developments provide the potential to improve the scheduling of payments consistent with the occurrence of project costs. That said, DoHA prepared advice for the approval of the spending on the Royal Hobart Hospital project that proposed significant prepayments at a time when the internal audit's findings and recommendations were known. The department also provided advice to the Health Minister on the finalisation of the implementation plans for the Victorian Comprehensive Cancer Centre and Midland Health Campus projects after it had responded to the internal audit's recommendation. This indicates that more emphasis needs to be given to the guidance in DoHA's structured milestone and payment model, to reinforce expectations that program management arrangements adopted internally should also be appropriately reflected in advice to the Health Minister and brought to the attention of the financial approver.

Conclusion

4.59 As a result of a misalignment between the time when monies are required by recipients and when payments were made, or contracted to be made, the ANAO has calculated that approximately $145 million in interest payments has been foregone on behalf of the Commonwealth in net present value terms.

4.60 While there was Ministerial agreement to bring funding forward, including from the 2012–13 financial year, changes to funding profiles for some projects had the effect of materially altering the original spending profiles

[170] The background and operation of the Centre for Capital Excellence is discussed at paragraph 4.78.

considered by the financial approvers—giving rise to new spending proposals which were not considered for the purposes of the financial management framework, specifically FMA Regulation 9.

4.61 There is considerable scope for DoHA to improve its advice to the Minister in cases where early payments are proposed for spending proposals relating to the HHF, to take into account the full financial implications of such decisions, and to bring any such Ministerial decisions to the attention of financial approvers for their consideration when approving spending proposals.

Recommendation No.2

4.62 To enable decision-makers to form a considered view on the proper use of Commonwealth resources to fund Health and Hospitals Fund projects, the ANAO recommends that the Department of Health and Ageing provides advice to:

(a) the Health Minister on the risks, if any, and opportunity costs of making payments to funding recipients in advance of need; and

(b) the FMA Regulation 9 approver on government decisions, if any, relating to payments in advance of need and the implications of those decisions for spending proposals requiring consideration under FMA Regulation 9.

DoHA response

4.63 The Department of Health and Ageing agrees with this recommendation.

Managing project risks through contracts

4.64 In addition to assessing financial risks, it is important for agencies to ensure that agreements entered into with successful proponents have terms and conditions that enable them to adequately manage project risks. The ANAO examined a sample of 13 funding agreements, implementation plans and project agreements[171] to determine the extent to which these:

[171] The ANAO sample included agreements for Round 1, 2 and 3 projects executed at various points in time.

- specifically identify the infrastructure output and its usage;
- require reporting against progress;
- provide an adequate means for verifying the accuracy of the reporting;
- address the means by which infrastructure will be made operational and maintained consistent with its purpose into the future;
- identify arrangements to remediate (including recovering funds) when the recipient has not complied with funding conditions either in the development of the infrastructure or its ongoing use; and
- have appropriate variations to reflect the risks associated with particular projects.

Funding Agreements

4.65 The funding agreements negotiated with non-government entities are legal documents covering a range of risks and reflect the perceived higher level of risk to the Commonwealth presented by this type of funding recipient. The funding agreements examined by the ANAO contained provisions to address the risk mitigation factors described above. While the specific risks associated with individual projects have not been documented in funding agreements, there is a standard requirement that project documents prepared by the funding recipients include a detailed risk management and contingency plan.

4.66 The same standard funding agreement format has been used for approved projects across each of the funding rounds.

Implementation Plans

4.67 As states and territories were considered to present a lesser risk to the Commonwealth than non-government agencies[172], the implementation plans prepared in accordance with the Federal Financial Relations Framework were relatively brief documents and did not address risks as comprehensively as in the funding agreements with non-government entities. While the provisions contained in implementation plans are not considered to be legally

[172] DoHA advised that 'state and territory governments are subject to legislation in their jurisdiction which provides obligations and accountability in the expenditure of Commonwealth funds under HHF. However as non-government organisations do not have these obligations, the entity is directly accountable to the Commonwealth and there is a greater exposure of risk for the Government'.

enforceable, there is an implicit expectation that the parties' commitment to the implementation plan is not lessened by this fact.

4.68 The implementation plans examined in the ANAO's sample adequately described the infrastructure output and required reporting against progress. In a recently executed implementation plan, the reporting requirement was strengthened to include quarterly reporting through DoHA's online project reporting system. DoHA advised that this provision will be included in all future implementation plans and project agreements.

4.69 In general, of the five implementation plans examined by the ANAO, there were limited means specified for directly verifying the accuracy of reporting. In particular, of the five implementation plans, only one Round 2 implementation plan included a provision that described the type of evidence that might be submitted to the Commonwealth to demonstrate that a milestone has been met. Another two implementation plans included some means that could be used for verification, but would not necessarily be efficient for DoHA to take up. Specifically, these implementation plans included the establishment of project management committees with an option for Commonwealth participation.

4.70 None of the five implementation plans examined by the ANAO referenced the means by which infrastructure will be made operational and maintained in line with its purpose into the future, a factor that all applicants needed to address in applications to be eligible for funding.[173] A standard inclusion in all implementation plans, however, provided that the state or territory government would be responsible for all aspects of the project.

4.71 The implementation plans examined contained no provision for remediation in the event of non-compliance. All provided for either party to terminate the agreement by providing 30 days notice in writing and limited the Commonwealth's liability to payments associated with performance benchmarks achieved by the date of effect of the termination.

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[173] Criterion 5 (a)—'proponents identify how the facilities will be operated and maintained beyond the period of HHF funding, including where relevant, the capacity to integrate facilities funded by the HHF into their ongoing operations'. The funding guidelines also advise that 'applicants are expected to outline the whole-of-life use of any asset'.

Project agreements

4.72 Project agreements have replaced implementation plans and will be used to formalise agreements with states and territories for all Round 3 and 4 approved projects. The provisions contained in project agreements are similar to those in implementation plans.

4.73 As at 31 December 2011, only one project agreement, in respect of the Royal Hobart Hospital Redevelopment, had been executed and was examined as part of the ANAO sample. The comments above in respect of the sample of implementation plans apply to this project agreement. The issue of not including project-specific risks takes on a particular significance with this project, given that DoHA has identified risks at a level that would suggest additional risk management measures should be included in the agreement.[174]

4.74 While DoHA has implemented a means of gaining assurance relating to the accuracy of reporting[175], there would be benefit in DoHA identifying means to strengthen the following terms and conditions for inclusion in future project agreements:

- the means for maintaining the infrastructure in line with its purpose into the future; and
- arrangements in the event of non-compliance with funding conditions.

Ongoing management of contracts

4.75 Integral to the success of the grant funding process is an ongoing monitoring regime to determine whether funding recipients are meeting agreed milestones and other key requirements of their funding agreements. Monitoring is important throughout the project cycle, from the implementation stage through ongoing management to post-implementation evaluation.[176]

4.76 In assessing these aspects, the ANAO focused on: reporting by funding recipients to DoHA to adequately monitor projects and make payments against agreement milestones; and the means to ensure compliance with contract conditions.

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[174] This is discussed at paragraph 4.39.

[175] This is discussed in paragraphs 4.80 to 4.84.

[176] ANAO Better Practice Guide, *Implementing Better Practice Grants Administration*, June 2010, p. 94.

Reporting

4.77 The agreements negotiated with funding recipients made provision for periodic reporting of progress against project deliverables. The requirements have evolved during the various funding rounds and are different for non-government agencies and states and territories, as summarised in Table 4.5. The ANAO examined a sample of 13 funding agreements, implementation plans and project agreements[177] to determine the frequency, form and content of reporting required. With minor variations, reporting was found to be consistent with the frequency, form and content specified in funding agreements.

[177] The ANAO examined the same sample of agreements as that reported in the previous section of this chapter.

Table 4.5

Reporting requirements for each type of agreement

Reporting item	Original funding agreements with non-government agencies	Implementation plans	Recent or varied funding agreements and project agreements
Aim of project achieved	✓		
Works completed in accordance with project plan	✓		
Performance against benchmarks	✓		
Other matters that could impact on project aim or scope	✓	✓	✓
Works in accordance with building codes	✓		✓
Funds provided by Commonwealth expended on the project	✓		✓
Amounts expended on project to date	✓		✓
Balance of the bank account	✓		
Progress against milestones/ deliverables	✓	✓	✓
Numbers of staff employed on project	✓		
Promotional activities undertaken or expected		✓	
Analysis of forecast risks to project			✓

Source: ANAO analysis of DoHA information.

4.78 In mid-2010 DoHA, in consultation with the HHF Advisory Board identified: a number of risks to the successful implementation of HHF projects; and limitations in their current approach to managing these risks. In particular, DoHA was concerned with the adequacy of funding arrangements as a basis for compliance monitoring, and the expertise required to monitor the progress of HHF projects. As a result, in November 2010 DoHA commissioned an independent consultancy firm to provide advice on a compliance monitoring framework for these projects. In February 2011, the firm provided an internal report which identified a number of key issues and risks for HHF projects and recommended a best practice compliance monitoring framework to reduce the

impact of these risks. In response to the recommendations in the consultant's report and internal reviews and audits, DoHA took action to:

- centralise and coordinate the management of HHF projects[178];
- establish specific construction expertise and knowledge in the department, the Centre for Capital Excellence;
- monitor the key risks associated with individual projects more closely and accurately, which has resulted in more frequent project reporting, facilitated by the development of an online reporting system, the Capital Projects Internet Reporting Portal ('the Portal'), providing a standardised basis for the content of reporting; and
- implement project management and funding arrangements that better reflect the risks, costs and stages of the construction process.

4.79 The developments in project reporting in response to concerns about the frequency and content of reports have led to more frequent reports prepared on a standardised basis, assisting in the ongoing management of funding contracts.

Ensuring compliance

4.80 As part of their review, the consultants undertook an analysis of the compliance monitoring framework in place in DoHA at the time of their review in late 2010. This analysis highlighted two key risks in the arrangements then in use to monitor HHF projects:

- variation in the level of project-specific information and the level and detail of reporting provided across the HHF projects did not provide DoHA with consistent data to effectively assess both the performance of individual projects and to identify overall performance of the HHF programs; and
- variability in the frequency of reporting by funding recipients across the HHF did not provide DoHA with a consistent basis for assessing project-specific data to identify any issues and risks associated with the performance of individual projects.

[178] This is discussed at paragraph 4.12.

4.81 These risks have largely been addressed through the development of the Portal and more frequent reporting as reflected in new and varied funding agreements.

4.82 The consultant's report also identified that reporting and compliance monitoring at that time relied heavily on information from funding recipients with limited verification, presenting a risk that release of milestone funding may not always accurately reflect the level of progress on individual projects. The consultant recommended that DoHA should require non-government funding recipients to appoint an independent certifier and, for projects under implementation plans, the states and territories should select the party to provide certification.

4.83 In response, DoHA is implementing arrangements from Round 3 onwards whereby state and territory governments will be required to have their compliance reports certified by an appropriate senior delegate from within the responsible department. In addition, non-government entities are required to have their compliance reports independently certified by an expert third party approved by DoHA. The Centre for Capital Excellence has, through a public invitation-to-apply process, established a panel of suitably qualified experts from which recipients can draw their independent certifiers.

4.84 Implementation of the compliance monitoring framework provides a mechanism for introducing more effective monitoring of compliance by funding recipients.

Conclusion

4.85 Since Round 1, DoHA has progressed a number of process improvements in consultation with the HHF Advisory Board. The improvements have been informed by experience from Round 1 and include the development and implementation of a sound framework to provide guidance to project managers on a range of matters pertaining to the negotiation and management of funding agreements, including a number of difficult administrative aspects of the HHF, such as land tenure and project scope. In addition, DoHA has established a unit with specific construction expertise to provide guidance to project managers. DoHA has also substantially improved the reporting and monitoring arrangements, including through the use of independent certifiers for projects managed by non-government entities.

4.86 These developments will address a range of issues that have previously affected DoHA's negotiation and management of funding agreements, including:

- the time taken to negotiate agreements with funding recipients—with over two years taken in some cases, from the time successful projects were announced;
- funding agreements providing limited assurance that the projects meet the evaluation criteria, given significant changes to the project scope since the assessment by the HHF Advisory Board;
- a funding agreement providing limited means for DoHA to manage identified significant risks to a high profile project in receipt of $240 million funding from the HHF;
- changes to funding profiles which brought forward payments, limiting DoHA's capacity to manage projects against meaningful pre-defined milestones;
- inconsistent and infrequent reporting on projects, in the absence of standard formats; and
- limited means for DoHA to verify the accuracy of reporting, including claims for payments against construction milestones.

4.87 There remains, however, one area that has not been adequately addressed—that of ensuring payments to recipients are in line with costs incurred by the funding recipients for the projects. While this issue has been brought to DoHA's attention through an internal audit report, since that time further examples of funding agreements with payments prior to requirements have been finalised. In particular, the ANAO has estimated that $145 million has been foregone in interest from HHF investment by the Future Fund Board of Guardians, with most of this funding committed since the internal audit's findings were known. While advance payments are a matter for government decision, there is scope to further support the Health Minister by providing advice on the financial implications of such decisions. Further, where such policy decisions are made by Ministers, it is necessary to advise financial approvers of those decisions in the context of their consideration of spending proposals under the financial management framework, and as necessary, to revisit financial approvals if projects are no longer within the scope of existing approvals.

5. Monitoring and Reporting HHF Performance

This chapter assesses DoHA's monitoring and reporting of HHF performance against the mandatory and sound practice set out in the CGGs where they applied, the requirements of the Outcomes and Program Framework, and evaluation of program achievements.

Introduction

5.1 The main purpose of the HHF, as identified in the *Nation–building Funds Act 2008*, was the creation or development of health infrastructure.[179] While the Act does not further specify outcomes required from the investment, the Explanatory Memorandum to the *Nation-building Funds Bill 2008*, stated that projects financed from the HHF should 'demonstrate high benefits and effective use of resources'.[180]

5.2 The Government subsequently specified that the objectives for the HHF, whilst not replacing state and territory effort, are to:

- invest in major health infrastructure programs that will make significant progress towards achieving the Commonwealth's health reform targets; and
- make strategic investments in the health system that will underpin major improvements in efficiency, access or outcomes of health care.[181]

5.3 Based on HHF evaluation criteria, the outcome that HHF projects are aiming to achieve is a contribution to 'significant, sustainable and measurable ongoing improvements in health care' through investment in specific health reform priorities.[182]

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[179] *Nation–building Funds Act 2008*, s 212.

[180] Commonwealth of Australia (2008), *Explanatory Memorandum: Nation-building Funds Bill 2008*, cl 247.

[181] DoHA, *HHF Funding Application and Assessment Guidelines*, (p.3 (Round 1), p.3 (Round 3)).

[182] This outcome is part of criterion 2(a) of the HHF evaluation criteria and is also specified in the application guidelines across the funding rounds to date. The health reform priorities are outlined in paragraphs 2.9 and 2.12.

5.4 While noting that the health care benefits from HHF investments will not begin to be realised until projects are completed and the infrastructure is in operation, there is an improved health care outcome intended by Government from the HHF that should be measured. The extent to which projects have been progressed provides an indication as to when the community may expect health care benefits to be delivered from the HHF.

5.5 The ANAO assessed DoHA's monitoring and reporting arrangements established for the HHF in respect to:

- the mandatory and sound practice set out in the CGGs;
- the requirements of the Outcomes and Programs Framework; and
- planning for the evaluation of HHF achievements.

Mandatory and sound practices of the Commonwealth Grant Guidelines

5.6 The CGGs include a mandatory reporting requirement for grants, specifying that information on individual grants be published no later than seven working days after the funding agreement for the grant takes effect.[183] The ANAO assessed the extent to which DoHA had complied with this requirement for HHF payments regarded as grants.[184]

5.7 In addition to mandatory requirements, the Australian Government has established seven key principles for grants administration in the CGGs, including Principle 2, relating to an outcomes orientation. The CGGs also outline aspects of sound practice which agencies should have regard to in implementing the key principles. In adopting an outcomes orientation, the CGGs advise agencies that:

- performance information should make clear the extent to which the granting activity is contributing to government outcomes, as well as producing expected outputs[185]; and

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[183] Department of Finance and Deregulation, op. cit.

[184] As discussed at paragraph 3.6, only payments to entities other than state/territory governments are regarded as 'grants' for the purposes of the CGGs.

[185] Department of Finance and Deregulation (2009) *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration, July 2009*, p. 18. (See <http://www.finance.gov.au/publications/fmg-series/docs/FMG23_web.pdf> [accessed 14 March 2012].)

- the purpose of performance information is to assist management and stakeholders to draw well-informed conclusions about performance and take corrective action if necessary.[186]

5.8 Well-structured funding agreements establish performance measures and reporting processes and are the means of ensuring that funding recipients provide the information required to assess performance against outcomes.

5.9 The ANAO assessed whether DoHA had met the mandatory reporting requirements for grants, and the extent to which the funding agreements entered into by DoHA established an adequate basis for monitoring performance.

Meeting mandatory reporting requirements for grants

5.10 DoHA extracts information about grant funding agreements that have been executed from its financial management system and manually uploads the details onto its website three times a week. Up until September 2011, the financial management system restricted DoHA officers from entering the details of funding agreements until the agreements were executed—these details needed to be entered into the system within seven working days to satisfy the mandatory reporting timeframe. Any delays by the Health Minister or delegates passing on the executed documents increased the risk of not meeting this reporting requirement. Since that time, a new interface for the financial management system has allowed details to be entered prior to execution of the agreements, with delegates also able to finalise entry at the time of execution, minimising the risks of delays.

5.11 The ANAO examined the period of time between the date of effect of the funding agreement and its recording in DoHA's financial management system, for a sample of 20 funding agreements signed between June 2009 and July 2011. The results of the analysis of this sample are presented in Table 5.1.

[186] ibid., p. 18.

Table 5.1

Number and value of a sample of grants by period between the date of effect of the funding agreements and entry onto the financial management system

	Period between date of effect and financial management system entry (working days)			
	Within mandatory timeframe	Outside mandatory timeframe		TOTAL
		Less than 14 days	15 days and over	
Number	12 (60%)	5 (25%)	3 (15%)	20 (100%)
HHF funding ($m)	357.4 (47%)	248.5 (33%)	147.7 (20%)	753.6 (100%)

Source: ANAO analysis of DoHA documents.

5.12 Based on the ANAO's sample, 60 per cent of funding agreements were reported within the mandatory timeframe. Forty per cent of funding agreements, however, were reported outside the mandatory period, representing over half of the value of funding; each of these agreements was executed prior to October 2010. Three agreements were reported at a time significantly outside the required period—that is, over seven working days more than the requirement. Of these, the agreement with the largest amount of funding, the Lifehouse at the Royal Prince Alfred Hospital which is funded for $100 million, was entered into the financial management system 50 working days after the date of effect of the contract; this agreement was signed on-site by the Prime Minister with the Health Minister as a witness, an arrangement that potentially delayed the return of the document to DoHA for system entry.

5.13 Based on the ANAO's analysis, prior to October 2010 DoHA did not meet the mandatory reporting required for grants made under the HHF. Since that time, timeliness is likely to have improved as new processes introduced in September 2011 have simplified relevant data entry and minimised the risk of not satisfying this mandatory requirement in the future.

Monitoring performance through funding agreements

5.14 The HHF funding agreements, implementation plans and project agreements specify that funding recipients are required to provide DoHA with

a range of reporting related to the compliance of projects with particular specifications (for example, building codes), expenditure and construction progress.[187] This information is intended to provide a basis for identifying the progress made towards constructing infrastructure with the potential to contribute to health care benefits.

5.15 For those projects managed by non-government entities, DoHA is able to require additional reporting through the terms of the funding agreement (section 11.5(b)). DoHA must, however, specify this during the term of the agreement. This period ends 60 days after the receipt of the final report and all deliverables required under the agreement—that is, the completion of the construction of the project. DoHA has used this funding clause to require non-government entities to increase the frequency of their reporting and to report through the Portal.[188]

5.16 In addition to regular reporting on the progress of the project, non-government recipients are required in their funding agreements to submit a report annually on compliance with the designated use of infrastructure for the full period of the designated use. Funding recipients are also contracted to participate in evaluations and analysis of the projects for the purpose of analysing the success of the project in achieving the HHF objectives. However, the funding agreements do not contain key performance indicators which could be used by recipients for this purpose.

5.17 Another DoHA funding program, the Medical Research Infrastructure program, requires recipients to ensure the facility delivers the specified designated use over an extended period. DoHA commissioned an independent consultant to review and report on post-project evaluation and designated use compliance monitoring. The consultant reported in June 2011 with recommendations including that 'the post-completion and designated use reporting be carried out on an annual basis. This facilitates the use of a single form and allows the transfer of knowledge and the ability to undertake trend analysis as the timeline progresses.' The consultant, in consultation with DoHA, developed a model single form that included both designated use and performance information. The consultant also recommended that the

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[187] See Table 4.5

[188] See paragraph 4.78.

information be submitted electronically using the portal being developed at the time for HHF project reporting purposes. Given the similarity to the HHF, there would be merit in DoHA considering whether the approach adopted in the Medical Research Infrastructure program provides insights for the development and implementation of reporting on the outcome performance of HHF projects during the designated use period.

5.18 In the case of state and territory government projects, neither the implementation plans nor project agreements include provision for any reporting throughout the designated period following project completion. There was no documented explanation of this inconsistency with the non-government entity funding agreements. However, DoHA advised these differences have arisen given the perceived higher level of risk to the Commonwealth with non-government entities.

Outcomes and Programs Framework requirements

5.19 Advice from Finance on the policy workings of the new Outcomes and Programs Framework was released in late 2008 to allow entities time to prepare portfolio budget statements (PBS) for the 2009–10 Budget. Key elements of this Outcomes and Programs Framework are:

- specification of the outcomes the Government is seeking to achieve in the community;
- identification of programs and their associated deliverables;
- establishment of a performance management regime that enables the measurement and assessment of the impact of the program on a selected population and its contribution to the broader respective outcome; and
- annual performance reporting on the delivery of programs and achievement against a set of key performance indicators (KPIs).

5.20 DoHA is required to report in its annual report on how it is achieving specified outcomes. The key performance indicators and reference points or targets required for the year are identified in the portfolio budget statements. To examine the extent to which DoHA met the requirements of the Outcomes and Programs Framework, the ANAO assessed the performance information:

- provided on the HHF in the Health and Ageing Portfolio Budget Statements; and
- reported on in DoHA's annual reports.

Key performance indicators for measuring HHF performance

5.21 The relevant PBS current at the time of the audit was the Health and Ageing Portfolio 2011–12 PBS. The HHF is reported under Outcome 10: Health System Capacity and Quality, which is recorded in the PBS as:

> Improved long-term capacity, quality and safety of Australia's health care system to meet future health needs, including through investment in health infrastructure, international engagement, consistent performance reporting and research.[189]

5.22 Specifically, the HHF is the major activity for program 10.6, Health Infrastructure. The program objective is described in the PBS as follows:

> Through Program 10.6, the Australian Government aims to: invest in major health infrastructure programs that will support objectives of reform of the Australian health and hospital system.[190]

5.23 The qualitative and quantitative key performance indicators for the HHF identified in the Health and Ageing Portfolio PBS are presented in Table 5.2.

Table 5.2

Qualitative and quantitative key performance indicators in the Health and Ageing Portfolio PBS relating to the HHF

Qualitative Indicator	2011–12 Reference Point or Target
Effective monitoring of HHF projects for compliance with agreed outputs	Progress reports are received for all projects in the required timeframe and remedial action taken
Quantitative Indicator	**2011–12 Budget and Forward Year Targets**
Percentage of progress reports that meet agreed requirements	100%

Source: Department of Health and Ageing Portfolio Budget Statement 2011–12.

5.24 While these key performance indicators provide information on one element of program management—the extent to which progress reports were provided by grant recipients according to specified timeframes—they do not provide any meaningful information on progress expected against the program 10.6 objective, such as the anticipated rate of progress in realising the Commonwealth's investment in health infrastructure. Similarly, the KPIs specified in DoHA's 2010–11 PBS focused on the submission of progress

[189] Australian Government, *Portfolio Budget Statements 2011–12: Health and Ageing Portfolio* p. 269.

[190] ibid, p. 303.

reports in line with funding agreements and the percentage of progress reports that met agreed requirements.

Reporting HHF achievements

5.25 The ANAO examined the *Department of Health and Ageing 2010–11 Annual Report*, which was the most recent report available at the time of the audit. The HHF was covered in this report in the Secretary's Review[191], Highlights of 2010–11[192], and under programs 10.6 and 10.7 as shown in Table 5.3.

[191] The Secretary's Review included data on the number of applications: received for HHF Round Three; determined by the HHF Advisory Board as having met the evaluation criteria; and subsequently selected by the Government for funding.

[192] Department of Health and Ageing, *Annual Report 2010–11*, p. 3.

Table 5.3

Outcomes 10.6 and 10.7: Research Capacity and Health Infrastructure

10.6 Research Capacity	10.7 Health Infrastructure
Qualitative Deliverables:	Qualitative Deliverables:
Provides funding for health and medical research organisations through the Health and Hospitals Fund 2010-11 Reference Point: Funding provided in a timely manner. Result: Deliverable met	**Provision of appropriate and timely support to the Health and Hospitals Fund Advisory Board.** 2010-11 Reference Point: Advisory Board members satisfied with support provided. Result: Indicator met.
Review performance of funded projects against agreed implementation milestones 2010-11 Reference Point: Project milestones reviewed in accordance with individual funding agreements Result: Deliverable met	**Review of funded project performance against agreed milestones** 2010-11 Reference Point: Project milestones reviewed in accordance with individual funding agreements. Result: Deliverable met
	Submission of progress reports by funded organisations in accordance with individual funding agreement. 2010–11 Reference Point: Progress reports submitted by organisations funded through the HHF. Result: Indicator met.
Quantitative Deliverables:	Quantitative Deliverables:
Percentage of payments processed within agreed timeframes. 2010–11 Target/Actual: 100%/100% Result: Deliverable met	**Percentage of payments progressed within agreed timeframes.** 2010–11 Target/Actual: 95%/100% Result: Deliverable met
Percentage of projects that meet agreed requirements. 2010–11 Target/Actual: 100%/>90% Result: Indicator substantially met	**Percentage of progress reports that meet agreed requirements** 2010–11 Target/Actual: 100%/88% Result: Indicator substantially met

Source: Department of Health and Ageing *2010-11 Annual Report*, pp. 275 and 277.

5.26 In common with the approach adopted in the 2010–11 and 2011–12 Health and Ageing Portfolio PBS, the annual report focused on measures relating to elements of HHF program management and recipient compliance, rather than progress in realising the Commonwealth's investment in health infrastructure—including the delivery of completed projects.

5.27 DoHA does, however, develop internal reports that identify the progress made in delivering projects. These reports are used to inform the Minister on a quarterly basis and identify projects which are ahead of schedule and completed projects, as well as those delayed and the reasons for delays.

HHF project progress to date

5.28 In the absence of publicly reported progress against national health priority areas, the ANAO has presented in Table 5.4 a summary of progress as at 31 December 2011, for all projects funded under Rounds 1 to 3.

Table 5.4

Number and value of funded proposals[1] by priority and progress achieved at 31 December 2011

Priority area		In negotiation	In progress	Completed	TOTAL
Cancer Care	Number	7 (19%)	28 (76%)	2 (5%)	37 (100%)
	HHF funding ($m)	187.4 (14%)	1159.2 (86%)	1.6 (0%)	1348.2 (100%)
Acute Care	Number	24 (59%)	15 (37%)	2 (5%)	41 (100%)
	HHF funding ($m)	935.2 (40%)	1244.1 (54%)	134.0 (6%)	2313.3 (100%)
Primary & Community Care	Number	27 (49%)	9 (16%)	19 (35%)	55 (100%)
	HHF funding ($m)	224.6 (93%)	11.6 (4%)	7.7 (3%)	263.9 (100%)
Workforce Training	Number	2 (33%)	4 (67%)	0 (0%)	6 (100%)
	HHF funding ($m)	6.1 (4)	144 (96%)	0 (0%	150.1 (100%)
Translational research	Number	2 (18%)	8 (73%)	1 (9%)	11 (100%)
	HHF funding ($m)	85 (21%)	278.5 (69%)	39.8 (10%)	403.3 (100%)
Total	**Number**	62 (41%)	64 (43%)	24 (16%)	150[2] (100%)
	HHF funding ($m)	**1458.3 (33%)**	**2837.4 (63%)**	**183.1 (4%)**	**4478.8 (100%)**

Note 1: The HHF funding of projects for those in progress and completed reflect that in the funding agreements (or equivalent) rather than announced funding.

Note 2: The project numbers separately count parts of projects which have been split into stages, given that these can be at different stages of completion.

Source: ANAO analysis of DoHA documents.

5.29 In summary, 16 per cent of projects (a total of 24) had been completed while 41 per cent of projects were being negotiated (a total of 62) and 43 per cent were in progress (a total of 64). Most of the projects completed are

smaller primary and community health care projects. Of the 64 projects in progress, two projects (three per cent) with total funding of $25.6 million were six months or more behind schedule. A total of 22 projects (34 per cent) with funding of $766.9 million, were at least some degree behind schedule.

5.30 Table 5.4, along with reports to the Minister, demonstrates that DoHA has the data and capability to report on progress in a more meaningful way to promote transparency and accountability for the achievements from HHF funding, noting that information reported annually will require brevity, given the breadth of DoHA program responsibilities.

Planning program evaluation

5.31 The ANAO assessed whether DoHA had a planned approach to undertaking program evaluations for the HHF.

5.32 The importance of program evaluation as a critical element of the policy cycle is highlighted in DoHA's guidance to its managers on policy formulation and advice, which states that:

> all programs and policies should be evaluated as regularly and systematically as possible … Program evaluation is essentially an assessment of a program, or part of it, in order to aid judgements about its appropriateness, efficiency and effectiveness.[193]

5.33 The value of evaluation of outcomes from the HFF was specifically acknowledged by the Department of Regional Australia, Regional Development and Local Government (DRARDLG) in a briefing to government in September 2011 on the Regional Priority Round of the HHF:

> While acknowledging the complexity of measuring health outcomes from any individual input (such as this program), DRARDLG suggests that there would be benefit in considering the feasibility of and options for measuring the benefits of these investments to people in regional Australia in terms of improved health outcomes.

5.34 In its own briefing to government at this time, DoHA identified that it would evaluate the HHF program against measures of project completion; this

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[193] Department of Health and Ageing (2007), *Policy Formulation and Advice—Advanced*. Presented by CIT Solutions Pty Ltd on behalf of the Australian Public Service Commission for DoHA, pp. 72, 187, 189. The guidance refers to UK National Audit Office report, *Modern Policy-Making: Ensuring policies deliver value for money*, Report of the Comptroller and Auditor General, November 2001. (See <http://www.nao.org.uk/publications/0102/modern_policy-making.aspx> [accessed on 28 February 2012].)

approach was agreed by government. However, DoHA has not yet developed an approach to evaluating the HHF outcomes, other than to identify within funding agreements the requirement that non-government recipients participate in future evaluation activities.[194] As a result there would be merit in DoHA planning an appropriate evaluation strategy, given the significant past and anticipated Commonwealth expenditure under the program.

Conclusion

5.35 The Australian Government's intended outcomes for HHF funded projects were 'significant, sustainable and measurable ongoing improvements in health care' through investment in specific reform priorities. The progress reports received for individual projects provide an interim measure of benefits realised by the program, and DoHA has informed recipients that they will be required to participate in evaluations. However, DoHA has not yet identified key performance indicators to measure outcomes, or settled an evaluation strategy. To date, DoHA's approach to evaluation has focused on the progress of individual projects against construction milestones, and there would be benefit in further developing the evaluation strategy to determine the program's overall contribution to improving health outcomes.

[194] See paragraph 5.15.

Recommendation No.3

5.36 To improve the transparency and accountability of reporting on the outcomes achieved through HHF funding, the ANAO recommends that the Department of Health and Ageing further develops its evaluation strategy to determine the program's overall contribution to improving health outcomes, in addition to measuring progress against project milestones.

DoHA response

5.37 The Department of Health and Ageing agrees with this recommendation.

Ian McPhee
Auditor-General

Canberra ACT
20 June 2012

Appendices

Appendix 1: The HHF Advisory Board Terms of Reference

The HHF Advisory Board terms of reference as approved by the Health Minister in January 2009, following on from a related Government decision on 29 September 2008, state the following:

> The Health and Hospitals Fund (HHF) Advisory Board is established by the *Nation-building Funds Act 2008*. Appointments to the Advisory Board are made by the Minister for Health and Ageing.
>
> The function of the HHF Advisory Board is to advise the Minister for Health and Ageing about:
>
> - matters referred to it by the Minister; and
> - the making of payments in relation to the creation or development of health infrastructure.
>
> In providing advice to the Minister for Health and Ageing, the Advisory Board will:
>
> - be responsible for providing advice to the Minister for Health and Ageing regarding the extent to which proposals for HHF funding:
>   - align with current reform directions; and
>   - meet each of the evaluation criteria;
> - recommend that proposals that do not meet the criteria be rejected;
> - be able to identify which proposals need more work in order to meet the evaluation criteria; and
> - take into consideration issues in relation to geographic diversity to ensure the maximum benefit from the HHF expenditure.
>
> In assessing proposals, the Advisory Board will have regard to guidelines issued by the Minister, including the Funding Application and Assessment Guidelines and Guiding Principles to manage proposals that are relevant to both the HHF and the Education Investment Fund.
>
> The Department of Health and Ageing provides administrative support to the Advisory Board, and administers HHF grants including entering into contracts, making payments and monitoring HHF grants. The department also provides advice on eligibility, as well as background and contextual information to the Advisory Board during the proposal assessment process.

Appendix 2: HHF funded projects as announced by Government for Rounds 1 to 3

Table A 1

Projects approved for HHF funding as announced by Government

	Project	HHF funding ($m)[a]	Location	Priority Area
Round 1	Lifehouse at the Royal Prince Alfred Hospital (the new Sydney Cancer Centre)	100.0	NSW	Cancer[195]
	Nepean Health Services Redevelopment (Stage 3)	96.4	NSW	Hospitals[196]
	Garvan St Vincent's Cancer Centre (Kinghorn)	70.0	NSW	Cancer
	Ingham Health Research Facilities	46.9	NSW	Translational research[197]
	Hunter Medical Research Institute	35.0	NSW	Translational research
	Narrabri Multidisciplinary Health Care Centre	27.0	NSW	Hospitals
	Blacktown Hospital Clinical School, Research and Education Centre	17.6	NSW	Hospitals
	Nepean Clinical School	17.2	NSW	Training[198]
	Clinical Medical Education and Best Practice in Ambulatory Care	11.4	NSW	Training
	Victorian Comprehensive Cancer Centre	426.1	VIC	Cancer
	Australian Red Cross Blood Service: Victoria/Tasmania Principle Site Development	120.0	VIC	Hospitals
	Monash Health Research Precinct Translation Facility	71.0	VIC	Translational research
	Melbourne Neuroscience Project (Florey)	39.8	VIC	Translational research
	Northern Health Research and Education Precinct	14.0	VIC	Translational research

[195] 'Cancer' refers to the priority *Better Cancer Care*.

[196] 'Hospitals' refers to the priority *Supporting a World Class Hospital System*.

[197] 'Translational research' refers to the priority *Investing in Translational Research*. Translational research is the transfer of information between a scientific research environment and a clinical environment in order to prevent, diagnose or treat disease, also known as "bench to bedside" research.

[198] 'Training' refers to the priority *Improving Training Infrastructure*.

	Project	HHF funding ($m)[a]	Location	Priority Area
Round 1	Donor Tissue Bank of Victoria—new facility	13.0	VIC	Translational research
	Clinical Medical Education and Best Practice in Ambulatory Care	11.4	VIC	Training
	Children's Bioresource Centre	4.7	VIC	Translational research
	Townsville Hospital Expansion	250.0	QLD	Hospitals
	University of Queensland Oral Health Centre	104.0	QLD	Training
	Rockhampton Hospital Expansion	76.0	QLD	Hospitals
	Translational Research Institute	40.0	QLD	Translational research
	New Rehabilitation Unit, Fiona Stanley Hospital	255.7	WA	Hospitals
	Midland Health Campus	180.1	WA	Hospitals
	Kimberley Renal Services	8.6	WA	Hospitals
	Replacement Paediatrics Unit, Broome Hospital	7.9	WA	Hospitals
	Health and Medical Research Institute	200.0	SA	Hospitals
	Stage 2 Menzies Building (Hobart)	44.7	TAS	Translational research
	Acute Medical and Surgical Unit, Launceston General Hospital	40.0	TAS	Hospitals
	Eccles Institute—John Curtin School of Medical Research Stage 3	60.0	ACT	Translational research
	Research and Training Facility, Menzies School of Health Research (Darwin)	34.2	NT	Translational research
	Northern Territory Medical Program	27.8	NT	Hospitals
	Royal Darwin Hospital—Short-term Patient Accommodation	18.6	NT	Hospitals
	Alice Springs Hospital Emergency Department	13.6	NT	Hospitals
	Digital Mammography for BreastScreen Australia—Total	120.0		Cancer
	• NSW	18.9	NSW	
	• VIC	32.1	VIC	
	• QLD	26.7	QLD	
	• WA	13.3	WA	Cancer

	Project	HHF funding ($m)[a]	Location	Priority Area
Round 1	• SA	17.4	SA	
	• TAS	4.0	TAS	
	• ACT	5.0	ACT	
	• NT	2.5	NT	
	• Development of national standards	0.1	National	
	Primary Care Infrastructure in Rural Australia —Total	9.2		Primary Care
	• Gunnedah Rural Health Centre	0.5	NSW	
	• Forbes Walk-in Walk-out Medical Facility	0.5	NSW	
	• Extension of Scone Medical Facility	0.5	NSW	
	• Retention of GPs in Rylestone/Kandos Area	0.3	NSW	
	• Urbenville Medical Practice	0.3	NSW	
	• Securing the Health of Bombala	0.3	NSW	
	• GP Clinic at Gilgandra MPS (hospital)	0.2	NSW	
	• Murchison Medical Centre	0.5	VIC	
	• Merino Bush Nursing Centre Redevelopment	0.5	VIC	
	• Cobram Dental and Medical Clinic Development	0.5	VIC	
	• Inglewood Medical Practitioner Residence	0.4	VIC	
	• Ouyen Dental Service—sterilisation area upgrade	0.1	VIC	
	• Inglewood Medical Centre	0.5	QLD	
	• Nebo Medical Centre	0.5	QLD	
	• Wheatbelt GP Network—GP Consulting Rooms	0.5	WA	
	• Boddington Medical Centre	0.5	WA	

	Project	HHF funding ($m)[a]	Location	Priority Area
Round 2	• New Medical Centre, Donnybrook	0.5	WA	
	• Western Desert Kidney Health Project (Kalgoorlie)	0.5	WA	
	• Tumby Bay Primary Health Centre—Medical Practice	0.5	SA	
	• New Beachport Medical Centre	0.5	SA	
	• Cummins Medical Clinic Expansion	0.1	SA	
	• Padthaway Medical Centre	0.1	SA	Primary Care
	• Scottsdale Primary Care Centre	0.5	TAS	
	TOTAL ROUND 1	2611.9		
	Regional Cancer Centre (RCC)—New England and North West	31.7	NSW	
	RCC—Central Coast	28.6	NSW	
	RCC—North Coast	17.1	NSW	
	RCC—Shoalhaven	23.8	NSW	
	RCC—Illawarra	12.1	NSW	
	RCC—Lismore patient accommodation	2.6	NSW	
	RCC—Ballarat	42.0	VIC	
	RCC—Gippsland	22.0	VIC	
	RCC—Statewide enhancements	9.5	VIC	
	RCC—Rotary Centenary Gippsland accommodation	1.5	VIC	Cancer
	RCC—Albury/Wodonga accommodation	1.5	VIC	
	RCC—Central Queensland	84.6	QLD	
	RCC—Toowoomba and SW Queensland	9.6	QLD	
	RCC—Townsville and Mt Isa	70.1	QLD	
	RCC—Nambour	12.7	QLD	
	RCC—St Andrew's Toowoomba	6.7	QLD	

	Project	HHF funding ($m)[a]	Location	Priority Area
	RCC—Strengthening Cancer Care in Rural WA	22.3	WA	
	RCC—South West Health Campus	23.4	WA	
	RCC—Whyalla	69.8	SA	
	RCC—Burnie, Hobart & Launceston	18.7	TAS	
	RCC—Capital Cancer Centre	29.7	ACT	
	TOTAL ROUND 2	539.9		
Round 3	Bega Valley Health Service Redevelopment	160.1	NSW	Hospitals
	Port Macquarie Base Hospital Expansion	96.0	NSW	Hospitals
	Tamworth Redevelopment Stage 2	120.0	NSW	Hospitals
	Wagga Wagga Base Hospital Redevelopment	55.1	NSW	Hospitals
	Dubbo Base Hospital Redevelopment	7.1	NSW	Hospitals
	Cancer Centre services for the Wingecarribee Shire	0.5	NSW	Cancer
	Dalmany Dental	0.2	NSW	Dental
	Walgett Aboriginal Medical Centre Multidisciplinary Health Care Centre and Accommodation	3.0	NSW	Indigenous
	Drug & Alcohol Services—Detoxification & Rehabilitation Facility	3.4	NSW	Mental Health
	Our House—Lismore Patient & Carer Accommodation	1.0	NSW	Patient Accomm'tn
	Albury-Wodonga RCC	65.0	VIC	Cancer
	Integrated RCC	26.1	VIC	Cancer
	Ballarat Dental Clinic	8.3	VIC	Dental
	Expansion of Kilmore and District Hospital	10.0	VIC	Hospitals
	Expansion of Echuca Regional Hospital	12.1	VIC	Hospitals
	Expansion of Kerang Regional Hospital	18.4	VIC	Hospitals
3	Dialysis Unit Upgrade	1.1	VIC	Other

Project	HHF funding ($m)[a]	Location	Priority Area
Colac Youth Health Hub	1.2	VIC	Primary Care
Ambulatory Care Centre	6.8	VIC	Primary Care
Integrated Primary Health	1.0	VIC	Primary Care
Expansion of Mildura Base Hospital	9.4	VIC	Hospitals
Strengthening Aboriginal Services to Close the Health Gap	5.1	VIC	Indigenous
Central Primary Health Care Facility	11.6	VIC	Primary Care
Development of Wallan Integrated Primary Health Care Centre	2.6	VIC	Primary Care
Expanded Integrated Primary Health Care Facility Shepparton	3.8	VIC	Primary Care
Townsville Base Hospital—Planned Procedure Centre	12.1	QLD	Hospitals
Cairns Base Hospital—Planned Procedure Centre	12.1	QLD	Hospitals
Regional Mental Health Community Care Units	40.4	QLD	Mental Health
Regional Acute/Subacute/Extended Inpatient Mental Health Services	33.1	QLD	Mental Health
Bloomhill Cancer Help Community Therapy House	0.5	QLD	Cancer
Mater Misericordiae Hospital Mackay—Operation Theatre Expansion	3.0	QLD	Hospitals
Operating Theatre Equipment Upgrade Rockhampton	3.0	QLD	Hospitals
St Stephen's Regional Hospital (Construction)	25.9	QLD	Hospitals
St Stephen's Regional Hospital eHealth Initiative	21.2	QLD	Hospitals
Mental Illness Fellowship of Far North Qld Mental Health Hub	1.7	QLD	Mental Health

	Project	HHF funding ($m)[a]	Location	Priority Area
Round 3	Royal Flying Doctor Service (RFDS) Charleville Base Redevelopment	2.2	QLD	Primary Care
	RFDS Mt Isa Base Redevelopment	2.7	QLD	Primary Care
	Patient & Family Accommodation Project	3.6	QLD	Patient Accom
	Cairns Health & Wellness Stay Centre Development	1.9	QLD	Patient Accom
	Retention of GPs in the McKinlay & Julia Creek area	0.5	QLD	Primary Care
	Busselton General Dental Clinic	2.6	WA	Dental
	Bringing Renal Dialysis & Support Services Closer to Home	45.8	WA	Indigenous
	Centre of Excellence in Aboriginal Primary Health Care & Training for Rural WA	3.8	WA	Indigenous
	Renal Dialysis Unit Expansion	2.6	WA	Indigenous
	Multipurpose Health Centre Eucla	2.6	WA	Primary
	Wallaroo Community Dental Clinic	3.3	SA	Dental
	Mount Gambier Health Service Redevelopment	26.7	SA	Hospitals
	Port Lincoln Health Service Redevelopment	39.2	SA	Hospitals
	Mount Gambier Ambulance Station	3.5	SA	Other
	Riverland Oral Health Centre	6.0	SA	Dental
	Primary Health Care Enhancements on the Anangu Pitjantjatjara Yankunytjara Lands	2.3	SA	Indigenous
	Kincraig Medical Clinic Development	1.4	SA	Primary
	Royal Hobart Hospital Redevelopment	240.0	TAS	Hospitals
	Medical Centre Cygnet	1.2	TAS	Primary
	Sheffield Multi-purpose Health Precinct	1.8	TAS	Primary
	Improving Critical Care outreach and training in the ACT and South East NSW	2.3	ACT	Other

Project	HHF funding ($m)[a]	Location	Priority Area
The Palmerston Hospital	70.0	NT	Hospitals
Redevelopment of the Emergency Department, Tennant Creek Hospital	3.7	NT	Hospitals
Redevelopment of the Emergency Department, Gove District Hospital	13.0	NT	Hospitals
Improving Aboriginal Access to Primary Health Care in Remote NT	50.3	NT	Indigenous
Short-term Patient Accommodation, Katherine Hospital	7.7	NT	Patient Accom
Short-term Patient Accommodation, Gove District Hospital	5.8	NT	Patient Accom
Laynhapuy Homelands Clinic & Multipurpose Rooms	0.6	NT	Indigenous
TOTAL ROUND 3	1329.0		
TOTAL TO DATE (31 December 2011)	4480.8		

Source: DoHA.

Appendix 3: HHF Evaluation Criteria and Guiding Principles

Table A.2

Core HHF evaluation criteria across funding rounds

Criteria	Sub-criteria
Criterion 1: Extent to which the proposal addresses national priorities, including that:	a. ensures significant progress will be made in achieving the Commonwealth's reform targets; b. is consistent with or will complement reform activities and assist the Commonwealth in building a health system for the future; and c. will contribute to a balanced infrastructure investment across Australia.
Criterion 2: Projects result in improvements in health outcomes consistent with the level of investment, including that the proposal:	a. can demonstrate that the project will contribute to significant, sustainable and measurable ongoing improvements in health care; b. is supported by a good evidence-base that the project will lead to improvements in health outcomes; c. provides an indication of the relevant economic, social, and environmental costs, and relevant health, economic, social, and environmental benefits of the proposals; and d. demonstrates, comparing benefits and costs, that the proposal represents value for money.
Criterion 3: Extent of co-investment and collaboration, including that proposals:	a. generally will not impede investment in health infrastructure by other organisations, including the states and territories (states), universities, philanthropic and private organisations; b. leverage, where possible, existing funding sources to maximise the impact of projects receiving HHF funding; and c. where relevant, the distribution of any financial proceeds from the project is agreed before the commencement of funding.
Criterion 4: Project quality and efficiency including that proposals:	a. have a project design consistent with current health sector standards; and b. demonstrate that a range of options for achieving the outcomes have been considered, and that the option put forward in the proposal is the most effective, strategic option.

Criteria	Sub-criteria
Criterion 5: Capacity of the organisation to support, maintain and integrate new infrastructure into ongoing operations including that:	a. proponents identify how the facilities will be operated and maintained beyond the period of HHF funding, including, where relevant, the capacity to integrate facilities funded by the HHF into their ongoing operations; b. proponents should demonstrate that they possess sufficient capacity and any other resources (such as funding for project maintenance or associated recurrent costs) to ensure the delivery of the project and realisation of expected benefits; c. the organisation has access to, or will acquire, the human resources necessary to ensure the realisation of expected benefits from the proposal; d. the proponent has developed a comprehensive implementation plan which, where relevant, demonstrates how infrastructure will be implemented in stages (allowing for payments to occur on milestone completion); and e. the proponent has developed a comprehensive risk management strategy, with risks clearly identified and allocated.

Source: DoHA.

Table A 3

Regional Cancer Centre Round guiding principles

Guiding Principles	Explanation
Guiding Principle A: Demonstrate need	The intention of the regional cancer centre initiative is to optimise the coverage of essential cancer services to benefit the maximum number of cancer patients through every stage of their patient journey and fill gaps in current service arrangements. While regional cancer centres are likely to be configured differently across Australia, there must be a demonstrated need for the proposed location including a sufficient population catchment to provide optimal cancer outcomes and to support the particular services the centre provides. A proposed regional cancer centre will need to address current gaps in cancer services at a regional level and meet an area of need. It will have a sufficient regional population base and cancer caseload to make the particular services it provides viable and sustainable. As an example, a fully comprehensive centre that provides radiotherapy for patients will need a significantly larger catchment population than a centre that does not provide this service. A proposed regional cancer centre will service rural, regional and remote populations in ASGC-RA 2-5.[199]
Guiding Principle B: Aligns with cancer services	A proposed regional cancer centre will align with state and territory cancer services plans, be part of a collaborative network of cancer services and have appropriate referral pathways. Applications–whether for a new or expanded Centre–will need to show how they align with existing or planned state and territory cancer services plans. This will require agreed referral pathways to and from local and regional general practitioners and primary care services, as well as to and from existing metropolitan cancer services for the delivery of treatment for selected, rare or complex cancers and procedures.

[199] ASGC–RA refers to the Australian Standard Geographical Classification–Remoteness Areas. See <http://meteor.aihw.gov.au/content/index.phtml/itemId/466873> [accessed 18 January 2012].

Guiding Principles	Explanation
Guiding Principle C: Provides or links to comprehensive cancer care	A proposed regional cancer centre will provide access to the essential elements of cancer diagnosis, treatment and supportive care. This will be available either regionally or by appropriate referral to or from other services, including specialist cancer services, screening services, primary care, or other relevant mainstream clinical or diagnostic services. Wherever possible, regional cancer centres will provide comprehensive, multi-disciplinary care locally to patients. Where appropriate and feasible, outreach services will be provided from the regional cancer centre to surrounding local communities. However, some cancers need specialised treatment and/or expensive equipment that can only be provided in larger population centres. Applications will need to demonstrate how a regional cancer centre will provide access to comprehensive cancer care, where local care and treatment is not possible or will not provide the best outcomes for patients. Applications will also need to show how patients who will be given cancer care at a proposed regional cancer centre will be provided with optimal multi-disciplinary care. The cancer specialties involved will usually comprise, but may not be limited to, the following: diagnostic services; surgery; radiation oncology; chemotherapy; nursing; allied health services; and palliative care. Effective strategies for multi-disciplinary team work, role delineation and coordinated care should therefore be addressed in the application.

Guiding Principles	Explanation
Guiding Principle D: Provide equitable and affordable access	A proposed regional cancer centre will provide equitable access to and affordable services for patients in rural, regional and remote Australia, and must consider the needs of Indigenous Australians and people experiencing socio-economic disadvantage. The services should provide appropriate supportive care to meet the needs of cancer patients and their carers. When people need cancer treatment away from home, appropriate patient travel support and accommodation facilities become vital. Regional cancer centres will be well sited to minimise avoidable travel, accommodation and related expenses for regional cancer patients and their carers. This will help to ensure that people with cancer can access the right care at the right time, as close as possible to home and family, irrespective of where they live or their social circumstances. Applications will need to include a detailed business case that demonstrates how equitable and feasible access (including evidence of direct transport links) to the planned regional cancer centre will be provided. The business case will also need to demonstrate how the regional cancer centre will provide affordable services for patients that are sustainable over time.
Guiding Principle E: Addresses sustainability and workforce issues	A proposed regional cancer centre will be a sustainable and efficient venture and will be adequately staffed. HHF funding is for infrastructure. Applications will need to include a business case that demonstrates there is capacity to support and maintain a regional cancer centre, including addressing workforce needs and recurrent costs. The business case will also need to provide reasonable evidence that a regional cancer centre is sustainable and that relevant stakeholders have been consulted. Applications will need to show how a regional cancer centre will attract, fund, train, mentor and support essential regional cancer health professionals. This should include an outline of how regional cancer centre staff will have access to professional support and continuing professional development, with effective team planning, role delineation and multi-disciplinary care. Consideration should also be given to the provision of professional development and support for primary health professionals caring for cancer patients and their families in the region.

Guiding Principles	Explanation
Guiding Principle F: Supports clinical research networks	A proposed regional cancer centre will have links to and support effective clinical research as part of a best practice approach to cancer care. This includes links to appropriate clinical trials for eligible cancer patients. Applications should outline how optimal and evidence-based patient care will be achieved within a regional cancer centre, with appropriate links to major research units. There should also be a planned strategy for a regional cancer centre to be a part of or support clinical research. This should include, where appropriate, the provision of regular mentoring, professional development, education and registrar training support.
Guiding Principle G: Demonstrates systems to monitor, evaluate and manage performance and report on outcomes.	A proposed regional cancer centre will establish systems that support the monitoring, evaluation and management of performance and outcomes, including data collection, analysis and reporting tools. These systems are necessary to support accountability as well as to contribute to significant, sustainable and measurable ongoing improvements in health care and the cancer patient journey.

Source: DoHA (2009), *Health and Hospitals Fund—Regional Cancer Centre Initiative—Funding Application Guidelines*, pp. 29–31.

Table A 4

Regional Priority Round additional guidance

Additional guidance	Sub-criteria
Additional Guidance A: Address the health needs of regional, rural and remote areas of Australia:	a. ASGC–RA 2–5; or b. non-capital city RA1 which can demonstrate that the project will exclusively or predominantly service the health needs of regional patients; or c. capital city RA1 which can demonstrate that the project will exclusively or predominantly service the health needs of regional patients.

Additional guidance	Sub-criteria
Additional Guidance B: Provide or link to other health services to provide comprehensive multi-disciplinary care:	a. optimise access to essential health services to regional patients; b. provide comprehensive, multi-disciplinary, integrated care locally to patients; c. strengthen linkages and the coordination of care between the acute and primary health care settings; d. project links with services provided in larger population centres; e. demonstrate how the proposed project will help achieve state or territory health priorities and, where applicable, how the project aligns with jurisdictional health planning; f. level of support from state or territory governments or departments; and g. demonstrate local support for the application and how the project will foster local engagement.
Additional Guidance C: Provide equitable and affordable access:	a. provide equitable access for patients in regional communities; b. provide affordable services for patients in regional communities that are sustainable over time; c. consider the needs of Indigenous Australians and people experiencing socio-economic disadvantage; d. minimise travel, accommodation and related expenses for patients and their carers

Source: DoHA (2011), *Health and Hospitals Fund—Regional Priority Round—Funding Application and Assessment Guidelines*, pp. 6–12.

Appendix 4: Allocation of funding for HHF projects across electorates

Analysis on a two-party preferred basis

Basis for analysis

The ANAO examined the extent to which the allocation of funding across federal electorates was influenced by the distribution of votes at the previous election. Particular note was made of the distribution of funding to:

- electorates whose voting outcomes favoured the Government on a two-party preferred basis; and
- electorates which marginally favoured the Government or Opposition on a two-party preferred basis.

The ANAO recognised that particular funded projects address wider needs than those in their immediate vicinity. Examples include:

- translational research institutions, which could reasonably be expected to serve the interests of the state or territory in which they were located; and
- regional centres whose patients are drawn from a catchment wider than the electorate in which the facility is located. For example, the Toowoomba and South Western Queensland Regional Cancer Centre has a catchment population from the Federal electorates of Groom (the location of centre) and Maranoa, which covers the area of south-western Queensland.

The ANAO therefore examined the distribution of HHF project funding across electorate types, based on the catchment of projects, as well as the actual location of projects.

Approach

There are 150 Federal electoral divisions. The Australian Electoral Commission publishes the outcome of each Federal election, including the percentage of votes on a two-party preferred basis by division. The two 'parties' that the Australian Electoral Commission uses for its classification are: the Australian Labor Party (ALP) and the Liberal/National Coalition (Coalition).

The Australian Electoral Commission also determines the 'seat status' of each division, classifying seats as: 'safe'; 'fairly safe' and 'marginal'. Where a winning party receives less than 56 per cent of the vote, the commission

classifies the seat as 'marginal', 56–60 per cent as 'fairly safe' and more than 60 per cent as 'safe'.

The ANAO identified the electoral division in which each project was located, and those of broader catchment areas where applicable, and the outcome of the election prior to the decision on funding; that is, the 2007 Federal Election for Rounds 1 and 2, and 2010 Federal Election for Round 3. The HHF project funding in each of the electoral categories based on the 'two-party by seat status' classification, was identified for location and catchment analysis. Where a catchment covered a number of electoral divisions, the project funding was equally distributed across the divisions.

The ANAO compared the distribution of HHF funding across the 'two-party by seat status' classification with the percentage of electoral divisions in each of the classification categories. In order to account for differences in outcomes between the 2007 and 2010 Federal Elections, the percentages of divisions which fell into each category at each election were weighted by the percentage of funding allocated following the 2007 and 2010 Federal Elections respectively. In particular, the 2007 results were weighted by .704 to reflect the funding allocated to projects from Rounds 1 and 2 as a percentage of funding across the three rounds. Consequently, the 2010 results were weighted by .296.

Results

Table A 5 shows the distribution of HHF funding based on the location of projects across the electoral division categories current at the time that each project was announced.

Table A 5

Distribution of HHF funding based on project location across electoral division categories at time of project announcement (percentage of total funding across three rounds)

Election outcome on a two-party preferred basis	Seat status (per cent)					Total funded amount ($m)
	Safe	Fairly safe	Marginal	NFS[1]	Total	
Australian Labor Party	27.7	12.2	11.3	2.3	53.5	**2405.0**
Coalition	13.7	6.3	16.7	2.0	38.6	**1735.9**
Split across electorates[2]	0.0	0.0	0.0	7.9	7.9	**355.6**
Total	41.4	18.5	27.9	12.1	100.0	**4496.5**
Total funded amount ($m)	**1861.8**	**832.3**	**1256.5**	**545.9**	**4496.5**	

Note 1: NFS – not further specified. This refers to funding for proposals with locations that span more than one electoral division, and each of these electoral divisions are held by a single party but differing status classifications.

Note 2: Funded proposals with locations that span two or more electoral divisions that are not held by a single party are categorised as 'split across electorates'.

Source: ANAO analysis of DoHA data and Australian Electoral Commission Federal election information.

Table A 6 identifies the distribution of HHF funding based on the catchment of projects across electoral division categories current at the time that each project was announced.

Table A 6

Distribution of HHF funding based on project catchments across electoral division categories at time of project announcement (percentage of total funding across three rounds)

Election outcome on a two-party preferred basis	Seat status (per cent)				Total funded amount ($m)
	Safe	Fairly safe	Marginal	Total	
Australian Labor Party	17.8	12.4	18.5	48.6	**2185.3**
Coalition	18.5	10.0	22.9	51.4	**2311.2**
Total	36.3	22.4	41.3	100.0	**4496.5**
Total funded amount ($m)	**1632.2**	**1007.2**	**1857.1**	**4496.5**	

Source: ANAO analysis of DoHA data and Australian Electoral Commission Federal election information.

Table A 7 shows the distribution of electoral divisions across categories based on two-party preferred election outcomes and seat status. These results are weighted to reflect the percentage of funding allocated from the three HHF funding rounds that was announced when each of the 2007 and 2010 election results were current.

Table A 7

Distribution of electoral divisions across outcome categories, weighted by HHF funding allocated when election results were current

Election outcome on a two-party preferred basis	Seat status (per cent)				Electoral divisions (No.)
	Safe	Fairly safe	Marginal	Total	
Australian Labor Party	24.3	13.0	16.4	53.6	**80.4**
Coalition	13.7	12.3	20.3	46.4	**69.6**
Total	36.3	22.4	41.3	100.0	**150**
Electoral divisions (No.)	**54.4**	**33.6**	**62.0**	**150**	

Source: ANAO analysis of DoHA data and Australian Electoral Commission Federal election information.

Comparing results in Table A 5 with Table A 7, indicates that there was a slight pattern of distribution favouring funding proposals located in ALP electoral divisions, as 53.6 per cent of electorates were ALP on a two-party preferred basis, while such electorates had projects located in them valued at 53.5 per cent of HHF funding, not taking into consideration those proposals split across electoral division types, valued at a further 7.9 per cent. This slight pattern disappears though once the catchments for projects are taken into account. Table A 6 when compared with Table A 7, shows that HHF funding has a slight distribution towards funding proposals in electorates held by the Coalition on a two-party preferred basis. In particular, Coalition electorates benefit from 51.4 per cent of funding, while holding 46.4 per cent of the seats.

Across electoral divisions, Table A 7 indicates that 41.3 per cent of seats were marginally held. Table A 5 and Table A 6 show that the percentage of funding which went to such seats was 27.9 and 41.3 per cent on a location and catchment basis respectively. This indicates that in determining proposals, there was not a pattern of funding favouring those either located in or serving communities in marginal electorates.

Analysis on the electoral results

The ANAO undertook a second analysis similar to that above, based on the electoral outcome from the election preceding the funding decision, using the following types of electorates:

- Australian Labor Party;
- Coalition; and
- cross-bench.

Table A 8 shows the distribution of HHF funding based on the location of projects across electorate types current at the time that each project was announced. Excluded from this analysis is the funding committed to the Independent Members of Parliament to allow the Australian Labor Party to form government in 2010—these promises were for up to $240 million for the redevelopment of the Royal Hobart Hospital, and $75 million for the redevelopment and expansion of Port Macquarie Hospital, provided these projects were assessed as eligible by the HHF Advisory Board. These projects have been excluded from this analysis in recognition that the Government publicly announced its commitment prior to funding Round 3. However, as Port Macquarie Hospital ultimately received HHF funding of $96 million[200], the difference between the Government commitment and funding, $21 million, has been included.

[200] The NSW Government's subsequent application relating to the Port Macquarie Hospital upgrade sought an additional $21 million from the HHF—a total of $96 million for the project—which was assessed as meeting the evaluation criteria and was funded for $96 million. While the ANAO's analysis excluded the funding as originally agreed ($75 million), the additional $21 million in funding was included as part of the ANAO's analysis of funding against electorate types.

Table A 8

Distribution of HHF funding based on project location across type of electorates at time of project announcement (percentage of total funding across three rounds)

Electorate types	Total funded amount (per cent)	Total funded amount ($m)
Australian Labor Party	51.8 (57.8)[2]	**2165.0**
Coalition	34.3 (38.3)	**1436.3**
Cross-bench	3.5 (3.9)	**147.1**
Split across electorates[1]	10.4	**433.1**
Total	**100.0 (100.0)**	**4181.5**

Note 1: Funded proposals with locations that span two or more electoral divisions that are not held by a single party are categorised as 'split across electorates'.

Note 2: Percentages in brackets are estimates of distribution excluding funding split across electorate types.

Source: ANAO analysis of DoHA data and Australian Electoral Commission Federal election information.

Table A 9 identifies the distribution of HHF funding based on the catchment of projects across electorate types current at the time that each project was announced.

Table A 9

Distribution of HHF funding based on project catchments across type of electorates at time of project announcement (percentage of total funding across three rounds)

Electorate types	Total funded amount (per cent)	Total funded amount ($m)
Australian Labor Party	46.5	**1945.7**
Coalition	48.2	**2014.2**
Cross-bench	5.3	**221.6**
Total	**100.0**	**4181.5**

Source: ANAO analysis of DoHA data and Australian Electoral Commission Federal election information.

Table A 10 shows the distribution of electoral divisions. These results are weighted to reflect the percentage of funding allocated from the three HHF funding rounds that was announced when each of the 2007 and 2010 election results were current.

Table A 10

Distribution of electorate types, weighted by HHF funding allocated when election results were current

Electorate types	Seat outcome (per cent)	Electoral divisions (No.)
Australian Labor Party	53.2	**79.7**
Coalition	44.7	**67.1**
Cross-bench	2.1	**3.2**
Total	**100.0**	**150.0**

Source: ANAO analysis of DoHA data and Australian Electoral Commission Federal election information.

Comparing results in Tables A 8 and A 10, indicates that there was a slight pattern of distribution favouring funding proposals located in ALP electoral divisions, excluding funding split across electorate types. In particular, projects in ALP seats received 57.8 per cent of HHF funding while holding 53.2 per cent of seats. This slight pattern is changed in favour of Coalition seats, when the catchment of project is taken into account. Comparing the results in Tables A 9 and A 10, shows that the proportion of project funding for projects serving Coalition-held seats was 48.2 per cent while the Coalition held 44.7 per cent of seats. This indicates that in determining proposals, there was not a pattern of funding favouring those either located in or serving communities in government and opposition held seats.

Both on a project location basis and project catchment basis, funding slightly favoured those electorates whose members sat on the cross-benches in the House of Representatives at the time funding was announced. The proportion of seats held by those on the cross-benches is estimated at 2.1 per cent. Such seats received 3.9 per cent of HHF funding on a project location basis and 5.3 per cent of funding on a project catchment basis.

Appendix 5: ANAO methodology for determining the opportunity cost of interest foregone

Upfront payments

The basis of this analysis is a comparison of payment profiles submitted by proponents as part of their funding applications with the profiles reflected in executed funding agreements. Adjustments have been made to the amounts of funding when there are differences between funding applied for and funding as agreed by Government.

For each period, interest was calculated on the amounts paid (or expected to be paid) in that particular period less the amounts identified as being required by recipients for their projects in that period, plus any balances from the prior period. Unless specifically specified in funding agreements or applications, the ANAO has assumed that payments are made at the beginning of the period. Until the December quarter 2011–12, the rates of interest used were obtained from the quarterly Future Fund Portfolio updates. Subsequently, the interest rates have been based on the 3-month overnight index swap rate as at 23 March 2012, as published by the Reserve Bank of Australia[201] + 0.3% (4.42%). This is to reflect Health and Hospitals Fund Investment Mandate Directions 2009 issued by the Treasurer and the Minister for Finance and Deregulation, that states 'the Board is to adopt a benchmark return on the Fund of the Australian three month bank bill swap rate + 0.3 per cent per annum, calculated on a rolling 12 month basis (net of fees). In targeting this benchmark return, the Board should invest in such a way as to minimise the probability of capital losses over a 12 month horizon.'[202] The current rate has been used as it is broadly reflective of expected swap rates going forward given the relatively flat yield curve.

The resulting calculation of interest foregone across the total period was discounted to the net present value at the time of the finalisation of funding agreements. The Government bond yield applicable at the start of the project for a term that is most reflective of the expected project duration has been used as the discount factor.

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[201] Reserve Bank of Australia, *Interest Rates—Bank Accepted Bills—Interest Rates & Yields—Daily F1*. (See <http://www.rba.gov.au/statistics/by-subject.html> [accessed 27 March 2012].)

[202] See <http://www.comlaw.gov.au/Details/F2009L02893> [accessed 15 March 2012].

The methodology and the parameters to determine interest foregone were reviewed by an expert consultant engaged by the ANAO, with recommended changes applied as required.

Public-Private Partnerships

The basis of this analysis is a comparison of payment profiles as in the implementation plans and payment profiles whereby the Commonwealth pays the state government 20 annual payments of equal size totalling the same amount as that agreed by the Government. The 20-year period payments start at the time of construction commencing. All other aspects of the methodology are the same as used to determine interest foregone for upfront payments.

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Department of Health and Ageing

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